MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom  
Ronald Reagan Building  
International Trade Center  
1300 Pennsylvania Avenue, NW  
Washington, D.C. 20004

Thursday, December 6, 2018  
9:24 a.m.

COMMISSIONERS PRESENT:

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PROCEEDINGS [9:24 a.m.]

DR. CROSSON: We will now begin the December MedPAC meeting. For those of our guests, maybe some of you haven't been here before, this is the time of the year, December and January, when MedPAC takes up the issue of payment updates to those portions of the health care industry that Medicare pays directly. We focus in some cases on additional policy issues that relate to the payment update, but primarily the work for today, tomorrow, and then a portion of the January session will be recommendations to Congress, for the most part to Congress with respect to payment for the year 2020.

Our first discussion will be a discussion of payment updates for physicians and other health care providers, and as I mentioned, we have a policy issue in addition to discuss. Kate, Ariel, and Brian are here, and it looks like Kate is going to begin. Thanks very much.

MS. BLONIARZ: Good morning. This session will kick off the payment adequacy assessments for 2020. So in this session, Ariel and I will review the payment adequacy assessment for physician and other health professional
services and present the Chairman's draft recommendation.
And Brian will present a separate set of draft recommendations that you talked about last in October about payment policies for advanced practice registered nurses and physician assistants. And we'd like to thank Kevin Hayes, Carolyn San Soucie, and Emma Achola for their help putting it together.

Here is the Commission's payment adequacy framework that we use for all sectors. There are four key concepts: access to care, access to capital, quality, and Medicare payments and provider costs.

For clinician services, we directly measure beneficiary access using a telephone survey asking people about whether they can get the care they need, and we also review supply of providers and volume of services. We don't review access to capital, given the many small entities that make up the sector.

For quality, we look at a few population-based measures assessing some features of the ambulatory care environment. And I'll also give you an early read-out of Medicare's new value-based purchasing program.

Clinicians do not report their costs to the
Medicare program, so we don't calculate a financial margin. For the last category, we review differences in compensation and the ratio of Medicare's payment rates to private insurance payment rates.

This is some background on the sector. Total spending for clinician services in all settings was $69 billion in 2017, or 14 percent of fee-for-service benefit spending.

There are just under a million clinicians billing the program, and services provided by physicians and other health professionals in all settings are paid using the physician fee schedule under Part B of Medicare.

Under current law, there is no statutory update to the fee schedule conversion factor in 2020. But there is a 5 percent incentive payment for certain clinician participants in Advanced Alternative Payment Models.

For access, we rely heavily on a yearly telephone survey asking Medicare beneficiaries and individuals with private insurance about their ability to access care they need.

For many years, beneficiary access to clinician services has been stable and as good as or better than
access for privately insured individuals. That remains the case in 2018.

Some groups experience more trouble with access. In particular, minority beneficiaries -- black and Hispanic -- report waiting longer than they wanted to in order to obtain needed care than non-Hispanic whites.

There continues to be almost no detectable difference in reported access between rural and urban beneficiaries in the survey.

Here’s a longer time trend for one of the measures that we track, with Medicare on the left and the privately insured population on the right.

Overall, Medicare beneficiaries are less likely than privately insured individuals to report that they had to wait longer than they wanted for regular or routine care.

And you can also see here that there appears to be a bit of a secular rise over time among both groups since about 2012.

Moving to quality, MedPAC has established a set of principles for quality measurement in Medicare. The quality measurement should be patient-oriented, encourage
coordination, and promote change across the delivery system. Quality incentive programs should use a small set of clinical quality, patient experience, and resource use measures.

Along these lines, in your mailing materials we've reported national data for a couple of population-based measures. But those don't form a complete picture of quality in this sector, so we've generally reported that quality is indeterminate.

But I would also draw a contrast between the Commission principles and Medicare's current quality program. That program, the merit-based incentive payment system, or MIPs, assesses performance using measures chosen and reported by clinicians themselves. So there are a lot of process measures and a lot of measures with very compressed performance. And for these reasons and others, the Commission recommended eliminating MIPS in the spring of this year.

But here's a brief overview of how MIPS is working for the first year of the program. For year one, CMS set a very low MIPS threshold -- 3 points out of 100. Basically, clinicians had to report one measure to receive
a neutral or positive payment adjustment, and nearly all clinicians did so.

In particular, 24 percent of clinicians qualified for a positive MIPS adjustment, and an additional 71 percent qualified for a positive adjustment plus an exceptional performance bonus. And just to reiterate that, 95 percent of clinicians in the first year were above the performance threshold of 3 points out of 100.

Overall, as we generally predicted, MIPS does not appear to be a good or effective way of identifying high- or low-performing providers. And the process will get more complex, idiosyncratic, and arbitrary over time.

So I'll turn it over to Ariel for the rest of the payment adequacy assessment.

MR. WINTER: Another indicator of access is the share of clinicians who are in Medicare's participating provider program, which means that they agree to take assignment for all claims. In other words, they accept the fee schedule amount as payment in full.

In 2018, 96 percent of clinicians are in the participating provider program, and almost all claims are paid on assignment.
We also look at annual changes in the number of clinicians who bill Medicare. The overall number of clinicians -- not adjusted for enrollment growth -- increased in 2017.

When we account for enrollment growth, the total number of clinicians per beneficiary was about the same in 2016 and 2017.

The number of primary care physicians and specialists per beneficiary fell slightly, but the number of advanced practice nurses and physician assistants per beneficiary increased.

We also compare Medicare's payment rates for clinician services with commercial rates paid by PPOs. In 2017, Medicare's payment rates were 75 percent of commercial PPO rates, the same as 2016.

The next indicator of payment adequacy is volume growth. Volume growth accounts for both changes in the number of services and changes in the intensity or complexity of services. For example, the substitution of a CT scan for a plain X-ray represents an increase in intensity.

Across all fee schedule services, average annual
volume growth per fee-for-service beneficiary was 1.0 percent between 2012 and 2016.

In 2017, volume growth was slightly higher at 1.3 percent. This growth occurred while services were shifting from physician offices to hospital outpatient departments, which had the effect of dampening volume growth. So in the absence of this change in setting, volume growth would have been higher.

In 2017, growth by type of service ranged from 1.0 percent for evaluation and management services to 2.2 percent for major procedures.

Next we look at physician compensation.

In 2017, median compensation from all payers was much higher for some specialties than others, similar to prior years.

The specialty groups with the highest median compensation were radiology, at $460,000; the nonsurgical, procedural specialties, such as cardiology and gastroenterology, at $426,000; and surgical specialties, at $420,000. By contrast, median compensation for primary care physicians was $242,000.

Mispricing in Medicare's fee schedule for
clinician services may contribute to these income disparities. This is because primary care physicians tend to focus on ambulatory E&M visits, which are underpriced in the fee schedule relative to other services.

Addressing the mispricing in the fee schedule could increase payment rates for ambulatory E&M visits and reduce the compensation disparities among specialties.

In prior reports, the Commission has recommended ways to correct inaccuracies in the fee schedule.

To summarize our analysis, payments appear to be adequate. Access indicators are generally stable, as measured by our annual telephone survey, the share of clinicians who are in Medicare's participating provider program, and the number of clinicians billing Medicare per beneficiary.

Quality was indeterminate. The ratio of Medicare's payment rates to private PPO rates did not change, and there was an increase in the volume of services.

So the Chairman's first draft recommendation reads: For calendar year 2020, the Congress should update the 2019 Medicare payment rates for physician and other
health professional services by the amount determined under current law.

As Kate said earlier, current law calls for no update.

In terms of implications, there would be no change in spending compared with current law, and this should maintain beneficiaries' access to care and providers' willingness and ability to furnish care.

Now I'll hand things over to Brian.

MR. O'DONNELL: So, switching gears a bit, I'll now talk about Medicare's payment policies for advanced practice registered nurses -- APRNs -- and physician assistants -- PAs.

This work was started in response to Commissioner interest, expressed during our January 2018 meeting on rebalancing the physician fee schedule, and the Commission most recently discussed this topic at its October meeting.

In today's presentation, I'll provide some background on APRNs and PAs, their billing trends, and estimates of "incident to" billing before discussing the Chairman's draft recommendations.

Moving on to the background, the term APRN
includes four categories of clinicians: nurse practitioners, or NPs; certified registered nurse anesthetists; clinical nurse specialists; and certified nurse midwives.

APRNs are registered nurses with additional training, most commonly a master's degree. Similarly, PAs must graduate from a PA program, which is generally a post-baccalaureate master's.

States license APRNs and PAs and determine the activities that these clinicians can perform. Over time, states have substantially increased the authority and independence of APRNs and PAs.

Before I move to the next slide, it's worth noting that this presentation focuses on NPs and PAs because they are the two largest subgroups of APRNs and PAs, but I'd be happy to discuss the other types of APRNs on question.

This next slide provides an overview of the specialties in which NPs and PAs practice. NPs and PAs have historically been concentrated in primary care. However, they increasingly practice outside of primary care, in specialties such as dermatology and orthopedics.
In fact, recent estimates suggest that only half of NPs and 27 percent of PAs practice in primary care. Despite the variety of specialties in which they practice, Medicare has limited specialty information for these clinicians. For instance, Medicare classifies all NPs as one specialty. This shift in specialty selection is also important because it likely means that, over time, Medicare's "incident to" billing policy increasingly provides additional funding for specialty services.

So moving on to Medicare's billing rules, this slide walks through the basics of direct billing and "incident to" billing using a service performed by a physician assistant as an example.

If billing directly -- the left side of the graphic -- the service is billed with the PA's NPI, and Medicare's payment rate is 85 percent of the fee schedule amount.

If billing the same service under Medicare's "incident to" rules -- the right side of the graphic -- the service is billed with the supervising physician's NPI, and Medicare's payment rate is 100 percent of the fee schedule amount.
It's also worth noting that "incident to" billing is not allowed in all circumstances. For example, a PA's service provided in a hospital cannot be billed "incident to" and instead must be billed directly.

This next slide provides an overview of trends in allowed charges billed by NPs and PAs and the number of such clinicians that billed Medicare from 2010 to 2017.

I won't walk through all the details, but the number of NPs and PAs billing Medicare and the allowed charges they billed have grown rapidly from 2010 to 2017.

For example, over that time period, allowed charges billed by NPs tripled from $1.2 billion to $3.8 billion, an average growth rate of 17 percent per year.

These numbers only represent directly billed services. Therefore, the allowed charges and number of NPs and PAs are understated because of "incident to" billing.

While we know the numbers on the previous slide are too low, we don't know the precise magnitude of the undercount because Medicare claims don't indicate when a service is billed "incident to."

Therefore, to give the Commission a better sense of the prevalence of "incident to" billing, we conducted
two original analyses, both of which suggest that a substantial share of services performed by NPs and PAs are billed "incident to."

For example, we estimate that roughly 40 percent of Medicare E&M office visits that NPs performed for established patients in physician offices were billed under a physician's NPI in 2016.

In your mailing materials, we walk through a list of potential motivations for addressing "incident to" billing, and it's worth noting a few here.

At a very basic level, "incident to" billing limits transparency by obscuring policymakers' knowledge of who is actually providing care for Medicare beneficiaries.

"Incident to" billing could also inhibit accurate valuation of fee schedule services and increases Medicare and beneficiary spending.

These issues have likely been accentuated over time as the number of APRNs and PAs billing Medicare has increased dramatically.

Medicare's limited specialty information for APRNs and PAs may also create issues, especially as these clinicians increasingly practice outside of primary care.
For example, Medicare's limited specialty data impedes the program's ability to target resources towards areas of concern, such as primary care, and inhibits the operation of programs that rely on identifying primary care providers.

Given these issues, the Chairman has two draft recommendations related to APRNs and PAs, the first of which reads: The Congress should require APRNs and PAs to bill the Medicare program directly, eliminating "incident to" billing for services they provide.

In terms of implications for program spending, the draft recommendation would produce modest savings compared with current law.

The draft recommendation would also reduce beneficiaries' financial liabilities and is not expected to adversely affect beneficiaries' access to care.

In terms of effects on providers, APRN and PA services would be billed under their own NPIs instead of physicians' NPIs. And some practices that employ APRNs and PAs would experience a modest decline in revenues.

The Chairman's next draft recommendation reads: The Secretary should refine Medicare's specialty
designations for APRNs and PAs.

The draft recommendation is not expected to substantially affect program spending, beneficiaries' access to care or financial liabilities, or provider revenues.

This last slide summarizes the Chairman's three draft recommendations that Ariel, Kate, and I have discussed today.

In addition to comments on the draft recommendations, we are seeking feedback on any information or context the Commission would like to include in future write-ups of these draft recommendations.

With that, we look forward to your comments, and I turn it back to Jay.

DR. CROSSON: Thank you, Kate, Ariel, and Brian. I appreciate the presentation. We're now open for clarifying questions. Jon.

DR. CHRISTIANSON: I guess both of these are for Brian. So on your implications, I think I would add to that slide the good point that you made earlier, which is with "incident to" billing, we don't know who's delivering care to Medicare beneficiaries. That's one of the
implications there. And the other thing there's a question, under the Medicare Advantage Plan do we have any idea -- which now is, of course, a third of beneficiaries -- do we have any idea whether they're getting care from advanced practice nurse or PA versus a physician? Is there anything in the encounter data that tells us that or any way we can tell?

MR. O'DONNELL: So I don't know on that first point, but we did look at some MA plans' policies and whether they follow the "incident to" billing rules or not, and so a lot of plans do. MA plans do follow fee-for-service "incident to" rules, but we found a few examples where they didn't.

So to the extent you look at the MA data -- and I'm looking at my MA teammates. To the extent you did look, you would encounter some of the same issues that we have in fee-for-service.


DR. JAFFERY: Yeah. Just a quick clarifying question, and this is for Brian. In the mailing material, talking about some of the potential drawbacks for the last
point around special designations, but the point that APRNs and PAs might work across specialties, is there any evidence that that happens or to what extent it happens?

MR. O'DONNELL: So, no, I don't think we have that.

What we did is we went out and talked to folks. We did hear examples of this happening, and so that's why we put that in there.

DR. CROSSON: Kathy.

MS. BUTO: Ariel, I think this is for you. Have we always considered volume to include both units of service and intensity?

MR. WINTER: Yeah. So we've been doing this table --

MS. BUTO: For a number of years? I just haven't noticed?

MR. WINTER: -- this analysis at least since I've been here, which is 2001, and maybe that's about when it started. I'm trying to get Kevin's eye here. And we show both changes in units of service, which is simply that.

MS. BUTO: Right.

MR. WINTER: And we also show the changes in
volume, which is units of service multiplied by the RVUs for each of those services, which is a measure of intensity, volume and intensity.

MS. BUTO: Yeah. But we haven't shown them separately because they seem like very different factors, both the unit of service and then the intensity that may relate to increased use of technology or upgrading the nature of the service that's given.

I only bring this up because it seems to me that when we're looking at, down the road, issues around payment or even looking at appropriate payment, we want to better understand intensity versus increase in volume.

The paper points out that -- I think it is Care management has the highest percentage increase in volume, but it is really minuscule in terms of overall spending, expenditures in Medicare.

I'm trying to tease apart these different factors and how important they are.

MR. WINTER: So when you say show them separately, we currently show separately the change in units of service and the change in volume, which is a combination of both units and intensity. Are you
suggesting we should show separately --

MS. BUTO: Units and intensity.

MR. WINTER: -- the units from intensity?

MS. BUTO: Right.

MR. WINTER: Okay. We'll go back and think about that.

DR. CROSSON: Other questions? Bruce.

DR. PYENSON: Thank you very much.

I think this is a question for Brian. There is a very dramatic exhibit in the materials in Figure 6, which shows the updates and the fee for physicians year after year and the spending per beneficiary along with the Medicare Expenditure Index.

My understanding is the Medicare Expenditure Index, which had been used for physician updates, is based on a sole practitioner, the expenses incurred by sole proprietor physician working on his own or her own in an office.

I am not an expert in the area, but it seems if that's the case, it's not going to capture the kinds of changes with nurse practitioners and physician assistants that we've talked about. I'm wondering if that's even
appropriate on this table because it could be used in a misleading -- misinterpreted as saying here's what Medicare says the underlying costs are and look at how little physicians are getting. It's almost an apples-and-oranges. I wonder if you could address that, Ariel.

MR. WINTER: So the cost categories in the MEI come from the 2006 survey conducted by the AMI and specialty societies called the Physician Practice Information Survey, PPIS, and it included a wide range of physicians, physician practices, both employed and self-employed, solo, multi, solo in larger practices, and so my understanding is the AMI does reflect at least the cost categories reflective of a wide range of physician organizations.

That being said, the data are from 2006, and so, clearly, there have been changes in -- probably been changes in the structure of physician costs over time, and those changes are not -- because the MEI has not been re-based since then, it does not reflect those changes.

You did mention the influence of NPs and PAs, and beginning in 2014, CMS revised the MEI to factor in the increase in MPs and PAs who bill Medicare independently,
and they did so by increasing the physician compensation weight for that category to reflect NPs and PAs that bill independently starting in 2014. So they did try to account for that, and that was in response to a recommendation from the MEI Technical Advisory Panel.

Dr. Pyenson: Thank you.

Dr. Crosson: Okay. Jaewon.

Dr. Ryu: Thank you for a wonderful chapter.

I want to get back to Kathy's question around volume growth and teasing apart the units and the intensity. I think the other component I'd be curious about is mix, patient mix, disease burden.

I know you mentioned in the readings that age and sex, the demographics have not proven to be substantially impactful there, but disease burden itself, I'm wondering if we know anything about the interplay between that and the volume growth.

Mr. Winter: When we've looked at this in the past, there has not been a substantial relationship between change in disease burden and change in volume growth, but we can go back and see if there's more recent literature on that topic.
DR. CROSSON: Paul.

DR. PAUL GINSBURG: Yes. You mentioned that the practice expense information comes from a 2006 survey. Are there any plans to update that survey at CMS?

MR. WINTER: No plans. There are no plans as far as I know.

DR. PAUL GINSBURG: Well, this is really -- oh, go ahead.

MR. WINTER: We highlighted this issue in our June 2018 report chapter on rebalancing the fee schedule towards ambulatory E&M.

DR. PAUL GINSBURG: That's right. We'll leave it up to you as to whether it's worth another mention.

In a sense, this is -- we spend many, many billions of dollars a year in physician payments. We have a lot of problems with keeping the fee schedule up to date, and this seems to be -- given what a survey would cost, it seems to be a no-brainer that we should be doing these surveys much more often. I'm wondering if we could be influential by pointing this out and urging CMS to quickly and subsequently on a somewhat regular basis to be updating these data.
DR. CROSSON: I think that seems like a reasonable suggestion.

Sue.

MS. THOMPSON: Yes. Thank you for this chapter. I think my question is for Kate. Given the difficulty or maybe just the fact that MA has not penetrated, MA plans have not penetrated rural parts of our country, and it's thought and experienced that many times network adequacy has been an issue from a standpoint of access to specialists. But yet the surveys year after year show there's not a great deal of difference from surveying the Medicare beneficiary around access to both primary care and specialists.

So is that an issue of the rules of network adequacy with MA, or is it a component of the survey itself? Because network adequacy continues to be a challenge in terms of making MA plans available to rural parts of our country. So I'm just interested in your thought about that.

MS. BLONIARZ: I'm not sure about the MA piece of it, but what I would say about access is when Jeff did a fair bit of work on the rural, for the rural report, my
recollection is that service use is actually fairly similar between urban and rural. 

What we see in terms of reported access, what beneficiaries tell us seems to be similar, and there seems to be slightly clinicians in rural areas have higher volume, I believe, or see more patients in a day, which might kind of mitigate, if there are fewer providers in a region, and then also some beneficiaries in rural areas drive to suburban or urban areas for their care.

So that's kind of what I can recall just overall on access. I'm not sure about the MA network adequacy piece.

DR. CROSSON: Brian.

DR. DeBUSK: On a related note, does the survey capture whether the beneficiary is seeing an extender or an actual physician?

MS. BLONIARZ: So we've seen for years that beneficiaries in rural areas are much more likely to see an NP or a PA for all or most of their primary care. That's a trend or that's a pattern we've seen for a long time.

DR. DeBUSK: So it's safe to assume that there are a number of beneficiaries that are using an extender as
their primary care physician?

MS. BLONIARZ: Yeah, that's right.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: I am curious if primary care was easier for Medicare beneficiaries than those in private plans, that there were fewer problems, they had easier access to care.

Since Medicare doesn't pay as well, I assume, as primary care physicians who are paid under private insurance, why is it that there's less of an access problem for people seeing a physician under Medicare than private insurance?

MS. BLONIARZ: This is something I talked about a little bit in the mandated report that we have to do this year on physician payment and its relationship to these measures.

There is not a tremendous amount of correlation between payment rates and access, not like you might expect to see. So areas that have very high private payer rates, that's often because the provider groups have a lot of negotiating power. But it doesn't seem to translate to widespread unfettered access for whatever reason.
I think the other thing is that Medicare fee-for-service, at least among payers, is seen as a relatively good payer, not because of its payment rates, but because it doesn't usually have prior authorization or step therapy. There are no networks. The payment is relatively quickly.

So I think there are a couple of other things other than payment rates that seem to affect it.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: If I could add something, Marge. I remember back in the days of the Physician Payment Review Commission, there was a family physician from a small town in Texas. I think it was one of two physicians. In a sense, there is this dynamic of if you're in a large urban area, you can decide to see fewer Medicare patients and figure that they will still get care.

But if you are the only physician or one of the small number of physicians, not treating Medicare patients is akin to saying they won't get care. So I think it's just the culture, is, of course, we take care of everyone, including the uninsured.

DR. CROSSON: Okay. We're going to move ahead to
the discussion in a second.

I would like to make one point here because it was brought up in the presentation, and that has to do with the issue of adequacy of physicians to provide primary care services to Medicare beneficiaries.

Unlike some previous years, we don't have a recommendation this year directed to that end. That should not be read as the Commission forgetting about or taking its eye off this ball.

First of all, we have two standing recommendations from previous years, one from 2011 that is a recommendation to the Secretary to seek other data sources, particularly with respect to updating the time element of the physician payment formula where we believe over the years significant changes have taken place that, if corrected, would have the net result of redirecting more money to adult primary care services particularly.

Secondly, we have a recommendation standing to the Congress that was brought forward here in 2015 with the end of the physician primary care bonus that Congress had put in place for 5 years, that that be replaced by a per capita payment for the care or primary care. That has not
taken place so far.

It is our intention to continue to work on this issue, and the expectation is that within the next year or so, we will be coming back with more specific proposals and a reiteration of our position in this regard.

So let's move on to a discussion of the recommendations. If we could have the last slide up?

I think for purposes of time, even though we have both an updated recommendation as well as a policy change here, we'll take these together as opposed to dividing the question.

The discussion here should be directed at the recommendations. I would urge Commissioners, in making comments, to say, in effect, whether or not they support the recommendations or don't, and if there's a Commissioner who feels that they cannot support the recommendations, say why, and if possible, make a suggestion for how it could be improved.

So we'll take Paul first.

DR. PAUL GINSBURG: Yes. I'm glad you mentioned the previous work on primary care payments by the Commission.
I was thinking very much about the June 2018 chapter, which recommended for outpatient evaluation management services, that there would be higher rates coming out of the payment from other services by physicians, and I was wondering whether we can use this opportunity for our annual recommendation to Congress on payment updates to actually put in a concrete thing as to maybe 1, 2 percent increase for these evaluation management services and an offsetting decrease for other services that would be much budget-neutral rather than forgetting about, because unlike the previous year's recommendation about physician payment, the one in June 2018 really fits into an updated recommendation. So that's my comment there.

I'm supportive of the recommendations on the "incident to" billing.

DR. CROSSON: And, Paul, I apologize. I should have mentioned that as well as the other two.

DR. PAUL GINSBURG: Yeah.

DR. CROSSON: Go ahead, Jim.

DR. MATHEWS: Just to clarify, though, we did not make a formal recommendation regarding that rebalancing of the fee schedule. We proposed it as a potential way to
address some of the inequities that have evolved over time, given greater efficiencies of procedural services, but we didn't bring that to a vote in front of the Commission.

DR. PAUL GINSBURG: Well, then perhaps this would be an opportunity to bring it to a vote on basically using an incremental year-by-year basis to move in that direction.

DR. CROSSON: As a general policy issue, we like to kind of have continuity between what we discuss and present here as a recommendation in December and what we vote on in January. So I'd like to hear in the subsequent discussion, support for or lack of support for Paul's suggestion because if I come to the conclusion at the end of this discussion that that's something we should do, we will carry that forward into January. If not, we will not. Is that clear?

Okay. Kathy.

MS. BUTO: So to Paul's suggestion, I have no problem reiterating the June 2018 sense of the Commission, but I would have an issue of specifically recommending a certain increase in fees for E&M services because it's a complicated issue. And I think in June, we tried to say
this is multifactorial, so we wanted to bring back in
issues around the primary care bonus, a number of other
things that -- factors like we ought to take a broader look
at primary care supply. I think you would also want to
discuss the role of nurse practitioners and physician
assistants.

I just feel like it's a bigger conversation and
don't feel ready to just hone in on the fee because I think
the fee is only one component. So that's kind of where I
would be. Could be persuaded, but I sort of feel like this
would just be hitting at that one issue.

I support the recommendations. I would just like
to point out a couple of things. One is on the issue that
I raised before of the sort of bringing together of --
under volume, both intensity and units of service. The
reason I brought that up is this comes up in the context of
the payment update as a way to talk about volume, as a way
to talk about the adequacy of payment. And I think that's
appropriate, and it's well done.

What I feel like we may miss in a way is looking
at the flip side of this, which is if we could look
separately at units of service and intensity, we might be
able to identify some areas of high growth, where the reimbursement system is actually driving intensity more inappropriately, and areas where we might look from a policy perspective to better target policies in the future in this area, not in the payment chapter, per se. But I just want to make sure we don't lose that ability to hone in and assess what's really going on with total expenditures, units of service, and intensity as we look at appropriate payment, not just in the update.

And, secondly, I think I've said this before, but maybe not strongly enough, is I really have an issue with talking about compensation, total compensation. I think it's fine here, again, in the context of overall appropriate incentive to participate in Medicare and therefore provide access, but I don't think payment equity among primary care and specialty is the same thing as payment adequacy for primary care.

I don't think adequacy is a different issue than equity, and I don't think -- I personally am not for paying all physicians the same amount. And I don't think anyone is driving there, but the implication of our continuing to focus on compensation seems to imply that we want to drive
primary care at the same level of compensation as other specialties. And I don't think we'd say that, and I really don't want to support that.

So I just feel like we ought to tread there more lightly. I think it's fine in this chapter, but I do support the recommendation.

DR. CROSSON: Yeah, thank you, Kathy. Maybe it's an opportunity to clarify what we -- you know, what our compelling interest in here is. It is not paying all physicians the same, and I know you didn't really mean that. But it's not even -- to my mind, it's not even a sense of equity. The issue, I think, that we've been pursuing, and at least as I think about it is, to what degree is payment from the Medicaid program an important element in the choice of specialty that physicians coming out of medical school make? It's not the only element. We know that. There are other issues with respect to work-life balance, as it's currently called, and other things that make physicians choose certain specialties over another. But income, particularly in the face of debt burden, is one of those things.

From the perspective of the Medicare program, I
think it is in our interest to do the best we can to see that enough physicians choose adult primary care so that, over time, Medicare beneficiaries have a choice of from whom they would like to receive that care. And in many cases that care is provided, in an excellent way, by nurse practitioners, physician assistants, and other.

What I don't think we want to evolve as a country into a situation where a Medicare beneficiary that wants to receive primary care services in general, or certain primary care services from a physician, cannot because there are none. And that is the problem, I think, that we've tried to address over time.


DR. JAFFERY: Yeah, thank you. So to start off with addressing Paul's recommendation, and maybe building on what Kathy and Jaewon were just talking about in terms of adequacy versus equity, I do think that this is something that probably does require a bit more discussion. I think the question of whether we're trying to raise primary care compensation or whatnot to try and assure that there is an adequate workforce in the future versus thinking about something, through Paul's
recommendation, about redistributing towards E&M visits.

There is an issue that goes beyond primary care, and so the E&M visit one maybe helps get at that a little bit in that there are some other specialties, in particularly maybe some of the medical subspecialties that are also mostly E&M based, and I think we want to preserve access, adequate access to those specialists as well, or that workforce, going forward. So I think there is some nuance here that probably warrants some further discussion.

In terms of the three recommendations, I am supportive of them. The only thing I wanted to call out specifically was regarding number 3, refining the specialty designations, because this was talked about in the report, but pretty briefly. We talked about one of the benefits would be -- or one of the problems with the current system is that it inhibits some of the operations of programs that rely on identifying PCPs. We talked about that a little bit at a previous meeting but I just want to reiterate that that is a significant barrier, I think, to operating some of these programs. And so it wasn't really called out extensively in the discussion but it is, in my perspective, a pretty big deal, so I am very supportive of that piece.
DR. CROSSON: Okay. I saw Dana.

DR. SAFRAN: Thanks. Yeah. So I'll start by saying I am in support of the recommendations, and just to make a comment about how important I think one of the benefits of recommendation number 2, and ending incident billing, as well as recommendation 3, is that, you know, with payment reform have come, and we hope will come additional changes in the way teams are structured within care settings, and the whole idea of practicing to the top of the license and so forth to help drive efficiencies in care. And this will enable us to not only be blind to how that is unfolding and which types of clinicians are being used for which types of care, but also to then study how effective are different care patterns in terms of who is serving what purposes. So I am in full support of that.

On the issue that we're talking about, that Paul has raised, my thinking, like what Kathy and Jonathan have just outlined, is that it is a really important issue but I'm not ready for us to jump into recommendation about compensation for primary care. You know, I guess I'd reflect that over the last year, in particular, I hear kind of an increasing policy discussion about prices in the U.S.
as a big part of our cost problem, and so this notion that, gee, there is inequity and we have to bring primary care up to make it more fair, I think calls the question of is that the right direction? Is that where we have to go? And that then calls into question our training system and the kind of debt, you know, clinicians come out of training with.

And so I think you can't sort of address the issue in isolation. It's a very important one and one I think would be interesting and potentially quite important for us to address, but I think we have to do it in a pretty holistic way if we're going to do it at all.

DR. CROSSON: Thank you, Brian.

DR. DeBUSK: First of all, I support the recommendations as written and I want to take a moment and talk a little bit about number 2 and number 3. But first of all, to Paul's idea, I do think there is an opportunity here to at least include a placeholder recommendation of sorts that reminds the Congress that we have to do something, or do need to do something about primary care. To Kathy's point, I do think it's a very rich area, though. I don't think it's something that we could address
specifically in the payment update report. But again, I think it's an opportunity to at least include a placeholder there.

Dana, I really liked what you said about the role of teams and extenders and how that fits, and that really gets into my comments about number 2 and number 3. Getting rid of the "incident to" billing has been a long time coming. I think that's long overdue and I think it's excellent policy, for a number of reasons, not just for clinical reasons but also for data integrity issues.

I do have some concern that there's so much state-by-state variation in the role that these extenders play, and I think, again, Dana, to your comment about this team-based approach, I think there's an opportunity here to provide some standards and some direction on what are expectations are for these extenders. I mean, taking them from 100 percent, through "incident to" billing, taking them from 100 percent of the fee schedule down to 85 percent, at least in the non-hospital setting, again is good policy, but I would hope that we could also -- you know, I would even propose a fourth bold-faced recommendation here that would direct the Secretary to also
explore methods of allowing these extenders to complete
their degrees, some type of terminal degree where they
could become a licensed physician. And again, I don't know
the specific pathway there but I think that this would be
an opportunity for the Secretary to explore the
alternatives in some type of degree completion program.

So again, I support all the recommendations as
written, but I hope that we will explore a little bit more
around degree completion as well as what role do we expect
these extenders to play in a modern medical health care
delivery team.

Thank you.

DR. CROSSON: Brian, let me ask you a question.

While I understand the final point you made there it's kind
of hard to put something into a recommendation that we
haven't had a discussion among ourselves, or an adequate
discussion about. Would you be satisfied if that issue was
brought up in the text?

DR. DeBUSK: Absolutely, and to your point I
agree. We really haven't explored the role of the
extenders. But I do hope -- and, I mean, I'd love to get
other Commissioner feedback on potentially a recommendation
that would at least direct the Secretary to explore degree completion opportunities for these extenders.

DR. CROSSON: So let me just see if I understand. You're saying you want a bold-faced recommendation?

DR. DeBUSK: I'm throwing it out there as an idea, expected at least a few of my fellow Commissioners to tear it up.

DR. CROSSON: Okay. Well, we'll see if we can oblige you.

Paul, on this.

DR. PAUL GINSBURG: I'm very eager to get into this, Brian, because, you know, to me, with nurse practitioners and physician assistants, the success of that is that, so we've seen that there is a lot in medical care that people that are trained less extensively than physicians can productively do. And to take this and say, well, we just want it to be a path to becoming a physician by way of then going to medical school seems to defeat the entire purpose of these physician extender categories. So I am quite resistant about that.

DR. CROSSON: Well, it didn't take long, Brian, but go ahead.
DR. DeBUSK: Okay. If I can defend myself here. I'm not suggesting that all, or even a majority of these extenders should go on and do degree completion programs. It's frustrating to me to see people, to your point, who have demonstrated that they're very successful in delivering care. And the thought that if this person did want to go back and become a physician to say, "Hey, I've got a great idea. You're going to start over from scratch," as if you've never taken your first post-graduate class, and sit through medical school.

To me, it seems like there has to be a compromise there, because your only other alternative -- and this is why I had bundled it to some of Dana's comments about the team -- your only other alternative is to try to come up with a uniform standard of what these extenders can and can't do. And if I'm looking at someone who has been in the field for 10 years, very successful, very good at what they do, versus, say, someone who got their nurse practitioner degree in a 24-month Internet program, you know, it's hard to say, "Hey, here's a one-size-fits-all policy. This person can prescribe. This person can do procedures."
So, to me, it seems like there needs to be a step in there, at some level. But to your point, I don't think the majority of these people will do degree completion programs, nor should they.

DR. CROSSON: Okay. Over these, these recommendations here on the board here. Bruce, and then we'll go over here.

MR. PYENSON: I support the recommendations. I think they're really very good. I would welcome finding a way to introduce into the recommendation Paul's idea that the fee schedule has gotten out of sync because of productivity and other issues to the detriment of non-procedural techniques. So if we could find a way to introduce that, you know, with reference to the work we've done.

But I would support work along the lines that Brian has mentioned, on the different paths for the physician supply of the future. And I think that gets into some other issues of funding, and what Dana mentioned about, you know, the debt and how GME and IME and all of that works. So I think that's a really important issue for the future of the health care system. I'm not sure how to
fit it into this chapter, but I do support that.

DR. CROSSON: Well, let me just say. I usually
do this at the end but I just want to -- maybe this will
help, or not. Because I think where I'm going to go here
is suggest that in the chapter we have a text box that
takes on this issue of adequacy of primary care services,
and incorporates our recommendations from 2011 through the
Secretary, our recommendation 2015 to the Congress, the
recommendations with respect to, or the considerations in
the 2018 June report with respect to E&M services, and even
this potential -- because this would be about how do we get
more physicians available to Medicare beneficiaries for
adult primary care services. And Brian, you're suggesting,
which is there is, for some individuals, there this
additional pathway such that there would be more
physicians. So I can visualize a text box, you
know, going over what we've said before, some of the
considerations here in the discussion. But so far I don't
hear a consensus to change the recommendations on the
board.

Let's go for further discussion. Karen.

DR. DeSALVO: I'm not going to touch that third
rail, except in a slightly different way. So I support the
recommendations, I think particularly this issue around
"incident to" is an important one for us to address, and better understanding who is delivering care comes out of number 3.

I just want to call out what I see is a signal in some of the data around this issue of pipeline, because even where we were trying to solve -- if you're trying to solve for access through leverage PAs and NPs, it's clear to me from the data that they are migrating, also, to specialty care. So there's something fundamentally broken in the way that we're assessing what it costs, and all the meanings of that word, to practice primary care. And so I very much support this idea of better assessing not only the financial cost but then thinking about the care environment, which is to Paul and Dana's points about how quickly can we move to a care environment where it's really team-based and not so predicated on a fee schedule but really thinking more about global payment.

DR. CROSSON: Thank you, Karen. And again, this is an opportunity, I think, to be more specific. I said we were going to come back to this issue of pipeline. We
actually are this spring, so we will picking that up.

Sue.

MS. THOMPSON: I want to go on record in support of these three recommendations, and I particularly want to call out recommendation number 2, and recognize that these advanced practice nurses and PAs are playing an increasingly important role in terms of providing front-line primary care. And while I am not wanting to open up the discussion again about the third rail, I am quite intrigued with the third rail, because we have referred to them as physician extenders. They are becoming the face of primary care, and I think it is in that tension that we're feeling all of this. And I think we need to spend time thinking about -- and I think the data, as the "incident to" goes away and the data becomes much more clear about who is actually providing the care, I predict we will be quite impressed with that data, and I look forward to it. But I also look forward to the fact of advancing our conversations about the recognition and the role that these professionals are playing in our health care system today, because of our inability to fill these primary care slots.

DR. CROSSON: Right. And, Sue, thank you for
that, and again, it reminds me that -- and I think, to a certain degree, you're channeling a Commissioner who used to sit in that seat a lot of the time named Mary Naylor, who was the one who changed our typical language from physician update to physician and other providers. And so I think to the extent that we should be able to achieve, we should be using that terminology rather than physician extenders, and I thank you for that point.

Moving on. Marge.

MS. MARJORIE GINSBURG: I will touch the third rail just very briefly. Only my objection to the term "degree completion." I am a nurse. I have sister who is a nurse practitioner. She didn't go on from her RN degree to get a nurse practitioner degree, in order to step her way to be a physician. She has no desire to be a physician. And I think I'm sort of reflecting Sue's comments as well. There is a lot of obviously professional pride in the work they do, and to make this in any way appear that they are simply physicians that haven't yet happened yet is really a mistake.

However, having said that, the idea of -- and I can't believe there isn't already a medical school
somewhere who has -- I know there are medical schools who
take, I think it was Temple, that take people out of
college after their third year and move them immediately
and get a college degree and an MD in six years, that there
isn't a medical school that hasn't said, particularly to
master's-based nurse practitioners, those who are
interested, we can have you go through an MD program in X
amount of time, rather than --

I don't want to belabor that, but I did just want
to mention that.

I also wanted to mention I support all three of
these. I found it interesting that the rationale in the
report for getting rid of the "incident to" was not very
compelling to me. "Restrains policy-makers' ability to
evaluate the cost and quality of care by NPs and PAs,
derminating the accurate valuation of MD services, increase
costs" -- we get that -- "and raising program integrity
issues." Those other ones, this idea of increased cost,
feel very soft to me, and I wonder, assuming we go through
with this, that we're going to get incredible pushback, and
that a lot of programs are going to, you know, go to
Congress and say, "Don't take that out. You're going to
I say that only because I wonder whether there's -- I support it, but is there any compromise about capturing some of the -- mitigating some of the problems we have in the report while still getting what we think is reasonable and just, and that is that they are not using "incident to." I don't know if I've fuzzied that up, but just the rationale seems, except for the cost issue, seems fuzzy to me.

DR. CROSSON: So, Marge, let me be clear then, whether or not you support the recommendation and you'd like to see the justification clarified better, or you don't support the recommendation.

MS. MARJORIE GINSBURG: I do support it [off microphone].

DR. CROSSON: Okay.

MS. MARJORIE GINSBURG: [Comments off microphone.]

DR. CROSSON: Yeah, thank you. On that point, Brian?

DR. DeBUSK: First of all, your comment about the degree completion, I was using that term as remarkably tone
deaf, even by my standards.

[Laughter.]

DR. DeBUSK: So you will not hear that term come up again. You made an excellent point there.

And I think to your point earlier about the programs, the medical education programs, I think the difficulty would be in getting the programs accredited. So if you wanted to say, well, come in as a PA, come in as a nurse practitioner, we'll give you a certain amount of course credit already, we'll accelerate maybe your anatomy class or your physiology class because you already have that background, I think that's where I think the Secretary could provide maybe some insight working with accrediting bodies and trying to develop that alternative pathway.

DR. CROSSON: Okay. Let me see where we are. On this same point? Or we have got hands -- okay. I had Dana first, then Jon, then Kathy.

DR. SAFRAN: So on the third rail -- and I know we're not trying to solve this today, but I also know it's a compelling point and we're going to take it away and think about it. So the thing I just want to get on the table, which I think was a little bit of where Paul was
coming from in reacting, is, you know, that part of what
we're learning by having the team-based care is that not
everything needs the skill and knowledge of a physician.
And so the idea that we need to sort of move more
clinicians along that pathway to that degree is one that I
just have to question. You know, we've talked over the
past many months about the emerging understanding of the
importance of social determinants of health and, in fact,
that physician training is very poorly adapted and current
delivery systems very poorly adapted to address those; that
nursing training comes closer; that community health
workers come even closer.

So before we sort of decide that we need to
enhance the physician workforce by, you know, moving people
who have other kinds of training along, I just think we
also need to give thought to how are we actually going to
produce more health in the population, and what is the
workforce we need for that, as opposed to how are we going
to produce more health care services.

DR. CROSSON: Okay. Jon and Kathy, and then I
think -- and Jaewon, and then we're going to wrap up.

DR. CHRISTIANSON: I support the recommendations.
I have a couple comments or thoughts. I think it's a good thing to know who's delivering care. I wasn't reassured by Brian's comment, but I think this will help us know who's delivering care for two-thirds of our beneficiaries, but not for another third who are in MA plans. So I'm not sure how that all works out or how we get that. We talk a lot about being able to compare in the future, MA plans versus fee-for-service and these sorts of things. So I wish we would be able to get more information there.

The other thing I would say is that this whole discussion, kind of there's an elephant in the room here, which is, you know, really if nurse practitioners and PAs are delivering the same -- up to the top of their license, delivering the same quality care as physicians, why don't they get paid the same? I mean, what's the point of this 85 percent versus 100 percent thing if the care is the same in many cases? So that's probably a next step we're going to have to deal with.


MS. BUTO: I just wanted to make a comment back to Karen's comment about the migration of nurse
practitioners and PAs to specialty. Just family experience recently with both cardiac surgery and neurology, nurse practitioners are really performing E&M services even for specialty that are invaluable. So I want to make sure that as we look at this issue, we don't look to discourage that substitution, because that's a useful substitution as well, I think.

DR. CROSSON: And Jaewon.

DR. RYU: So it's that migration that I think I'm a little bit concerned about. I support the recommendation. I do wonder, especially as it pertains to hospital systems and multispecialty groups, whether this has some impact on how they choose to allocate nurse practitioners and PAs to different areas of the delivery system and how that may have an unintended consequence on the primary care areas of those systems, because I think the economics fundamentally change when the reimbursement — that 15 percent drop currently in the hospital world, you know, you don't have "incident to" billing, well, now you have parity between what the revenue would be for those services. And I don't know how that plays out or comes out in the wash, but that unintended consequence, it would be
good to understand a little bit of that, although I am
still supportive of the recommendation.

DR. CROSSON:  Okay.  Yes, Paul.

DR. PAUL GINSBURG: Responding to Jon with his
raising the issue of what happens in MA, is there a way to
state this recommendation in a way that it would apply to
MA as well?

DR. CROSSON: Jon, do you want to --

MS. BLONIARZ: I think we should probably check
with the MA people. Generally, I think stuff like this is
at the plan's discretion.

DR. CHRISTIANSON: In the encounter data? Would
you have to require that the MA has a code that says this
kind of provider -- you'd have to really go back and --
Jeff is shaking his head, so that's not there now. And so
I think this is a whole other discussion, Paul.

DR. CROSSON: Okay. So that could be a later
consideration.

I think we do need to move on. Let me tell you
what my conundrum is, and that is whether or not we come
back in January for a full presentation and full discussion
or we do this in the expedited way. Normally speaking, one
of the considerations is if there's not agreement on the
recommendations and, you know, we need to tweak them, then
we'll bring it back.

Here we don't have that, but what we've got is,
you know, some extensive attendant discussion around
emphasis in the chapter and other things of that -- a lot
of it having to do with this issue of primary care and
other providers and the like. We could bring it back again
in January and have that discussion. I'm not inclined to
do that because we're going to have that discussion right
away in March and April. And I think if we simply do that
again and then try to do it again, we've not made the best
use of the staff time.

So my inclination here, since there is, I think,
pretty much unanimous support for the recommendations that
we've got, is to assume that with some changes in the text
that have been suggested, including the emphasis around
primary care and E&M that were mentioned, that we assume we
have Commission support here for the recommendations and,
therefore, we'll have an expedited presentation in January,
and we will then take on the pipeline issue and some of
these other issues that have been brought up in -- what is
it? -- March or April, either March or April. But I want
to see if there's any objection to that.

[No response.]

DR. CROSSON: Seeing no objection, that's what we'll do. So thank you, Kate, Ariel, and Brian, for the presentation. This was a good discussion, and thanks to Commissioners, and we'll move on.

[Pause.]

DR. CROSSON: We're going to move on now to the second item of business for the December meeting, and that's assessment of the payment adequacy for ambulatory surgical centers, Dan and Zach. And it looks like, Dan, you're going to begin, right?

DR. ZABINSKI: Yes.

DR. CROSSON: Thank you.

DR. ZABINSKI: I'm doing the talking. Of course, all the mistakes are Zach's.

[Laughter.]

DR. ZABINSKI: In our assessment of payment adequacy for ambulatory surgical centers, we use the following measures: access to care, as measured by the capacity and supply of providers and the volume of
services; aggregate Medicare payments; and access to capital. Also, we have quality data for evaluation; and, finally, we're able to use margins or other cost-based measures because ASCs don't submit cost data to CMS.

Important facts about ASCs in 2017 are that:

Medicare fee-for-service payments to ASCs were nearly $4.6 billion; the number of fee-for-service beneficiaries served in ASCs was 3.4 million; and the number of Medicare-certified ASCs was about 5,600. Also, the ASC conversion factor will receive an update of 2.1 percent in 2019.

Finally, most ASCs have some degree of physician ownership, and corporate entities such as hospital systems have shown growing interest in owning ASCs.

We think it is important to compare ASCs with hospital outpatient departments because HOPDs are the setting that's most similar to ASCs and the ASC payment system is based on the outpatient prospective payment system.

There are some benefits to having surgical services provided in ASCs rather than HOPDs because ASCs offer efficiencies over HOPDs such as shorter waiting times for patients and greater control over the work environment.
for physicians.

In addition, ASCs have much lower Medicare payment rates than HOPDs, which can result in lower payments for Medicare and lower cost sharing for patients. However, encouraging greater use of ASCs should be considered alongside studies that show that the presence of ASCs in a market is associated with greater volume of surgical procedures.

Finally, we have found that there is very low concentration of ASCs in rural areas and in some states, especially Vermont.

In our assessment of payment adequacy, we use the measures that we presented on Slide 2. Also, once again we are not able to use margins or other cost-dependent measures because ASCs don't submit cost data to CMS.

On the table, the values for measures of payment adequacy in the second column indicate growth in the ASC setting in 2017.

As we see, the number of fee-for-service beneficiaries served increased slightly, and the volume of services per fee-for-service beneficiary, the number of Medicare-certified ASCs, and Medicare payment per fee-for-
service beneficiary had strong growth.

In particular, the very large increase in payments per fee-for-service beneficiary was largely due to a strong increase in the complexity of services in ASCs.

To evaluate ASCs' access to capital, we examined the growth in the number of ASCs because capital is needed for new facilities. A positive growth of 2.4 percent in the number of ASCs in 2017 indicates that access to capital has been adequate.

Also, there has been a fair amount of acquisitions and partnerships with ASCs by hospital systems and other health care companies. But keep in mind that the number of ASCs involved is less than 15 percent of all ASCs.

Also, it is important to understand that Medicare is only a small part of ASCs' total revenue, perhaps 20 percent. Therefore, Medicare payments may have a small effect on decisions to create new ASCs.

We have data from 2013 through 2016 from the ASC Quality Reporting program, or the ASCQR, and most of the quality measures showed slight improvement during that period.
However, some measures, such as the share of average risk patients that had the appropriate follow-up interval after a colonoscopy, are well below the maximum of 100 percent, so there is room for improvement.

We believe CMS should strengthen the list of measures in the ASCQR. In recent regulatory action, CMS decided to discontinue six ASCQR measures. In response, CMS could expand the list by adding claims-based outcomes measures because the current set of outcomes measures in the ASCQR do not apply to all specialties that are practiced in ASCs.

Also, we are concerned about CMS' decision to delay use of the CAHPS-based patient experience measures. One of the Commission's principles for measuring quality is that patient experience should be included, and the CAHPS measure would satisfy that principle.

Finally, the Congress should consider the Commission's 2012 recommendation to implement a value-based purchasing program for ASCs.

To summarize our ASC findings, indicators of payment adequacy suggest access is good. In 2017, all four of the measures of payment adequacy improved.
The increase in the number of ASCs suggests that access to capital is good, and corporate entities such as hospital systems have obtained and invested in ASCs.

Quality data show slight improvement in most measures, but the measures used in the program should be strengthened.

We remain concerned that ASCs don't submit cost data, even though the Commission has recommended several times to do so. We see no reason why ASCs should not collect and submit cost data, as other small providers such as hospices and home health agencies furnish cost data.

Moreover, ASCs in Pennsylvania submit cost and revenue data each year to a PA state agency without any apparent adverse effects.

Before moving to draft recommendations, we want to discuss an important regulatory change.

From 2010 through 2018, CMS based the update to the ASC conversion factor on the consumer price index for urban consumers, or CPI-U.

But for 2019 through 2023, CMS has decided to base the update on the hospital market basket, which is almost always higher than the CPI-U. During that period,
CMS plans to assess the possibility of collecting cost data from ASCs.

The reason for the regulatory change is that CMS is concerned that the large differences in payment rates between the ASC and the HOPD payment systems has caused services to migrate from ASCs to HOPDs. And CMS believes that using the higher hospital market basket will encourage services to migrate back to ASCs.

In its 2018 comment letter on ASC payments, the Commission disagreed with using the hospital market basket to update ASC payments because the cost structure is very different between ASCs and HOPDs.

Also, the Commission sees no reason why ASCs should not submit cost data, so CMS should use its authority and collect cost data immediately.

For the Commission's consideration, the Chairman has the following draft recommendation: The Congress should eliminate the calendar year 2020 update to the conversion factor for ambulatory surgical centers.

Given our findings of payment adequacy and our stated goals, eliminating the update is warranted. This is consistent with our general position of recommending
updates only when needed.

The implications of this recommendation for the Medicare program is that it would produce small savings. The anticipated update for the ASC conversion factor is 2.6 percent for 2020, and anything less than that will produce savings.

We anticipate this recommendation having no effect on beneficiaries' access to ASC services or providers' willingness or ability to furnish those services.

Now, the Commission has wanted ASCs to collect and submit cost data for several years, and the Secretary has the authority to do it. Therefore, the Chairman has a second draft recommendation: The Secretary should require ambulatory surgical centers to report cost data.

Collecting these cost data, as Medicare does for other providers, would improve the accuracy of the ASC payment system. The Secretary could limit the burden on ASCs by requiring a cost report that is limited in scope. Implementing this recommendation would not change Medicare program spending, and we also anticipate no effect on beneficiaries. But ASCs would incur some
additional administrative costs.

So that concludes our presentation, and we appreciate your time. We would like to open up the session to discussion about our analyses and the draft recommendations.

DR. CHRISTIANSON: Okay. Do we have clarification questions? Apparently, Zach is taking notes. [Laughter.]

DR. GRABOWSKI: Great. Thanks for this chapter, and I'm glad you raised the issue of the lack of cost data. I find that frustrating. It was frustrating last year when I first learned that, and I'm still frustrated by it. I'm intrigued by the State of Pennsylvania. You noted the all-payer margin in Pennsylvania is 25 percent. So two questions. First, does the state calculate a Medicare margin?

DR. ZABINSKI: No, they don't.

DR. GRABOWSKI: Two, could we get those data and actually calculate that ourselves? Could we do more with that data to kind of analyze it?

DR. ZABINSKI: The agency that does it, the Pennsylvania Health Care Cost Containment Commission, I
think it is, or Council -- whatever -- they were forthcoming in, you know, supplying me kind of the raw cost and revenue data, the aggregates for each ASC. I'm not sure how receptive they would be to -- you know, or if they even collect it by type of payer. So I'm not sure what sort of Medicare margin we'd be able to get. I could look into it, though.

DR. GRABOWSKI: Just to follow up on that, it seems like this could be a nice data resource, given all that's out there right now. Are some data better than no data? And so I would just push us to try to go as far as we can with those data.

DR. CHRISTIANSON: Kathy.

MS. BUTO: So two questions, Dan. One is, I think on Slide 3, you point out that there's a greater corporate interest in ASCs, meaning, I guess, hospitals are getting more interested in acquiring ASCs. Do we have any concern about physician ownership of ASCs? I know they're exempt from the Stark rules, and I know the administration is looking at liberalizing physician ownership and/or reducing the scope of Stark. I think you pointed out that, where they exist, there is an increase in volume. So I'm
just wondering if we think that's an issue, and I'm trying
to match that up with the issue of more corporate
ownership. Is that good or bad? Is that a substitution
for OPD? What's your perspective on that?

MR. GAUMER: I don't think we've ever kind of
criticized the physician ownership component of ASCs in
particular, but we are seeing fairly significant growth in
hospital ownership of ASCs, and it appears to be the big
guys, the large national chains that are getting into it,
and also private equity firms that are making large
acquisitions of --

MS. BUTO: Okay, so not hospitals.

MR. GAUMER: Pardon?

MS. BUTO: I thought you mentioned hospitals.

MR. GAUMER: Yeah, so large hospital associations
-- or hospital systems. Tenet in particular was one this
year that's doubled down on ASCs quite a bit.

MS. BUTO: That would seem to at least suggest a
shift to a lower-cost setting from the OPD, but maybe it's
just an increase in overall volume of services.

MR. GAUMER: And that is what we are reading in
their annual filings with the SEC, that it's typically a
push to try to lower volume -- go to a lower-value setting
to try to --

PARTICIPANT: Lower cost.

MR. GAUMER: Excuse me, lower-cost setting. Wow.

Lower-cost setting to try to get with the population health
trends.

MS. BUTO: Okay. And then the last question is
on Slide 5. Dan, I think you mentioned the Medicare
payment per fee-for-service beneficiary number, the change,
7.7 percent. That is at least partly due or largely due to
an increase in complexity?

DR. ZABINSKI: Yeah --

MS. BUTO: So let me -- so back to -- and then
volume per fee-for-service beneficiary, fairly small change
increase. So you haven't in this case, unlike the
physician payment area, you're not combining intensity or
complexity with volume, correct?

DR. ZABINSKI: No, we're not.

MS. BUTO: Okay.

DR. ZABINSKI: The large growth in the payment
per beneficiary, it's sort of a confluence of a number of
factors that -- the volume increase is actually
historically pretty large. There's the large increase in
the complexity of the cases, and also the payment update
was pretty large, relatively speaking, to previous years in
ASCs, and they all kind of combine together for a very
large increase overall when you put it all together.

MS. BUTO: Thanks.

DR. CHRISTIANSON: Other questions of
clarification? Pat and Bruce.

MS. WANG: On Slide 9, Dan, you talked about the
change in using the hospital update versus the CPI-U, and
the reasons are stated in the middle. CMS was concerned
about different payment rates and wanted to shift more back
to the HOPD setting. I don't under -- can you say more
about that? Why is that considered desirable? How was
that supposed to happen? Was there an assumption that
physician referral patterns would change? And why --

DR. ZABINSKI: Yeah, it's a case of they want to
increase the ASC payment rates relative to the HOPD, making
that sector more attractive. I think it's pretty much as
simple as that.

MS. WANG: Why? If the ASCs are providing the
same services at a lower cost, why would CMS be interested
in inflating expenditures for the service?

DR. ZABINSKI: I think the concern -- there was, starting about 2012 through, say, 2016, there was a pretty good slowdown, even a slight decrease in some years, in the volume that's occurring in ASCs, while the HOPD was seeing pretty strong growth in the ambulatory surgical procedures. And I think CMS got concerned about it and wanted to find a way to get more services done in the cheaper setting. You know, increasing the ASC payment rates at the same rate as HOPDs really kind of, you know, narrowed the difference between the two payments, but it's not going to make it any larger. And I think that's sort of the -- they want to sort of stem the tide essentially of a shift from -- at least what they think is occurring from ASCs to HOPDs and try to get the shift to go back.

MS. WANG: Okay. I take that on face value. But it kind of is a segue to my second question about without cost data in an am surg center, these are all just proxy considerations for what things might cost or how much they might be increasing. It's detached from the reality of actual information. As David said, every year that we've talked about this, everybody gets frustrated. And I know
that when we have made firm statements to the effect that
ASCs should file cost reports, we get pushback from the
industry that says, "Well, we do file a lot of cost
information."

Can you help us parse that? Is there information
that is being filed now with Medicare that would allow some
understanding of costs and cost growth and allow the
calculation more accurately of Medicare margins? And, you
know, it's just baffling that a whole sector doesn't file
cost information, so it's a clarification question for you.

DR. ZABINSKI: I'm not aware of any information
that the ASCs furnish to CMS that would allow us to
determine what their costs are. As I said, the ASCs in
Pennsylvania, to my knowledge that's the most complete
information that's available, and I really haven't seen
anything beyond that.

MR. GAUMER: And this is why we turned to
Pennsylvania. You know, we also look at SEC filings, like
I said before, and a lot of the ASC companies that are
publicly traded have other lines of business that are
embedded into those filings as well. So it's even hard to
pull the ASC piece of that business out from other
physician practices that they may own and that kind of a thing. So we really are handcuffed.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Thank you very much. I've got two very different questions. On Table 5-5 of the material, there's a list of the common surgical service, and just a couple of questions about that. We have talked about services potentially migrating from or to hospital outpatient am surg centers, but many or maybe even most or all of the services listed here could also be performed in physician office. So in addition to the differential price between hospital outpatient and am surg, there's probably a cost differential with physician office as well. And that's -- I'm not sure if we've addressed that and what the implications are for that in the report.

A related issue is imaging isn't on here in the list, and I believe the Medicare fee schedule for imaging doesn't distinguish between -- there's no separation between physician office and freestanding imaging center. They're considered the same. And if that's the case, my impression is there's a lot of imaging that's done with the code indicating an ambulatory surgery center, and why
that's not in here. So that's my first set of questions around what goes on.

DR. ZABINSKI: All right. Let's see. On the imaging, well, okay. The Medicare ASC payment system, imaging services are -- they have their own lines in terms that they have their own payment rate and that sort of thing.

We gathered the information from the ASC claims, and the number of imaging services is very small. Maybe there's a distinction between what CMS defines as an ASC for the purposes of its payment system and what you're thinking of as an ASC in terms of the types that furnish a lot of imaging services. That's the only explanation I have for that.

DR. PYENSON: I'll just shift from physician office, the differential fees, where it's purely a physician component, of course, if it's a physician office versus moving to an ASC.

So, for example, colonoscopies can be performed in a physician office, and there's no facility fee for physician office versus what we're seeing on Table 5-5. Presumably, there's, of course, a professional component
plus there's a facility fee.

In this analysis, it seems like we haven't looked at those differentials.

DR. ZABINSKI: No, we haven't.

We have considered just going in that direction, but the only thing we ever considered is that -- a number of years ago, we considered, compared ASC and HOPD in terms of site-neutral payments between the two, but we haven't really thought about the physician office in ASC component.

MS. BUTO: Dan, just a clarification on Bruce's point. Maybe it doesn't exist anymore, but there used to be a rule that if something was done more than 50 percent of the time in the physician's office, it was not eligible for ASC payments. I don't know if that's still there or not.

DR. ZABINSKI: Yeah. What they do is they pay the lesser of the standard ASC rate or the non-facility expense rate from the physician fee schedule for those services that are done more than 50 percent of the time in physician offices.

DR. CROSSON: Okay. Bruce, do you have more?

DR. PYENSON: One different question. On page 30
of the materials, there's a bullet. This is talking about the cost report. I'll read it: Total charges across all payers and charges for Medicare patients. CMS could allocate total facility cost to Medicare based on Medicare's proportion of total charges. This is where you're describing a cost report. That seems to imply using the current charges-based infrastructure of Medicare cost reports; for example, the hospital Medicare cost report or others.

But do you know if ASCs even have such a thing as a charge master? Because that seems to be implied in that.

DR. ZABINSKI: I'm not aware of it.

MR. GAUMER: Yeah. We've never heard of a charge master that goes across systems of ASCs or anything. No.

DR. PYENSON: So what does that mean in terms of the recommendation to use the charges-based system?

DR. ZABINSKI: Well, this is just -- I wouldn't call that a recommendation. It's a thought in the direction one might go. This is a really unknown area. It's really a black box, and it's going to have to be worked out.

DR. CROSSON: Excuse me, Dan. I think Bruce is
referring to recommendation No. 2.

DR. ZABINSKI: Collecting cost data, yes.

DR. CROSSON: Collecting and report cost data.

DR. ZABINSKI: Right.

DR. CROSSON: Right.

DR. ZABINSKI: But in terms of using charges, that's not -- in and of itself, we're saying it to use charges and not a recommendation. It's a thought of here's how one might get started on it.

DR. CROSSON: Oh, I see. All right. I'm sorry. Bruce, did I misinterpret what you were saying?

DR. PYENSON: Well, I think you're both right.

DR. CROSSON: Okay. It's unusual.

DR. PYENSON: In the later conversation, I'll have a suggestion.

DR. CROSSON: Okay. Brian. Brian and then Dana.

DR. DeBUSK: I have two clarifying questions, but I'll ask the first one first. On Chart 9, could you walk me through from the moment the ASC schedule -- and I've seen -- we've done this before, and I've read it before, but I'd like you to walk me through. From the moment they started the ASC fee schedule, it was a percentage of OPPS
fee schedule, from the moment they carved it out. Could you walk me through roughly what percentage that was and then how it's evolved over the lifetime with different -- because I know one gets CPI-U updates. One gets market basket updates.

So if you could just -- for a clarifying question, where did they start? And describe their trajectories over, say, the last eight to ten years.

DR. ZABINSKI: Well, initially, my recollection is back in 2008 when the current version of the ASC payment system was established, it was about -- ASC payment rates were about 65 percent of HOPD rates.

Since then, well, it's been a slow, steady decline over time, and now in the area of 52 to 53 percent.

DR. DeBUSK: Okay. So at 52 percent, every time a case moves from the HOPD to the ASC, the program enjoys about a 48 percent savings on that case?

DR. ZABINSKI: Correct.

DR. DeBUSK: Okay. Well, then here's my second question. I want you to check my math, and this is not a rhetorical question. It's legitimate. If you're looking at a 2.6 percent update on a $4.6 billion spend, I've got
that as $119 million, round numbers. If I'm going to save
52 cents on the dollar, what I need to do is convert about
$260 million worth of HOPD business to get my 2.6 back,
right? 260, if I take 48 cents on the dollar of that in
savings, that will get me to my 119.

So if I'm looking at $260 million and the OPPS spend is $66 billion, all I need to do to get my 2.6 back
is to convert 0.4 percent of the HOPD spend to the ASC, and
all of a sudden, I'm back in the black. Do those round
numbers make sense?

DR. ZABINSKI: I will completely defer to you on
that. They seem reasonable to me.

DR. DeBUSK: Again, this is why I wanted someone
to check because I've been playing with these numbers, and
it just seems if we do advance the schedule, if we give
them a 2.6 percent update and we only have to get one-half
of 1 percent or less than one-half of 1 percent of these
procedures shifted, it seems like an overwhelmingly easy
decision to make.

DR. SAFRAN: Except that very little gets
shifted, and it's just increased new volume and new
capacity. That's the question.
DR. DeBUSK: Well, is it inducing volume? I think that's a legitimate question, but that's a Round 2.

DR. PAUL GINSBURG: Yeah. I mean, I think that's a great question.

DR. RYU: Or would it shift anyway, even in the absence of the 2.6? I think that's the other question.

DR. ZABINSKI: I would say the data we have for 2017, one could argue it's only one year. I don't want to draw any conclusions from it, but the growth in the ASC, the services that are covered under the ASC system was much stronger in ASCs than it was in HOPD. So one could say that perhaps there was already beginning of a shift back, but it's only one year. You can't reach a conclusion from that, I don't think, but --

DR. DeBUSK: In the reading materials, you mentioned that the growth had appeared to have flattened out at one point, and so presumably, this 2.6 is to spur that growth.

Okay, that's it. No more questions.

DR. CROSSON: Bruce, did you have a comment on this?

DR. PYENSON: Yeah. Just on that, there's
another shift from physician office to ASC that would need to be balanced out of that, I think.

DR. ZABINSKI: Yeah. I was just going to say we really know very little about how relative payments determine the proportions, the shifts, and it would be great to find out. It would be a significant study, I think, to do it. I'm not sure that it's worth the staff's time, but I think we ought to figure that we really have a great deal of uncertainty. It's hard to have that go into our recommendations.

DR. CROSSON: Okay. Dana.

DR. SAFRAN: Thank you.

I just have two questions for you. The first one has to do with quality measurement. I saw your summary of what's known in your recommendations about some additional quality measures for ASC. Do we have any way to compare, understanding there could be some nontrivial case-mix differences between the hospital outpatient and the ASC? Do we have any way to compare across those settings on existing quality measures? And, specifically, I'm interested in the hospital-acquired complication measures.

MR. GAUMER: So there's not complete symmetry
between the measures that are used on the outpatient and
the ASC side, and that's something that we've been talking
about for a few years now.

One of the reasons why we want to do these
subsequent hospitalization measures, which we think are a
really good idea that CMS is starting to implement these,
but I think the data just are not there yet. The measures
are just not there yet on either side.

DR. SAFRAN: Okay. And the algorithms for HACs
don't allow us to actually just take the claims data and
compute what they would be in the ASCs?

MR. GAUMER: That's not something we've tried
yet, so we'd have to give that some thought.

DR. SAFRAN: I'd encourage you to look into that.
Yeah.

MR. GAUMER: Okay.

DR. SAFRAN: I mean, I can just say that some
clinicians that I know and work with who are expert in the
quality and safety field believe that there's a lot about
the ASC setting that makes it safer. So I think that would
be good to know.

My other question ties back a little bit to where
Brian was going and just gets at the issue of volume increases that you pointed to, and I'm wondering if there are methods that you've thought about or that might get included in the chapter to start to get at appropriateness.

MR. GAUMER: Can you say that one more time?

DR. SAFRAN: So you point to volume increases, and you note differences in markets where there are ASC and not. So it's suggesting if you build it, they will come, right?

So do you have any mechanisms to think about appropriateness that you're going to be talking about in the chapter?

MR. GAUMER: Let's see. We don't really. That's something we could consider as well. We've thought a little bit more this year about where these facilities are locating and how they're tending to cluster in certain locations and why.

Do you have thoughts on this?

DR. ZABINSKI: That's a complicated issue to address, something to consider, though, of course. That's about it.

MS. BUTO: Dan --
DR. SAFRAN: I'll just add and then pass the mic that in some of the work that we've been doing that uses patient-reported outcome measurement before and after procedures, it's leading to some pretty fascinating insights where you can know with baseline data with 90-plus percent certainty whether a patient will or won't benefit from a procedure. We've looked at hip and knee, and so it's pretty compelling. You have to find a way to make it not gameable, but I'd just offer that as one idea.

DR. CROSSON: Kathy, do you want to comment on that?

MS. BUTO: I wanted to comment that at least if you look at the 20 procedures in Table 5-5, a lot of them are ophthalmology and GI procedures, and CMS, I know in coverage guidelines, whether administered by the MACs or whoever, set certain thresholds for appropriateness or medical review. And I think that sort of serves as an appropriateness guideline.

They may not be perfect, but it's a way they ensure that there are at least some standards that are applied and whether or not something is approved for payment.
DR. CROSSON: Karen. Pass?

Sue.

MS. THOMPSON: I'll be quick. I have two quick questions. In the narrative, you note the beneficiaries who live in rural areas can travel to urban areas because obviously the geographic location is much more predominant in urban areas. So we know if they do or not? Do we have any data to help us look at the utilization of rural beneficiaries?

MR. GAUMER: We have not looked to see what share of surgeries for rural beneficiaries are occurring at ASCs and how that's changed over time. We've looked at that on the hospital side, and we have seen an increase in benes from rural locations coming into urban hospitals to get surgery done. That's gone up in the last five years, but we have not looked at that in ASC. And that's an increasing thought. We could do that.

MS. THOMPSON: And the second question -- and I don't expect a ton of dialogue about this, but what's going on in Maryland? I mean, 40 ASCs per -- I mean, the next grouping is 20. It's double, and so does that have anything to do with their all-payer model?
MR. GAUMER: Dan lives in Maryland, so he's going to answer this.

MS. THOMPSON: Thank you, Dan.

[Laughter.]

DR. ZABINSKI: I'll tell you just within the short distance of my house, there's a lot of ASCs. There really are.

The only thing I can chalk it up to, Maryland actually has a CON law on ASCs, which should say, well, why are they so high, but they have this loophole that says you don't have to get one if you're a very small ASC. Most ASCs are very small, so it's essentially a moot point.

But other states don't have CON laws, and they're not nearly as high as Maryland. So, yeah, it's a good question of what's going on.

I don't have an answer perhaps that it's the all-payer. I'm not sure.

DR. RYU: It's my guess that that's what it is because the ASCs would come out of their waiver, and services that sit inside that inpatient waiver, there's a limitation if you're a health system as far as what your profitability is there. And so the more services you can
move out, I think, I would imagine it helps them.

DR. CROSSON: Okay. As a potential explanation,

thank you.

So we're going to move on now to the discussion
period. We have the recommendations on two different
slides, but I think everybody knows what they are. No
update and then a reaffirmation of our requirement for cost
reporting. So we'll take them together as a discussion.

We'll start with Jon.

DR. PERLIN: Well, thanks, and thanks for an
interesting presentation on this topic.

I'm kind of with Brian in terms of the logic, why
you'd disincentivize something that has substantial savings
relative to alternative sites of care.

This is anecdotal, but I think we should validate
with data. I don't think this is going to be substantive
for office practice not only for the mechanistic aspects of
Medicare policy, as noted, but a lot of these things are
intensely complex. And there's a lot of specialized
equipment, et cetera.

Putting that aside, actually going a slightly
different direction here and built from Dana's observation
of clarifying, the chapter goes through pains to outline the necessity of some quality measures. I really think we need to focus on value here and to build the infrastructure if we're thinking about value in the future.

I'd like to see either with great clarity in the text or alternatively as a specific recommendation for us to build a set of quality measures. Otherwise we can't understand the relationship of outcomes to cost. Ideally, they'd have some capacity for risk adjustment to understand the relative complexity of patients compared to other settings, HOPD and hospital specifically. And I think there's some very fundamental measures that are quite specific, transfer to hospital being the most obvious, as you've indicated quite correctly in the chapter.

Additionally, other things like surgical site infection, but one could think here of that same sort of quadrat of safety quality, efficiency, and experience as the basis for understanding this slate of outcomes for the resources utilized.

Thanks.

DR. CROSSON: Jon, I'm going to ask you in a second to clarify where you are with the recommendations.
But I think in partial answer to where I think you're going, at least in terms of discussions in prior years, I think the Commission has been kind of reluctant to provide updates in the absence of understanding what the costs were for the reasons you said, basically. It's difficult for us to make a judgment, whether it's about margin or it's about value, without that information. So I think that's partly behind where we are with the recommendations.

But where are you on the recommendations?

DR. PERLIN: I'm ambivalent for the reason that Brian mentioned, but can live with the recommendation.

DR. CROSSON: Okay. Brian.

DR. DeBUSK: I'll start with the easy one first. If you could go to recommendation number 2, I do support the recommendation as written. I think it is -- that they absolutely need to provide cost reports. Furthermore, I think they need to continue to report meaningful quality measures. And again, I would go even a step further to say that there should be measures in place to make sure that there isn't induction and that these procedures aren't unnecessary or low-value care. So again, I think anything
we do in that space I could completely support.

Going back to recommendation number 1, I'm a little bit torn because I do understand -- and, Jae, you just mentioned -- in the absence of cost report data it is difficult to make a recommendation, and I do feel like that's -- I do think that's something that we would have to consider.

Having said that, I do think ASCs play a really important role in surgical care, because I do think they preserve a pathway to physician autonomy. They also -- you know, there's a lot of collective angst here about policies that drive physicians toward employment. You know, this is one of the few areas where we can actually encourage and foster the development of this payment area and help maintain some physician autonomy. And it's frustrating to me to think, you know, what other opportunity are we going to get to create a pathway to physician autonomy that comes packaged with a 52 percent -- or, I'm sorry, 48 percent program savings, if we can migrate the procedures from the OPPS to the ASC correctly. And, Dana, your point was well made. If we don't manage the transition correctly it could be a huge disaster.
The final thing is I really do want to support this area, and that's why I was encouraged to see that CMS was going to give them the market basket update this year. I do want to support this area for one other reason, which is it does allow physicians to self-select -- the ones that are more entrepreneurial, the ones that are more willing to take on risk. I like the fact that we've given them this safe haven, if you will, where they can operate, because I suspect these are the same doctors that we're going to come back to and say, "Hey, I've got a great idea. Why don't you participate in a two-sided ACO?" or "Why don't you take on risk?" And I think it's just -- I think giving them this area -- it's a relatively small payment area -- I hope as we go into the January meeting and have discussions about this update that we'll balance the need to preserve physician autonomy with our long-standing position that if you don't file cost reports we can't responsibly give you an update.

So, Jae, I apologize but I'm sort of -- I'm looking forward to January. How's that?

DR. CROSSON: I'm not sure I am.

[Laughter.]
DR. CROSSON: But thank you. That's so much clearer.

Kathy and Karen.

MS. BUTO: I support the recommendations. I actually question how much migration we're going to see from OPDs in to ASCs, where ASCs exist. Maybe you're talking about stimulation more formation of ASCs, which is, I think, a slightly different issue. Because I look at the procedures and the gastroenterologists and ophthalmologists are two of the most aggressive in setting up ASCs, and so I know that they're already where there are opportunities looking to do that.

I would ask that, Zach, you and Dan look at some of the coverage guidelines that will address some of the concerns I hear about appropriateness, because I think some of them are the ones that medical review guidelines that are being followed put a break on inappropriate utilization. So at least some reference to some of those would be helpful, for cataract surgery and maybe for colonoscopy and endoscopy.

DR. CROSSON: Karen.

DR. DeSALVO: I support the recommendations. I
want to particularly talk about the second, which is related to accountability. I think any responsible business would want to be accountable to the taxpayers and so they ought to be publishing their cost data, just as we ought to be holding them accountable for value or quality as a pathway to that.

I just would like to add a dimension about what it feels like on the ground when ambulatory surgery centers arrive. One of the unintended consequences is that specialists can stop having hospital privileges, which means that when you arrive in the ER and you need a gastroenterologist or an ophthalmologist, because you've got some trauma or an emergency, you may not have anyone on staff. And I don't know the prevalence of that but it's a very common clinical narrative that has many physicians concerned. So for all of the good that we've discussed, I do think there are other consequences that we should pay attention to.

And I just wanted to go back to Pennsylvania or any other opportunities where we might have a proxy, where they may have some more data, not just only in cost but perhaps in quality or migration from other environments.
that we could try to begin to get some sense to help guide
the future policy in this area.

DR. CROSSON: Thank you. David.

DR. GRABOWSKI: Great. Thanks. I’m also
supportive of the Chairman's draft recommendations. I
really like this principle. If you won't show us your cost
data we won't give you a rate increase. I think that
should be very firm.

Two other points I wanted to touch on. One,
Brian, this issue of savings that you're pushing towards.
I'm really skeptical of where that substitution is going to
come from and whether it's going to come. And so I don't
know if this is new spending or kind of actual savings.
I'd be really careful there without further analysis. The
second -- and I'm really glad Dana and Jon pushed us about
the quality measures here. I think they're really lacking
in this sector and we could go a lot further there. So I
hope we'll continue not just to push on cost data but also
on the quality measures. Thanks.

DR. CROSSON: Okay. Marge, Dana, and Pat.

MS. MARJORIE GINSBURG: I'm a little confused
about the relative cost of ASCs and hospital outpatient
1 departments. So my understanding is it costs more to get
2 the work done in the hospital outpatient department than it
3 does in an ASC. ASCs are -- their revenue from Medicare
4 looks very good, which is one of the reasons. So why, if
5 the equivalent procedure can be done in a less-expensive
6 setting, then is any of this doing anything to push the
7 services out of outpatient departments into ASCs? And if
8 not, why not? Or, said a different way, if it's less
9 expensive to do in an ASC, shouldn't we drop what the
10 reimbursement is to outpatient departments to be equivalent
11 to the site where it's most effective -- most efficient.
12 Excuse me.
13
14 That's all. Oh, and I do support the
15 recommendations.
16
17 DR. MATHEWS: If I could weigh in here, Marge.
18
19 So with respect to whether or not the presence of the
20 lower-cost setting is sufficient to drive utilization, that
21 is very much an open question, and there is some research
22 that suggests that an ASC comes into a market and it's not
23 necessarily siphoning off services from a higher-cost
24 setting but it's actually inducing additional utilization.
25 So that's one issue where the data is not completely clear.
Then with respect to whether or not you want to set hospital outpatient department payment rates at the level of the lower-cost setting, that is something we have contemplated in the past. It's been several years ago now. We did not bring this to a formal, you know, recommendation for a vote in front of the Commission. But the issue here that we need to be sensitive to is that ASCs are not uniformly available in all parts of the country, and so if you set the OPD rates at a level that might work in Maryland and not compromise access that could be a disaster if you tried to do the same thing in Nebraska or a state where there are no ASCs as alternative, lower-cost settings for these services. So we would want to be careful about, you know, reducing OPD rates to an ASC level of payment.

DR. CROSSON: Dana.

DR. SAFRAN: Thanks. So I'm in support of both recommendations as written. You know, I think the point that Brian raised, you know, is, of course, one that we should be thinking about, but I think we've had enough other conversation here about the uncertainty of whether the volume -- whether the additional volume that we see is appropriate. A complete lack of information about what the
costs are, and so whether an addition 2.6 percent is actually needed to support the cost structure. The last thing we want to do is drive up the cost structure by driving up the rates.

And also the lack of data to help us compare quality across the setting, compels, I think, from my perspective, just to hold off, get a broader view of this. And, you know, assuming things look as we, you know, little bits of data tell us they might look, let's think about how we can confidently try to put incentives in place to move care from hospital outpatient to ASC where that is appropriate.

And one mistake I'll just mention that we don't want to make, that was made by Massachusetts policymakers was to say that ASCs had to be tied to a hospital. So enough said there.

DR. CROSSON: Okay. So I had Pat, and now Jonathan, Bruce, and Paul -- Pat? I'm sorry.

DR. PAUL GINSBURG: Just to save us time to say that the way David said it is perfect for me.

DR. CROSSON: Okay. Adding quality. Is that right? Now I'm confused. All right. So I've got Pat,
Paul is off, Jonathan, and Bruce. Right?

MS. WANG: I'll be brief. I support the recommendations as written. I think the part of the statement that I agree with David, because David, you know, had a lot of substance in his comments, and as a general principle I agree with what David says.

But just to sort of put a period at the end of the sentence that, you know, there's no reason -- I don't think we should tolerate that a sector doesn't submit cost information and the fact that we're even talking about a 2.6 percent update, which is kind of substantial, you know, in the absence of real cost information and, you know, the transparency of what's going on and whether it's good, bad, or indifferent is a problem for me. Even if there were cost data, I don't think that there is at all enough information to say that we should induce additional volume in the centers and that there actually would be a substitutive effect for hospital outpatient departments. I don't think that we know nearly enough about that. The fact that Medicare beneficiary access where the ASCs are located seems to be good and increasing suggests that there's not a problem with the current payment rate. So I
think the recommendations are very appropriate.

DR. CROSSON: Jonathan.

DR. JAFFERY: Thanks. I am also supportive of both recommendations, and I won't reiterate it for the reasons that have just been said. The lack of cost data is very frustrating so I'm sure those of you who have been sitting through this multiple years must be extremely frustrated.

The only other comment I wanted to make was to respond to something I think Brian had said a little bit ago about this group of providers, maybe their entrepreneurship and encouraging that in looking forward towards two-sided risk models. And I guess I'm fairly skeptical at this point, that these providers will have the same level of sort of entrepreneurship. I think the risk is very different if you're talking about jumping into a volume-driven model of care delivery than a two-sided risk model that's based on different outcomes, financial outcomes.

DR. CROSSON: Thank you. Bruce.

MR. PYENSON: I support the recommendations but as someone who works with claims data, and has for years,
the cost report issue has been -- throughout the health care system has been troubling because of the dominance of charge master that vary from one organization to the next. And that's a legacy of Medicare cost reports for decades and decades. And it would be a real shame if we don't take this opportunity to say a little bit about what sort of cost reporting we want.

And a simple way to do that, which I've mentioned in the past, is to have a universal charge master, that everyone is an ASC uses the same charge master. Now they can negotiate whatever they want with private payers and so forth, but to have that in place, that would be, in my opinion, a great thing for hospitals, for the Medicare system to force on hospitals as well.

But that's a bigger job. We have a clean slate here so let's get it right. Let's not repeat, you know, this nightmare of cost report accounting that dominates so much of the data that we have to deal with. So I'd really like to see if we could get a phrase or a sentence or two on that into the recommendation. I see a few nodding heads.

Just to pick up on, I think Kathy made a really
excellent point on the appropriateness guidelines that are already in place. And since colonoscopies are a really big item here, and probably most of them are screening, and there are definitely guidelines for how often colonoscopies should be repeated, if you're going to follow up on Kathy's suggestion, if you could ask someone at CMS if they actually tabulate that data. Like if it's supposed to be 10 years between colonoscopies when someone is not high risk, if they actually look back in the data. Maybe a question or two. Thanks.

DR. CROSSON: Okay. Thank you. Good discussion again. We're going to need to move on.

I would like to summarize. I think there are two issues on the table here. The first is we do not have unanimity in support of the recommendations. Therefore, on that criterion, we will bring this back for further discussion in January.

Secondly, there have been some suggestions --

MR. PYENSON: I thought it was unanimous.

DR. CROSSON: No. I've got two Commissioners -- unless -- let me ask Jon and Brian to state their positions then.
DR. PERLIN: I said I had some ambivalence for the reasons mentioned but I'm supportive.

DR. CROSSON: Okay. Brian, you --

DR. DeBUSK: And I had mentioned, you know, trying to weigh not filing the cost report data versus the update. If my fellow Commissioners feel that the absence of cost data outweighs, then I'm on board. So I'm a yes vote.

DR. CROSSON: Okay. Brian, in all honesty I think that's where we would end up in January, to be frank.

Yeah, Jonathan.

DR. PERLIN: I do think, though, that we heard a pretty good signal about the importance of quality measures, so we have some further work to do on that.

DR. CROSSON: We did. We did. Sorry. Without objection, I'm going to suggest that -- and we had two suggestions for improving the second recommendation, yours, Bruce, and then the more common one with respect to adding quality to that. So I'm going to ask the staff, Jim and the staff, to consider, without objection, adding to the second recommendation, to the extent that it's feasible, so that you can come back and say -- and I realize time is
short, but if there are some general thoughts about how to improve quality reporting, and if you, perhaps in discussions with Bruce, can come to a conclusion that it would be appropriate to add universal to that notion, then we would do that in January. We would come back with the same first recommendation, perhaps a slightly amended second recommendation, and if I hear no objection to that, that's what we'll do.

DR. DeSALVO: And to merge in the quality measurement with cost --

DR. CROSSON: It would be --

DR. DeSALVO: -- and accountability.

DR. CROSSON: And again, I'm making it up on the spot, but it would be to require cost reporting and then to potentially require more advanced quality reporting.

Because I think that's the suggestion I heard. David, is that right? Karen?

DR. GRABOWSKI: Yes.

DR. CROSSON: Karen, is that troubling?

DR. DeSALVO: Yeah. It's not troubling. It's about accountability and it's important. I just wouldn't want -- I think the cost seems to be such an important
issue in and of itself I just wonder if there's -- if there is a recommendation which also is about developing quality measures that allow for comparability between types of service and for outcomes.

DR. CROSSON: You're saying separate recommendation.

DR. DeSALVO: Add a third.

DR. CROSSON: A third recommendation.

DR. GRABOWSKI: I like that suggestion of separating them out.

DR. MATHEWS: So if I can get in here for a second. So, one, I don't think we will have difficulty reflecting the collective discussion here in the next draft of the chapter. So to the extent we want to highlight issues related to the kinds of costs that we think would be beneficial to collect we can do that. We can also emphasize the need for robust and comparable quality information that would allow us to assess meaningful differences between ASCs and OPDs. We can do all of that in the narrative underlying the discussion, and to the extent we need to enhance what we've got now I don't think that's going to be a problem.
I am a little concerned about being extremely specific about inserting the word, say, "via a universal charge master" in the bold-faced recommendation language. I would be hesitant to tie the Secretary's hands in a way that -- speaking only for myself -- I wouldn't necessarily understand the downstream implications of. And so my preference -- speaking only for myself and the staff -- would be to be at this level of generality with respect to the cost reporting recommendation.

And then with respect to a bold-faced recommendation on quality, I'd like to reserve the right to determine whether or not that's feasible to come back in January. I think there's going to be some analytic work that we would need to do, and I just can't guarantee we can do that in the next, you know, basically three weeks.

There is also a question -- and this is for you, collectively, to adjudicate. We typically do have a two-times rule when we present recommendations for the Commission's consideration, and this would be one that we would be making out of whole cloth. And what you should be hearing here is some skittishness on my part about making a substantial recommendation along these lines for a vote in
January, which, in effect, is tomorrow for present purposes.

So I can commit to a more robust discussion in the text. I would like some leeway in terms of what we can do with respect to bold-face recommendations.

DR. CROSSON: Kathy.

MS. BUTO: I support Jim on this because I think this bears more discussion, not just -- the term "quality" has a lot of appeal but I don't know exactly what people are talking about. I would add to that the appropriateness issue that Dana initially raised. I'd like a little more discussion about whether we think CMS ought to step up to the plate more and provide more guidance in that regard, on the front end, not just measure quality either process or outcomes on the back end.

So I think this bears a little more discussion before we take it on, but I think there can be a strong statement of our intent to take it on without having a specific recommendation. It's just very tough to imagine our recommending anything on quality except a process at this point, because there's not even cost data for ASCs.

So, anyway.
DR. CROSSON: Okay. So I think the approach here will be to add robustness to the text, based on the discussion, and we will come back in January with an attenuated presentation, as we have. Because I think I now support for that, so that's what we'll do.

Okay. Thank you, Dan and Zach. I appreciate it. Don't go far. You're up for the next one as well.

[Pause.]

DR. CROSSON: Okay. We are going to move along now to a discussion about hospital update for inpatient and outpatient services. I will presage a little bit by saying that, particularly for some of our guests who are interested in hospital payment, this particular December we will be addressing hospital payment overall in two parts: in this discussion, and then in the discussion that immediately follows lunch. However, this presentation will be given by Zach, Stephanie, and Jeff, and Dan's name is there, but I think he ran for the hills or something. I'm not sure. So who's going to start? Zach?

MR. GAUMER: Yes, sir. All right. Well, good morning again. This session will address issues regarding Medicare payments for short-term acute-care hospitals. In
this session we'll cover both hospital inpatient and outpatient payments, and we'll discuss whether payments are currently adequate.

As a part of this, we'll provide you with the Chairman's draft recommendation for updating hospital payment rates for 2020.

In line with MedPAC's common framework, we examine beneficiaries' access to care, providers' access to capital, and the quality of care provided in hospitals. We also examine hospital payments and costs, including Medicare and efficiency provider margins in 2017 and projected Medicare margins in 2019.

But before we jump into the adequacy structure, we want to touch up a general trend in Medicare hospital spending. As you can see on the bottom row of this table, in 2017 Medicare fee-for-service hospital spending totaled $190 billion, and from 2016 to '27, hospital spending per beneficiary increased 4.3 percent.

The components of this growth include a 2.5 percent increase in inpatient spending, an 8.4 percent increase in outpatient spending, and an anticipated decline in uncompensated care payments.
For context, the growth observed in inpatient and outpatient spending from 2016 to '17 was more rapid than the average annual growth over the last decade.

Access to hospital care is good, and we do not see any specific problems that would affect beneficiaries' access to care.

On the inpatient side, service use per beneficiary increased in 2017 by 0.7 percent, and this follows several years of declining inpatient volume. One driver of the inpatient growth was a relatively large increase in inpatient cases with short inpatient length.

On the outpatient side, service use per beneficiary also increased in 2017 by 0.7 percent. But different from the inpatient side, this follows several years of more rapid increases in outpatient service use, and this slowdown is in part due to the flattening of growth in ED and observation visits. However, two of the drivers of outpatient growth this year were increases in the number of clinic visits and Part B drug administration.

While the volume of Part B drugs increased, spending related to Part B drugs was the largest source of growth in the hospital outpatient setting this year. As we
told you earlier, overall hospital outpatient spending grew in 2017 by 8.4 percent, and this amounts to a $4.9 billion increase in one year. Approximately $2 billion of this one-year increase was for separately payable outpatient drugs.

In other terms, this is 40 percent of the total increase in hospital outpatient spending. And over a longer term, from 2012 to 2017, spending on separately payable outpatient drugs increased by $6 billion. This increase in drug spending is largely driven by two things: higher prices on existing drugs such as cancer drugs and growth in the use of new drugs, which are common referred to as "pass-through drugs." From 2016 to '17, spending on pass-through drugs increased by $1 billion.

While drug spending has increased, we also observed that at 340B hospitals, outpatient drug revenues exceeded costs, and what this means is that hospitals profited from the increase in Part B drug spending.

Other measures also suggest access to hospital care is good. The excess inpatient capacity observed in prior years persists. In 2017, the number of hospital closures declined, as did the number of hospital openings.
In a reversal of trends, more of the closures that did occur in 2017 were urban rather than rural.

Hospital occupancy rates remain low, but did not increase -- but did increase slightly, excuse me, in 2017. The aggregate hospital occupancy rate in 2017 was 62.5 percent and in rural hospitals 40.2 percent. And, overall, this means that many inpatient beds go unfilled and excess capacity in rural areas is more pronounced.

We also believe hospitals maintain a financial incentive to serve Medicare beneficiaries because the average marginal Medicare profit or the profit made from serving one additional Medicare beneficiary in 2017 was 8 percent.

Hospitals' access to capital remains strong, and this is apparent in several different measures that we look at.

The level of nonprofit hospital bond issuances in 2017 was consistent with the prior year, and relatively high, suggesting that hospitals have reasonable access to capital through the bond markets.

Construction spending in 2017 was also consistent with the prior year. Hospitals spent $24 billion improving
facilities or expanding, and the hospital industry does remain focused on building outpatient capacity right now. Mergers and acquisition activity within the hospital industry remains strong. In the reading materials, we mention the private equity acquisition of Lifepoint recently, but also large hospital systems that are national are active in recent years acquiring smaller hospitals.

Financial statistics pertaining the hospitals' entire book of business may provide the strongest evidence of the industry's general access to necessary capital. In 2017, hospital all-payer margins were 7.1 percent, and both operating margins and a common measure of cash flow, EBITDA, increased from 2016 to 2017.

We have plotted these three all-payer financial statistics on a chart so you can see the stability of these three trends. Total all-payer margins, identified by the green line in the middle, increased from 6.4 percent to 7.1 percent in the last year, and 7.1 percent is a relatively high number compared to past years, as you can see. The blue line on the bottom represents operating margins, which includes revenues and costs from all
hospital operations, but excludes income from investments and endowments. And operating margins were up slightly in 2017, but remain higher than levels observed earlier in the decade.

The white dotted line at the top represents the EBIDTA, the measure of hospital cash flow, as I mentioned. And here we see a slight increase in 2017, and we interpret this as generally improved stability.

So taken as a whole, the three measures demonstrate sustained growth and indicate that hospitals continue to grow their private sector revenues faster than their costs.

Okay. So let's shift gears to quality of care provided at hospitals. In 2017, we observed an improvement in hospital quality. As you know, we view hospital quality through the lens of patient experience, readmissions, and mortality rates.

The share of patients rating their overall hospital experience a 9 or 10, on a 10-point scale, improved slightly, increasing to 73 percent in 2017. All-condition 30-day non-risk-adjusted readmission rates in 2017 remained lower than in 2012,
coming in at 15.8 percent. And then all-condition 30-day risk-adjusted mortality rates are also declining. In 2017, the mortality rate was 6.4 percent, lower than observed in 2012.

And I also want to note that we observed a decline in raw or non-risk-adjusted mortality rates over this period. And because inpatient volume was declining over this period, too, and fewer people were using the hospital, this may underscore the improvements we're seeing in mortality rates.

And now to Stephanie.

MS. CAMERON: So let's talk about margins. We assess the adequacy of Medicare payments for hospitals as a whole, including Medicare payments across all patient care services and uncompensated care. We compare these payments to the allowable cost of providing services to Medicare fee-for-service beneficiaries.

Using the most recently available data, we find that the overall Medicare margin continues to trend downward, falling from negative 9.7 percent in 2016 to negative 9.9 percent in 2017. The decrease in the overall Medicare margin starting in 2014 was not unexpected given
several payment adjustments required by statute. These adjustments include: reductions to the annual payment update; adjustments for documentation and coding improvement; decreases in incentive payments for the adoption of electronic health records; and decreases in uncompensated care payments that correspond with increases in the insured population.

While the average overall Medicare margin was negative 9.9 percent in 2017, excluding critical access hospitals, rural hospitals had a negative 8.2 percent overall Medicare margin, which was 1.8 percentage points higher than the negative 10 percent margin for urban hospitals.

Major teaching hospitals had an overall Medicare margin of negative 9 percent, which is higher than the margin for the average IPPS hospital in large part because of the extra payments they receive through IME.

As in prior years, for-profit hospitals had the highest overall Medicare margins, well above the overall Medicare margin for nonprofit hospitals, but still negative at negative 2.6 percent.

Now let's turn to our relatively efficient
providers where we identify a set of hospitals that perform relatively well on both quality of care and cost measures. 

Looking at these hospitals' performance in 2017, we find 7 percent lower mortality and 7 percent lower readmissions, while keeping costs 9 percent lower than the national median. Lower costs allow about half of these hospitals to generate positive Medicare margins in 2017 with a median margin across all relatively efficient providers of around negative 2 percent.

It is important to remember that when we talk about efficiency, we are talking about quality and cost. While these relatively efficient providers are spread across the country and have a diverse set of characteristics, they are more likely to be larger nonprofit hospitals because these hospitals tend to have better performance in the quality metrics we analyze.

We project margins for 2019 based on margins in 2017 and policy changes that take place during 2018 and 2019. We estimate that the overall Medicare margin will decline from about negative 9.9 percent in 2017 to about 11 percent in 2019.

Although payment rate updates, increases in
uncompensated care payments, and case-mix growth will increase payments, cost growth is expected to be larger than the payment updates. The update is equal to the expected input price inflation, less an adjustment for productivity and an additional downward adjustment mandated by the ACA. The net is a 2.7 percent increase from 2017 to 2019. We expect the margin to decline due to expected cost growth of about 5 percent over two years on a case-mix-adjusted basis.

In summary of our payment adequacy findings, we find that access to care is good, access to capital remains strong, and quality is improving. Relatively efficient providers had a median Medicare margin around negative 2 percent. There are expected statutory and regulatory policy changes in 2018 and 2019 that reduce payments to hospitals. If current law holds, we would expect negative Medicare margins in 2019. That said, we expect hospitals to continue to have a financial incentive to see Medicare patients because we project that Medicare revenues will continue to exceed marginal costs in 2019.

This slide shows the estimated update for...
inpatient and outpatient rates for 2020, which would be 2.8 percent if the current estimates of the market basket and productivity remain at 3.3 percent and 0.5 percent, respectively. I want to note that the 2020 net update is expected to be the highest in a decade as this will be the first year since 2010 that hospitals have not received an additional downward adjustment to the update factor that was specified in law.

Based on this payment adequacy analysis, the Chairman's draft recommendation seeks to balance several imperatives. This includes maintaining pressure on providers to constrain costs to improve long-term program sustainability, minimizing differences in payment rates across sites of care consistent with our site-neutral work, rewarding high-performing hospitals, and moving Medicare payments toward the cost of efficiently providing high quality care.

Clearly, there are tensions between these objectives that require a careful balance that is sought in the Chairman's draft recommendation.

With this in mind, the Chairman's 2020 draft hospital recommendation is in two parts. You will see the
update portion now and the second part, which includes hospital value incentive payments, after lunch today.

With that, the Chairman's draft recommendation reads: For 2020, the Congress should update the 2019 base payment rates for acute-care hospitals by 2 percent. The difference between this update and the amount specified in current law should be used to increase payments in the hospital value incentive program.

To be clear, this is the first part of the Chairman's draft recommendation and is intended to be implemented in a budget-neutral manner such that, in aggregate, hospitals receive payment increases equivalent in dollars to the entire current law payment update. Therefore, from this part of the recommendation, we expect no impact on program spending or on beneficiaries or providers.

Beneficiaries maintained good access to care and providers continued to have strong access to capital, while quality improvement continued, despite negative Medicare margins for most providers. The 2 percent update with additional increases directed to the hospital value incentive program balances the need to maintain fiscal
pressure on hospitals to control their costs and the need
to have payments high enough to maintain access to care at
high quality providers.

Because of the growing payment rate differential
between freestanding physician offices and offices on a
hospital campus, site neutrality for similar outpatient
services across settings should be a priority.

As I mentioned, Ledia's presentation after lunch
will discuss the implementation of the hospital value
incentive program in a manner that is intended to further
increase payments to acute-care hospitals. While you will
be discussing the Chairman's draft recommendation during
that session, if agreeable, we will anticipate both
portions of the recommendation be presented together in
January.

And with that, I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie, Zach, Jeff.

We'll now proceed to clarifying questions. Bruce.

MR. PYENSON: A couple of questions. In the
introduction you note there's 4,700 hospitals. Are you
aware of any of those that in recent years have decided to
not participate in Medicare?
MR. GAUMER: No, I don't think we've had any indication -- we all look at different stuff, but I don't think we've had a big push on that at all.

MR. PYENSON: Thank you. My next question is on Slide 12. This is the efficiency study. In the first row of numbers there, the number of hospitals in this study is about 2,151, adding the relatively efficient and the other hospitals. And I realize that you've excluded about 54 percent of the hospitals that participate in Medicare from the analysis. And I think one of the exclusions was critical access hospitals and others.

It seemed as though rural hospitals had a higher -- or the non-urban hospitals might have had a higher margin. Do you think the excluded hospitals actually have better financials than this sample?

DR. STENSLAND: They might have slightly better financials, especially if you include the critical access hospitals, but the critical access hospitals are paid on their costs, and they're not paid on the rates that we're discussing adjusting.

DR. PYENSON: Okay. Thank you. I recall that you had explained that in the text as well.
My last question is on Table 6 of the reading materials, and this is the risk-adjusted 30-day post-discharge mortality rates. They've declined relative to expected mortality.

Going from 2012 to 2017, the expected mortality went up by about 25 percent, which is huge. What do you think is going on with that? Why did expected mortality go up that much in a few years?

DR. STENSLAND: I think the optimistic way to look at it, there was about a 20 percent -- over a 20 percent decline in the number of admissions per capita. So this would suggest that the easier cases probably aren't being taken on an inpatient basis, and if you look at the overall unadjusted, risk-adjusted mortality number, it's about flat. So we have fewer people entering the hospital, and amongst those that enter the hospital, about the same percentage die. So the good news is fewer people are going to the hospital and dying. So that's one reason. You could say that maybe the people are getting sicker because fewer cases are entering the hospital.

Part of it could also be coding. It would be really difficult for us to try to distinguish exactly how
much would be coding and how much would be the easier case mix because it depends on actually what goes in the medical record and what does the physician put down. So that would be a difficult task.

But I think the general direction, I think we can be pretty comfortable with, given the flat un-risk adjusted combined with the big decline of share of people going into the inpatient setting.

DR. PYENSON: Thank you very much.

DR. CROSSON: Jon, Amy, Paul, Jonathan, Kathy.

DR. CHRISTIANSON: Okay. This is a question clarification for Jeff because he looks disappointed that he wasn't able to present today.

[Laughter.]

DR. CHRISTIANSON: So the data, again, sort of raises the issue that clearly there's much higher profit margins, if you will, retained earnings for the non-Medicare business for hospitals, and we're often told by hospitals that the reason those margins are so high is because Medicare margins are low, and therefore, they need to have higher margins from the non-Medicare sector.

But the Commission -- I think your work and also
the economic studies I'm aware of kind of come up with a
different logical sequence here, and this might be a good
time, since this data show up here again, to kind of run
through how the Commission views those differences.

DR. STENSLAND: Well, traditionally, what they
would call the other way of looking at it would be the
cost-shift model. They would say if commercial rates go
up, then the providers will ask -- or if Medicare rates go
up, the providers will ask less from their commercial
payers. If Medicare rates go down, they will ask more from
their commercial payers. That's the general cost-shift
idea. If we don't get it from Medicare, we have to get it
from somewhere else.

And one of the key factors in there is the idea
that there is some money left on the table. The idea is
that we do have the financial power or the market power as
a provider to demand higher rates, but we're not going to
do it because Medicare pays it enough. So we're going to
leave that money there.

I think mostly this is an empirical question,
which is the good thing. So then you look at, well, what's
happened when people have seen a decrease in their Medicare
rates or an increase in their Medicare rates. What generally happens? What we generally see is that then their costs move.

There was a recent study by Zack Cooper when he looked at what happens when we see an increase in certain hospitals' payment rates, and what we see is certain hospitals got big increases through the 508 program when that was implemented into law, and then we said, "Well, what happened to them?" And they hired more staff and bought more equipment, and there were some salary increases.

So it looks like it wasn't a situation where they said, "Okay. I got more for Medicare. I'm going to call up Blue Cross and say you can pay me less this year." That isn't what happened.

When we looked at our studies, when we looked at the data before, we tried to look at, well, let's look at these hospitals that appear to be getting strong rates from their private insurers. How do they compare to the people that tend to get lower non-Medicare revenue, which you talk about in the report?

Generally, we see there's a cost differential
there. That those that are under financial pressure due to having low non-Medicare revenues tend to have lower costs. Those that have higher non-Medicare revenues, maybe strong private payer rates or lots of private payers in the commercial world, they tend to have higher costs. And there's a limitation to how much that differential is, but that's our general perspective in a nutshell is it looks more like that we have payments following costs as opposed to -- or costs following payments as opposed to having the cost of the provider being immutable and then them determining the payments.

DR. CHRISTIANSON: So, in that scenario, there's a high strategic component to what the cost base is, which plays into the large calculations as well?

DR. STENSLAND: That is the idea behind the relatively efficient provider margin and the average margin. What we also show in our report every year is what is the margin for hospitals under pressure versus those that are not under pressure, and we see that when the hospitals are under financial pressure, they have lower costs and better Medicare margins. They're still not positive this year, but they are better.
DR. CHRISTIANSON: One more thing, didn't you do some recent work too, or the staff, on the portion of hospital costs that are in fact variable versus fixed?

DR. STENSLAND: Yeah. We did look at that a couple of years and we looked at it a couple different ways, through a cost accounting way and also through some regression analysis, and what that generally showed was that in terms of how much can the cost vary as volume varies, and we said over a one-year period, it appears that about 80 percent of the costs for an average size hospital or a large hospital can vary with volume, meaning that if the hospital knows our volume is going to go down over the next year or they expect to have a lower volume, then they can lower staffing, and they can reduce 80 percent of those costs due to the lower expected volume. Twenty percent of it is going to be fixed, things like your building and your interest and stuff like that.

DR. CHRISTIANSON: So that's a larger number than I think we were used to seeing in the literature?

DR. STENSLAND: I divide the literature into two different groups. I think there's kind of the industry literature, which is kind of more the hospital
administrator physician kind of perspective of saying these
costs are all fixed. And in their mind, sometimes they
say, "Well, I'm going to assume that all my labor is
fixed."

Then there is more kind of the economist-type
perspective of saying, "Well, look what happened, actually
happened to costs when volume changed." And we can say
when the volume changes, the costs go down, and it goes
down as much as you would expect if about 80 percent of the
costs were variable. So it's kind of an empirical
standpoint versus more of an intuitive standpoint, and it's
also a feeling of whether you want to assume that labor is
fixed or not. And I think we show empirically it doesn't
look like it really is.

DR. CHRISTIANSON: Okay. Thanks.

DR. PERLIN: May I on this point --

DR. CROSSON: On that point.

DR. PERLIN: Thanks.

Well, wearing a hat in each camp, health services
researcher as well as clinician administrator, both may be
true. The problem is that while things may be
theoretically variable, that's destabilizing.
I think that some more quality metrics, more experience metrics, or staff experience metrics may actually be more instructive in this area in terms of understanding the destabilization.

Clearly, I published on those large-scale studies of the variation between staff experience and patient experience, and one of the biggest predictors of staff experience is the volatility of the environment.

So I just want to note that because I think both are potentially simultaneously true, and I think we simultaneously have to be appreciative of the unintended consequences in terms of the intent of our support of Medicare.

DR. CROSSON: Jon, in this context, can I ask you to explain destabilization?

DR. PERLIN: Yes. Let's play this out in a very concrete manner. Let's say that -- take a hospital that has seasonal differences. Take a hospital in an area of the country where a factory has closed, et cetera, where you begin to take staff, move them around all of a sudden. Nurses, for example, the thing that is most destabilizing to a constant nursing workforce is call-offs,
say, gee, our volume isn't just here, so all of a sudden --
and then inadequate shifts, and then all of a sudden, the
people who used to be your sort of fixed base of cost and
constant employees leave. Who leaves first? Best
employees.

What happens behind that is that you actually get
-- it would be interesting, the empirical data on this, but
I can tell you from some degree of experience that you
backfill them with alternative mechanisms like contract
labor, which tends not only to be more expensive but less
versed in the particular specialties of particular units.
All of a sudden, you have newborn intensive care nurses
cross-covering on adult intensive care, as an example, or
individuals who just don't know the hospital systems,
electronic records and the like.

So, in very practical terms, that's what I mean
by destabilization.

DR. CROSSON: Essentially, you're saying
workforce destabilization.

DR. PERLIN: Yes, indeed.

DR. CROSSON: Okay.

DR. PERLIN: Thanks.
DR. CROSSON: Thanks.

Amy.

MS. BRICKER: I wanted to chat a moment about 340B. It's referenced in the material, in the presentation today. I'm curious as to our insight into the hospitals that benefit under current 340B policy, not new proposed policy from the 340B program, and the impact of the prior policy on those margins and then, conversely, now with the modifications to the 340B program and the impact to those hospitals.

I know there's mention that there's some offsetting associated with that policy to other services and programs, but do we believe as a Commission that it is a one-for-one or the impact to that?

Oftentimes, the benefit of the 340B program shows up on the commercial payer less the Medicare payer, but there's been a dramatic reduction in associated payments associated with those products and therefore those institutions.

So I'm curious as to the insight that you all have on that change, current and then projected impact.

DR. STENSLAND: Okay. So the 340B, the data that
we're looking at is 2017 margin data, and at that point, the GAO -- Dan can correct me if I'm wrong -- had estimated something like a 30 percent discount. We're going to use 30 percent as a ball park.

If you're getting a new pass-through drug and it costs $100,000 as the average sale price and you're getting it for 70, so you have some margin there, and we're going to see two things in the data you've been there. One, you're going to see an increase in spending because you have these new expensive drugs. Next, you're going to see a little bit of improvement in the outpatient margin at the hospital because they got that spread. That's the old policy.

And the new policy is they were saying, "Well, we're going to start paying people -- they're going to get a rate of 22 percent below the average sale price." Is it 22? All right. Now they're going to get paid a lower rate than they're used to. They're not going to get that full spread of 30 percent. There still might be a little spread, but it's not going to be so big.

So what you're going to see then is the profitability of the drugs is going to go down a little bit
or down quite bit, but they did it in a budget-neutral manner. They said, "We're going to pay this much less for drugs, and we're going to take all this money. And we're going to spread it out amongst all the other outpatient services," whether that's a clinic visit or an x-ray or whatever else. So the profitability of all those other things is going to go up a little bit.

In essence, in the end, you're not going to see a big change from that effect on the overall hospital margin because that's really done budget-neutral in terms of what the hospitals are getting, but you're going to see a little bit of a shift in that the 340B hospitals will be getting a little less. The non-340B hospitals will actually be getting a little more because everybody is going to benefit from that increased payment for the E&M visit or the x-ray or whatever, where they're taking that 340B money and spreading it amongst everything else.

MS. BRICKER: So I know in theory, that's how it was crafted. I don't know if actually in practice if that's how it played out, meaning that the hospital feels budget-neutral, to use your word. Just given the reaction in the market, it doesn't feel as though that's how the
hospital administration is sensing it play out.

In addition, what about the impact of 340B, not on the Medicare program, but that of commercial? So that when you're able to acquire a drug at a 340B rate, yet be compensated at the commercial rate for your commercial population, that's a tremendous value to those hospital systems. We don't really talk about that.

So I think it was mentioned previously, if there's a way for us to consider all of the value that a hospital is receiving from a federal program, I think it would be worthwhile. I don't know how hard. It seems kind of hard, but if there's a way for us to bring that to light, I think it allows the Commission some insight so that we're making these recommendations with a full picture of the value that many federal health care programs are bringing to bear.

DR. CROSSON: Thank you, Army.

I want to make one point. This is a hospital update session, but it probably is useful, since part of our charge is beneficiary protection, to point out the fact that this change is going to dramatically reduce beneficiary costs for these drugs because part of the
problem that we addressed as a Commission when we made our recommendation, which is different from what's being implemented right now, was concern that beneficiaries were being charged co-payments based upon cost that the hospitals were not paying. And that will go away.

Paul.

DR. PAUL GINSBURG: I wanted to clarify the Chairman's recommendation. The way I read it here, my interpretation is that the current law is 2.8 percent increase, and 2 percent of the increase is going to come the usual way and .8 percent is going to come through the revised value program we're going to be discussing after lunch.

But I got the impression in talking with Jim just before this public session started is that there was perhaps more than the .8 percent funding the value program, and I think it's important that we know about that now, so that we can assess this recommendation.

DR. MATHEWS: Sure. As Stephanie said at the outset, this is one of two hospital-related recommendations that we're going to discuss today.

The effect of the update recommendation is that
given a current law projected update of 2.8 percent, we would give an across-the-board update of 2 percent, with the remaining .8 allocated to hospitals on the basis of their performance under our revised quality incentive program, the HVIP.

This afternoon, we are going to be talking about a recommendation specific to the HVIP that incorporates the Commissioners' comments from our previous discussion of this proposal, and it also includes a change in how we are going about funding the HVIP.

In the past when we've talked about consolidating four existing hospital quality programs, we've contemplated doing that in a budget-neutral way, and those four programs collectively have the effect of taking roughly a billion dollars out of the hospital payment bucket.

What we are now contemplating is an HVIP proposal that would forego those savings and put that billion dollars back into hospital payment, and so the net effect of these two recommendations combined would be hospitals would still get the full dollar value of a 2.8 percent update, although that money would be distributed partly through the update and partly through the HVIP. And there
would be an additional, roughly billion dollars of new
money put into the HVIP in addition to the .8 that is being
re-routed.


DR. JAFFERY: Thanks.

This conversation about variable cost, I think is
fascinating and actually much more than academic in terms
of a lot of the issues you're talking, probably beyond the
scope of today's discussion.

But I have a two-part question related to that.

One is I just want to verify that when the reports talk
about Medicare payments covering the variable costs of a
patient and so continuing to be desirable for the hospital
to admit those patients, the first part, is that using the
80 percent as the variable cost? So that's 80 percent
variable cost. Okay. So that's good to know.

Then you talked a lot about the different
capacities. I think the average hospital capacity was 62.5
percent, and in rural hospitals, it was about 40 percent.
The benefit of Medicare payments covering variable costs is
dependent, to some degree, on capacity issues. So is there
any empirical data about hospitals that have much higher
capacity -- or much lower capacity, whose capacity is at 85 or 90 percent, and what happens as Medicare payments change in those settings?

DR. STENSLAND: I'm not aware of any empirical studies of looking at those kind of markets, like Rochester, New York, where there's really high-occupancy rate kind of markets, what's happening there. I think what we would have to say is, on the one hand, the financial incentive is not there to admit a Medicare patient if your beds are all full and you could admit a commercial patient rather than the Medicare patient. So the financial incentive wouldn't be there.

But there is other concerns, certainly just good practice. I think they're going to want to admit the Medicare patients, and to the extent that they're a nonprofit facility, if they didn't admit the Medicare patients, they might lose their nonprofit status. So we don't see that happening in terms of the beneficiaries not receiving access. I think the only places that we've heard of that weren't taking Medicare is an occasional -- there's a for-profit chain of cancer hospitals, and in some cases, in some places, they don't take Medicare patients.
DR. CROSSON: Okay. Kathy and then Jon on this point.

DR. PERLIN: I'm just wondering how you're accounting for the sort of incremental nature of variable costs? I mean, you know, this strikes me as one of those, in theory, theory and practice are the same, and in theory and practice they're not. And the challenge here is that while I would stipulate, in the long run, all costs are variable, in practical terms, you know, if you discharge a patient a little bit earlier, if you have patients that are discharged you don't get savings until you actually have one less staff member there, but don't have one less person on the unit unless, you know, you've had that as a run for a while, and that creates a problem.

So there is this sort of step-wise nature that is not continuous, that's more of -- using the language from our earlier discussions -- clifled than continuous. I'm just wondering if we take that into account in our contemplation.

DR. STENSLAND: I don't think that we're saying that this is all continuous. It's not like you're going to get rid of one third of a nurse that day. You know, you're
going to have to reduce your nurse staffing by a whole number.

But if you look at the data for the hospitals where they actually saw a big drop in their volume or a big increase in their volume, what happened to their overall costs from one year to the next? They moved so that it looks like they were able to either eliminate 80 percent of their costs when their volume went down, or they moved so that the cost increases for their increased volume was like 80 percent of what the cost was for the average cost. So over that period of -- you know, you've got lots of little steps but it adds up to a fixed amount.

DR. PERLIN: I'm sorry to ask this question. This is the main question I'm going to ask. So you're aware of a hospital that flexed downward by some significant proportion of staff, right? I mean, theoretically, as a basis for this discussion, in theoretical terms, right?

DR. STENSLAND: Yes. When you look at the cost reporting and you look at what the reported costs were, in your X versus your X plus 1, and then you look at their volume.
DR. PERLIN: Is that the first place you want to send your mom?

DR. STENSLAND: I probably would -- I would have some other indicators that I would look at besides that. I would not say, "Oh, my indicator of quality is volume change."

DR. PERLIN: Yeah.

DR. STENSLAND: But I wouldn't say that we have any evidence to show that a lower-volume hospital -- say if you have discharges of 200 patients, that you're necessarily a worst hospital than someone that has 250 discharges.

DR. PERLIN: I'm not arguing the volume outcomes relationship. I mean, I think there's pretty good literature on that. What I am arguing is that an entity that has had to reduce variable costs substantially, in a unit period of time, probably is not performing at top level. And for me, personally, that would not be my first choice.

That's the nuance I'm trying to get at behind these data, and that's why I say, I agree that, in theory, both ends are accurate. But I think there is a sort of
incrementalization that, in practical terms, is problematic. I see a number of heads nodding, and I think those of us who have been in that clinical environment understand that challenge.

DR. CROSSON: Okay. Let me make two points. First of all, generally speaking, mothers are off the table. Secondly, we'll take Kathy and then we've already run out of time for the whole discussion so I'd like to move on to the discussion.

Kathy.

MS. BUTO: This will be fairly quick. I was trying -- on page 13 of the mailing materials we're talking about the greatest factor in increased spending for observation stays is the packaging of ancillary care. Although we point out that that's offset by, or there is a decrease in spending for those services that were packaged in. Does that mean net-net, that overall spending has gone up for outpatient care because of the packaging, or is it just for observation stays?

DR. STENSLAND: I think that's generally just observation stays.

MS. BUTO: Okay. So you'd expect that.
DR. STENSLAND: In large part it's an offset.

Yeah, you package more stuff in, you're going to expect it
to go up.

MS. BUTO: I was just trying to figure out
whether were against more packaging, but it doesn't sound
like it. Thanks.

DR. CROSSON: Okay. I think it's time to move on
to the discussion. We'll put up the recommendations. I'm
going to ask, as we have before, for people to express
their opinion about the recommendation -- in favor, not in
favor, why not, other ideas?

I will point out, though, that, as Stephanie
pointed out, because we're going to be combining this and
the second one, this will be brought back for full
discussion in January.

So comments on the recommendations?

[No response.]

DR. CROSSON: This perhaps is suggestive of
hunger -- I'm not sure -- or perhaps respect for our guests
because they haven't had a chance to make their comments
yet. But I will take it as it stands. We'll have more
discussion, as was pointed out, after lunch, and then
again, we'll be coming back to this total package in January.

So thank you, Stephanie, Jeff, and Zach.

DR. CROSSON: We now are open for public comment.

Those of you who would wish to comment on the business before us this morning, please come to the microphone so we can see who you are.

[Pause.]

Not seeing any movement towards the microphone we are adjourned until 1:30.

[Whereupon, at 12:31 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]
AFTERNOON SESSION

[1:30 p.m.]

DR. CROSSON:  Let's sit down and get ready.

Okay.  This afternoon we are going to continue our discussion about payments to hospitals, and we're going to have a discussion about the hospital quality incentive program.  Ledia and Jeff again -- Jeff is again here.  Jeff has done a lot of work today.  I like to see that.

It looks like, Ledia, you're going to lead off.

MS. TABOR:  Good afternoon.  In this session we will continue discussions about the Hospital Value Incentive Program, or HVIP.  The HVIP aligns with the Commission's principles for quality measurement, is simpler than the current hospital quality programs, focuses on outcomes, and promotes the coordination of care.

Today we will review the HVIP design, and a draft Chairman's recommendation to implement the HVIP.

As a reminder, the Commission has identified several issues with current hospital quality programs.

Primarily, aspects of the current hospital quality programs do not align with the Commission's principles for quality
measurement. The Commission believes there are too many, overlapping hospital quality payment and reporting programs, which creates unneeded complexity in the Medicare program and for hospitals. Also, the current programs currently use condition-specific readmissions and mortality measures, as opposed to all-condition mortality and readmissions measures, which are more stable.

Some of the programs include process measures that are not tied to outcomes and provider-reported measures that may be inconsistently reported.

Finally, the programs score hospitals using "tournament models," meaning hospitals are scored relative to one another and not on clear, absolute, and prospectively set performance targets.

Over the past cycle and a half, the Commission has discussed replacing current quality payment programs with the HVIP. In September 2017, the Commission discussed key design elements of the HVIP, for example, what measures to score and how to set scoring scales. In April 2018, the Commission reviewed results modeling the HVIP using current hospital quality data. In the June 2018 report to the Congress, we published results of the modeling as well as
reiterated the Commission's principles for quality measurement.

The Commission asked to continue to refine aspects of the design of the HVIP, for example, the weighting of measures, which we discussed this past September. I will highlight the results of this discussion on the next slide.

Throughout the past year, Commissioners have supported the HVIP and asked that we continue to move forward with a recommendation to the Congress. That brings us to today's discussion.

Based on the Commission's September discussion, we updated the design of the HVIP and modeling to incorporate three substantive changes. First, we added hospital-acquired infection rates as a measure domain, based on the Commission's discussion of the importance of tying infection rates to payment.

Second, consistent with the VBP Program, we scored all 10 patient experience measures, including the overall rating, as one patient experience composite rather than only the overall rating of hospital care. When the HVIP is implemented, CMS can refine the patient experience
measure domain using the federal rulemaking and comment process.

Third, we modeled the HVIP based on both a 2 percent and a 5 percent withhold amount, reflecting the September meeting discussion of transitioning to a higher HVIP withhold over time or beginning with a withhold higher than the current VBP's withhold of 2 percent.

In September, the Commission also discussed various approaches to weighting the HVIP measure domains. We presented analysis that showed small weighting changes didn't have large effects on groups of hospitals.

Consistent with the current VBP Program, in the models presented in this paper, we continued to use equal weighting. When the HVIP is implemented, CMS can solicit input through the federal rulemaking process regarding specific weighing of the measures.

This brings us to the current HVIP design. To improve focus and clarity, the new HVIP would be one program as opposed to separate programs. As illustrated on the left hand side of the slide, the HVIP would combine the current HRRP, VBP, and HACRP into one program, and eliminate the IQRP, which is an obsolete pay-for-reporting
Looking at the right-hand side of the slide, we would incorporate five existing, all-condition quality measure domains into the HVIP: readmissions, mortality, spending, patient experience, and hospital-acquired conditions, or infection rates. Per the Commission's principles, the HVIP would translate quality measure performance to payment using clear, prospectively set performance standards. The HVIP also accounts for differences in provider populations through peer grouping.

Similar to the current VBP, the HVIP would redistribute a pool of dollars to hospitals based on their performance.

I will briefly review the scoring methodology we used to model the HVIP, starting with how measure performance is converted to HVIP points.

One of the Commission's principles is that Medicare quality programs should reward providers based on clear, absolute, and prospectively set performance targets. So hospitals will know ahead of time what performance they need to achieve on each measure to receive HVIP points and payments. In our HVIP modeling, hospitals earn points for
their performance on quality metrics based on a continuous scale, starting at 0 points and gradually increasing to 10 points. All hospitals are scored on the same scale.

Medicare can define the performance scale using different methods. For our modeling we set the scale along a broad distribution of historical data so that most entities have the opportunity to earn credit for their performance. A hospital's total HVIP score is the average of all of its points earned across the five measure domains.

The Commission believes that the Medicare program should use peer grouping to take into account differences in a provider's population social risk factors of a provider's population. Based on these principles, we modeled the HVIP where quality-based payments are distributed to hospitals within ten different peer groups. Each peer group has about the same number of hospitals and those hospitals have about the same share of Medicare beneficiaries that are fully dual-eligible.

We use the same performance-to-points scale across all groups, but each peer group has its own "percentage adjustment to payment per HVIP point" based on
the group's pool of dollars and HVIP points. Like the
performance-to-points scale from the previous slide, each
peer group's percentage adjustment to payment per point is
prospectively set and known by hospitals.

Each peer group has an enhanced pool of dollars
with is distributed to hospitals within the peer group
based on the HVIP points each hospital earns. The pool of
dollars will be made up of two sources. First, as we have
discussed, the HVIP would be built on a withhold amount
from each of the hospitals in the peer group. The VBP
currently uses a 2 percent total base payment withhold. In
September, the Commission discussed that the HVIP can begin
with a 2 percent withhold and transition over time to a
larger withhold, such as 5 percent. Some Commissioners
also supported beginning with the higher withhold amount.

As Stephanie discussed earlier, the second source
for the pool of dollars is including part of the current
law payment update. For modeling the HVIP, we assumed that
0.8 percent of the total hospital payment update, which
applies to both inpatient and outpatient, would be added
the HVIP pool. This 0.8 percent roughly translates to a
little more than 1 percent of inpatient spending. So for
your discussion we modeled hospital performance using a pool of dollars based on a 2 percent withhold plus the 1 percent of total base inpatient spending, or a 3 percent pool, as well as a 5 percent withhold and 1 percent of total base spending, or a 6 percent pool.

In modeling hospital performance under a 3 percent pool of dollars, most hospitals, 95 percent, will receive a reward relative to their withhold. The unweighted, average net HVIP increase in payments is about 1.07 percent, meaning that 2 percent is withheld from the hospital and that, on average, 3.07 is redistributed to a hospital.

Under a 6 percent pool of dollars, less hospitals will receive a reward but still the vast majority, at 82 percent. The unweighted, average net HVIP increase in payments is about 1.13 percent, meaning that 5 percent is withheld from a hospital and that, on average, 6.13 is redistributed to the hospital. Under the 6 percent pool, the higher-quality hospitals will receive more of a reward, compared to the 3 percent pool, because the percentage adjustment to payment per HVIP point is higher in this larger pool.
Both average adjustment values are greater than the 1 percent added to the pool because they are unweighted, and different categories of hospitals have different HVIP performance. For example, on average, smaller rural hospitals will have slightly higher HVIP adjustments because they perform better than large urban hospitals on readmissions, patient experience, and MSPB measure domains.

In summary, consistent with the Commission's principles, the HVIP links payment to quality of care to reward providers for offering high-quality care to beneficiaries. It also rewards hospitals that efficiently deliver high-quality care. The HVIP is simpler than the current four, overlapping programs. HVIP uses a small set of population-based outcome, patient experience, and value measures that encourage providers to collaborate across the delivery system. A benefit of these measures is that Medicare could use these measures to compare across fee-for-service, accountable care organizations, and Medicare Advantage.

Overall, the HVIP reduces the differences in payment adjustments between groups of providers serving
populations with different social risk factors. I will now review the Chairman's draft recommendation for your discussion. The Congress should replace Medicare's current hospital quality programs with a new HVIP that includes a small set of population-based outcome, patient experience, and value measures; scores hospitals based on absolute and prospectively set performance targets; and accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping. The implications for this recommendation is that it would increase inpatient spending relative to current law due to eliminating current quality incentive programs. During previous meetings, we had discussed that the HVIP would be budget neutral to current quality incentive programs, but this recommendation would eliminate the penalty-only quality programs and therefore increase Medicare spending compared to current law. This is in response to the Commission's desire to move Medicare payments toward high-quality care and a simplified quality program. From the beneficiary perspective, the
recommendation may also improve their care by creating incentives for higher quality and more coordinated care.

The HVIP would be less burdensome for providers and may increase their willingness and ability to furnish services. The HVIP would give higher Medicare payments to hospitals providing higher-quality care.

This brings us to your discussion. After reviewing your questions and comments, we would like your thoughts on the Chairman's draft recommendation for a potential vote in January.

DR. CROSSON: Thank you, Ledia. We are now open for qualifying -- clarifying questions. Brian.

DR. DeBUSK: First of all, thank you for a fantastic chapter. I mean, I really like the work and it's very impressive, some of the examples you worked us through.

My question is on page 21 of the reading materials. And if you look at the total HVIP points, I notice it goes from 6.3 to 4.7, the third column over, but it's remarkably flat in the middle. And I noticed that in the reading. You could walk me through that and maybe help me understand that. Why the flatness? Does that say
anything about our choice of deciles and how those
intervals are constructed?

    MS. TABOR: So I will just reiterate that it is
the same performance-to-point scale across all the
different peer groups, so what you're seeing is that the
peers groups that have the lowest share of fully dual
eligibles are doing much better than the peer groups -- the
tenth decile, which has the highest share of fully dual
eligibles. So just by nature that are not performing as
well in the measured domains.

    It is very true that there is not a lot of
distinction kind of in the middle. We chose the 10 peer
groups because we thought that it was important to
distinguish between the 9th and 10th, for example, because
there is quite a difference between the number of dual
eligible in those groups. But, you know, perhaps using
quintiles or another number of peer groups could be more
appropriate.

    DR. CROSSON: Other questions. Yeah, Bruce.

    MR. PYENSON: Thank you very much. Could you
describe the issues for including the fully dual eligibles
as opposed to the partial dual eligibles and some of the

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thinking around that?

MS. TABOR: We chose -- you know, we chose, for this modeling, just to use the fully dual eligible. We thought it was a little clearer. But again, that would be -- you know, you can argue to also do it with the partial included.

MR. PYENSON: Could you talk a little bit about the pros and cons of that?

MS. TABOR: There could be -- if you did include the partial there could be differences within states, because of the differences in the Medicaid programs across states. That would probably be more obvious if you included the partial dual population.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: Just a quick question. You referenced, in the slides, the inclusion of hospitals, those within Medicare Advantage, yet it's not often that I've heard the term "Medicare Advantage" come up in this group. So it doesn't appear that we have done much evaluation of the programs within the MA plan. So could you explain both why that is added and how getting that information may be more or less challenging than the
information from non-MA plans?

MS. TABOR: We included that kind of idea just because one of the, you know, principles for the Commission is that we would like to have quality measures across the three different domains. And by fee-for-service Medicare kind of laying down these are the measures that are appropriate it could encourage Medicare Advantage plans to use those exact same measures.

I think we wouldn't be able to calculate, at this current point, the MA measures because of the encounter data that's still being worked through, but there is, you know, the hope to be able to do that in the future.


DR. JAFFERY: Thanks. So just a quick round one question that may inform a round two thought. Could you remind me the measure around the spending, per-beneficiary spending encompasses?

MS. TABOR: Yeah. So we did use the CMS specification here and also their data that's available on Hospital Compare, and it basically measures Part A and B spending for three days before inpatient stay, during the
inpatient stay -- or actually it's three days before admission and 30 days after admission, so all Part A and B spending.

DR. JAFFERY: Total spending, but episodic.

MS. TABOR: Yes.

DR. JAFFERY: Okay. Thank you.

DR. CROSSON: Jon.

DR. PERLIN: Thanks. Let me add my thanks for a terrific chapter. You made a statement on page 11 that for low-volume hospitals you used three years of data, and I assume that would park everybody into three years of data for comparability. And if one of the intents is to promote performance improvement then you're using data that are three years, some number of quarters in arrears, a la the readmission, then it would strike me as it would be somewhat difficult for the hospitals to do two things. One is to actually use those data as a signal for improvement, because it's kind of driving in the rear-view mirror. The second, by virtue of the thing, so incredibly a trailing indicator, to be able to have much mobility even if they were improving, say, for something that was mobile over a period of three more years, at a minimum.
MS. TABOR: Yeah, that would be an issue with using the three years of data. The Commission -- I think it was Dana, actually mentioned in the past, perhaps last year, that if we are going to use three years of data we could perhaps weight the most recent year more, so that if you did improve over the past year you perhaps -- you'd get more credit for it. So we could, you know, use the three years of data to kind of conquer the statistical problem of we need more numbers, especially for small or low-volume providers, but then also still continue to drive improvement and not penalize as much for the first year.

DR. PERLIN: What would you envision the HACs being, as they're now sort of rolled up into a sort of metric of a number of different acquired conditions?

MS. TABOR: Yeah. So the way that we modeled it, I will say, is that we took the six infection rates and averaged them, their standardized infection rates, and averaged them for our domain score.

DR. PERLIN: The reason I ask is, you know, Rich Platt has done some work. Here's the problem. You don't want these low-frequency bad events to occur. On the other hand, they are low frequency. And by virtue of the fact
that they're low frequency, especially in low volume, means that, you know, in terms of either accountability or interpretation, it's difficult because they may not be predictive of future performance. That's really what Rich Platt published on, that, you know, it operates more -- with more of a random characteristic than a predictive characteristic. Thanks.


DR. RYU: Yeah, I had a question on Table 4 on page 22. You give some range of under the 2 percent withhold and under the 5 percent withhold, what would the range of the payment adjustments be. And I was wondering how those ranges stack up against what current state looks like, as far as those ranges. Do you have any sense of that?

MS. TABOR: Yes. Well, I wouldn't be able to totally compare Table 4 to current programs because the peer grouping idea is new. But I will say, in general, the peer group 10, the highest share of fully dual eligible beneficiaries are performing worse, or getting penalized more under current programs than the top peer group.

DR. RYU: And when it's worse, I mean, do you
have a sense, is it -- here it says negative 1.4 to
positive 2.1 percent would be the range under a 2 percent
withhold. But what does that look like for that group
today under the four or five programs we have?

MS. TABOR: So for the peer group one, which is
the lowest share, right now they're being penalized 0.54
percent, and because of the peer grouping, they would now
get 1 percent adjustment, on average.

DR. RYU: Thank you

DR. CROSSON: Pat.

MS. WANG: So combining the two recommendations
under consideration, particularly pulling in money from the
update to fund this new program, what is the sustainability
model for that kind of funding going forward? So this
year, you know, the update is larger than it has been, or
the recommended update is larger than it has been in past
years. What happens when the recommended update goes down?
Is this viewed as kind of an ongoing funding mechanism for
the HVIP? Or is this like a one-shot?

DR. STENSLAND: Yeah, I think you can think of
the update, we talked about taking eight-tenths of 1
percent out of the update and putting it into the HVIP.
And if it was left in the update, it would be in the baseline, and that eight-tenths would continue forever in the base payment rate. So the way we would envision this would be a permanent increase in the HVIP, amount of dollars in the HVIP program. So there would permanently be more dollars in the HVIP program than just the withhold.

Does that make sense?

MS. WANG: Why -- oh, withhold from the update factor every year?

DR. STENSLAND: It wouldn't -- you think of the -- once you have this eight-tenths of 1 percent increase in your update in this year, then you kind of think of, well, wherever this -- the parallel lines would be that much higher if you had an extra eight-tenths of a percent in one year, because this update just moves the whole line up, and it continues on forever. So think of this --

DR. MATHEWS: So, Jeff, if I could get in, the 0.8 percent represents a one-time infusion of additional dollars, which results in the higher baseline going forward. But on an ongoing basis -- and correct me if I'm wrong -- the program would still operate under a withhold that would be reallocated plus or minus based on the
hospital's performance under the HVIP.

MS. BUTO: Can I just add a question to her question? But on an ongoing basis, we could contemplate in a future year taking an additional amount out of the update, legislated update, to put into this fund if we wanted to. In other words, yes, the whole pool goes up, but you could increase it even more going forward if you wanted to take another increment from the update. Is that right?

DR. STENSLAND: Yeah, you could think of it in that way, but I would think of it as we're taking what was, you know, the equivalent to, say, a billion and a half dollars in base payments that was going to increase base payments from here in perpetuity. And now we're saying let's take that billion and a half dollars and put it in the HVIP every year from here in perpetuity.

MS. BUTO: But you could take another $500 million and --

DR. STENSLAND: Yes, in future years you could move it up from what we're proposing.

DR. CROSSON: Okay. Pat still has the floor, then Jon. Oh, I'm sorry. Go ahead.
DR. JAFFERY: So maybe I'm not thinking through the math right, but I get that one-time payment would maintain these being those parallel differences as the future updates happen. But over time, wouldn't that erode such that the extra amount that's going into HVIP might be less and less significant?

DR. STENSLAND: I think it would just always be that you would always be taking eight-tenths of a percent of what your base payments would have been and adding that to the HVIP every year.

DR. CROSSON: It's not a dollar amount. It's a percentage.

DR. STENSLAND: Yeah.

MS. WANG: Thanks. To Marge's question about Medicare Advantage and the importance now that, you know, this program is going to, I think, make it easier for hospitals to focus on specific quality measures, there's going to be more money in it, and so it kind of just underscores the importance, I think, of trying to rationalize and bring the quality metrics of the program -- all of the programs together as much as possible, so everybody's working on the same thing. The only one in
here that really overlaps with the Medicare Advantage star measure that I can see is readmissions. Do you know offhand whether this is the same measurement of readmissions that is used in the Medicare Advantage program? Because, again, you don't want plans to be, like, saying -- you know, working with hospitals on one definition of a readmission measure and having the hospitals focused on this, which is a different definition of the readmission measure. So I'm curious if you --

MS. TABOR: I would say that the measure is close enough. I think the biggest difference is that the current hospital quality programs for fee-for-service use the condition-specific measures; whereas, MA uses an all-cause. So by us going to an all-condition measure here, we are moving us much closer to aligning to the MA.

MS. WANG: The only thing that I'd point out is that fee-for-service is now going to be ahead of MA in having, you know, an adjustment for socioeconomic status through the peer grouping, and MA doesn't have that, not really. It's theoretically in the measure specification, but not really. So that's a gap that should be brought together.
The final thing, to Bruce's question about partial duals, I would assume -- and I'd just ask if you have a comment -- that there is a correlation between the proportion of full duals and the sort of proportion of partial duals. The people live in the same community. They're either technically below the poverty level that, you know, makes them eligible for full, or they have $10 more a month which gives them eligibility for partial. But do you have a feel for that?

MS. TABOR: Mr. Rollins?

MR. ROLLINS: [Off microphone].

MS. WANG: Probably a pretty good proxy then for low-income.

MS. TABOR: Yeah. We can look into that, though.

DR. CROSSON: Kathy.

MS. BUTO: This is on HACs. I know we struggled with the idea that the HAC data are self-reported. Is there anything like an infection-sensitive adjustment in the payment system that might help us validate or help somebody validate, CMS validate the veracity of reporting from the hospitals on HACs? Do you know? Anything in the DRG claim -- anything at all that would help us provide
some measure of how valid the self-reported data are?

MS. TABOR: Yeah. I will say that the CDC National Health Safety Network that is the tool that's used to collect all the self-reported data does have a validation protocol developed. It's just unclear how much CMS uses it.

I know some states have used it. I've done some reading that the State of New York was very interested in the infection rates among hospitals, and they actually did some of their own audits and found that the results were actually not as surprising. I mean, there were some imperfections in the reporting, but it wasn't so bad.

And I will say with the claims data that there is a small amount of literature that has said when you compare infections or other patient safety issues that are reported by claims to the CDC system that the CDC system is more reliable than the claims. It's a small amount of literature, but I think that is meaningful to show that if you want to do infection rates, kind of the CDC system is the best way to do it.

MS. BUTO: Okay. Is there any value to mentioning some kind of audit, a look behind for some of these self-
reported data?

MS. TABOR: Yeah. We can definitely write about that in the paper.

DR. CROSSON: David.

DR. GRABOWSKI: Thanks for this work.

I wanted to ask you about the patient experience measures, and as you note in the chapter, there are different ways to construct this measure from an overall score to a subset of scores to using a composite measure of all the different domains. You opted for the third, kind of using all the different domains, yet there was a line -- and I just wanted to clarify -- that said the overall score was highly correlated with the composite, so why not just use the overall score that seems simpler to kind of --

MS. TABOR: Yeah. I think you could argue kind of the pros and cons, the different approaches. We initially went with the overall rating because we thought that was simpler, but there were also comments that you are kind of missing some other key factors like communication with the nurses, communication with doctors. So the more comprehensive measure may be a better approach to go.

DR. MATHEWS: David, you might not have been here
for that discussion.

DR. GRABOWSKI: Okay.

DR. CROSSON: Okay. Seeing no further questions, we'll move on to the discussion.

I would like to make a couple of points in part for our guests. I think you heard this referred to in the presentation, but this recommendation is one of two recommendations. The first one, we had this morning with respect to the hospital update.

It is our intention to -- in January, when we come to our final vote, to -- I think. We'll see how the discussion goes, but combine these into one set of comprehensive recommendations for the hospital update.

It's of note, and I think particularly for our guests, that for the last 20 years or so, MedPAC has made one hospital update that apply to all categories of hospitals, all hospitals for that matter. This is a departure that we're intending to take here based on the support of the Commission, and it is essentially directed towards, in this case, using the hospital update process to promote a very central and important Commission goal, and that is to reward hospitals, which have proven that they
can efficiently develop high-quality, deliver high-quality
care to Medicare beneficiaries, as Ledia presented in her
discussion.

This is not a small issue. It's a departure, as
I said, from what we've done in the past, but it's a policy
departure that we feel very strongly about because, again,
if we are able to bring this forward successfully in
January, it will bring a very strong message to the
hospital industry that we are supportive of hospitals, and we are particularly supportive
of hospitals who can prove over time that they can in fact
manage both the quality and cost of the care that they
deliver.

So let's open it up for discussion. Brian.

DR. DeBUSK: I would support the draft
recommendations as written on Slide 11, as written. I
think this is fantastic work. It's a major step forward in
consolidating the different value-based purchasing systems
that we have.

I also think your incorporation of peer grouping
is -- I'd really like to see us -- I'd like to see us in
this three-tier model for looking at peer group hospital
and then ultimately patient-level characteristics.

We've had this conversation before. I hope that when we publish in the March report that we can have a discussion around the mathematics behind some of these calculations, particularly around the fixed effects versus random effects models, but I would see that just as a detail in implementing a solution that has a much grander vision.

Hopefully, we'll see solutions similar to this in other venues in the future, so thank you.

DR. CROSSON: Jon.

DR. PERLIN: Let me add I think this is a really elegant way of bringing a number of disparate programs together, and that conceptually is extraordinarily appealing. Thank you for that.

Let me also acknowledge that -- and I've shared this before that, full disclosure, as vice chair of the National Policy Forum, we've wrestled with the notion of socioeconomic status adjustment, and so I think this approach is probably the best I've seen in terms of being able to do that in some sort of reasonable manner.

Just a sort of asterisk on our discussion about
full versus partial dual eligibles, if the intent is
actually better support for hospitals with a
disproportionate burden because of adverse payer mix, then
expanding to partial dual eligible, they may actually be
disproportionate burden because of adverse payer mix, then
retro or counter to the intent because, of course, you have
more partials in Medicaid expansion states, and that
obviously tempers some of the adverse payer mix that's
there, so just note that.

The broader construct I want to move to is that
we incorporate in this consolidated approach five domains,
readmission mortalities, medical spending -- Medicare
spending per beneficiary experience, and hospital-acquired
conditions. And I really, as I say, like the consolidation
and the composite. As the saying goes, the devil is in the
details.

I think we need to also offer some commentary
about the inadequacies of our measurement with respect to
the reality that we may not have better at the moment, but
we really need to acknowledge the inadequacies.

I think it's noble to say that we aspire to
health systems managing the continuity of care, but I've
got to tell you with full candor, I mean, I can take full
responsibility or credit for this first seven to ten days after hospitalization, and despite best intent, it's sometimes difficult to create the continuity that would be ideal to prevent readmissions.

Nevertheless, is the construct of readmissions good? Yes, it is.

What are potential adverse consequences? When I ran the VA health system, I actually did not have a 30-day readmission metric because I worried about the patient being excluded until Day 31 in conjunction with Medicare spending per beneficiary and the table that's in there that show the potential for dollars from those two metrics. I just worry that it not be a recipe for things that are counter to our intended high-quality care.

In the area of mortality, I know we looked at -- there is an argument in the chapter for all-cause mortality. Again, I think we need to be circumspect in realizing there may be utility in all-cause mortality that smooths variation. On the other hand, the really interesting signal might be in the particular clusters of disease. How do hospitals do and how do patients fare in areas of heart disease or stroke or cancer or whatever
other particular area?

But that same sort of concern applies in the area of spending, Medicare spending per beneficiary. One looks at the average. Just think about the difference between two theoretical hospitals, which I could actually give you absolute representatives of, one that specializes in orthopedic and joint surgery, and even with a somewhat adverse patient mix, very different from a hospital that has high constellations of patients with complex, multiple comorbidities, medical diseases, et cetera, that are really so highly covariate with the social determinants.

On patient experience, we've had good conversation on -- my own assessment is that there's no best metric. There are internal issues as well with composite, the discharge planning. Quite rightly, it should vary and in fact does with readmission, so you get a little bit of a double signal, and we just have to look for internal cross-correlation between the different domains as they're apt to co-vary.

Finally, in the hospital-acquired conditions, I think these are an absolutely imperative bucket to have,
multiyear assessment because I have concern that -- I
hadn't heard the concept of weighting the most recent year.
I think that may ameliorate it to some degree, but again,
you would want good measures being really qualified as good
by virtue of, one, that they're valid and reliable in terms
of reporting, to measure what they intend to measure; two,
that they're based on strong evidence because the measure
is essentially the interrogative of what should be an
evidence-based recommendation; and three, that they're
measures that help providers make improvement. That means
they have enough recency to be able to provide direction in
terms of what to change; and fourth, that they have enough
currency that there is the capacity for providers to shift
their relative position, unless they sort of arrest in
progress because the mathematics just make it impossible to
do that.

So, with those caveats, I absolutely like the
overall construct and consolidation. I think it's elegant
and thoughtful. Devil in the details. Thanks.

DR. CROSSON: Okay. Other comments? Draft
recommendations. Support? Don't support? Have another
idea?
DR. JAFFERY: That's a lot.

So I am supportive of these recommendations and do think this is great work, and pulling together these different programs, I think is a really smart idea.

I guess I want to caution against one thing in the summary slide, Slide 10, where we talk about we could use these measures to compare across traditional fee-for-service, organizations in Medicare Advantage. I'm not sure that as they're constructed that we can do that effectively in all these realms.

Going back to the spending per beneficiary, ACOs don't specifically look at their -- their main cost metric is to look at a full year across the board, and so episodes obviously make up a lot of that spending. And so there may be some overlap, but if we're just comparing those things, that can start to get complicated. And there may be other ways to try possibly even through updates, differential updates to encourage hospitals to become part of ACO-type models so that they are taking more accountability for those full year of costs.

And that may mitigate some of the -- one of the
concerns that Jon just mentioned around how do you keep somebody out for 30 days and not 31.

DR. CROSSON: Thank you.

Bruce.

DR. PYENSON: I also support the recommendation on Slide 10.

What I would seek a little bit of clarification on is which hospitals would be exempt from this program, if any, with the goal of having the program apply to as many hospitals as possible.

MS. TABOR: Some thoughts on it now. I think it would not apply to -- it would just be hospitals paid with IPPS, and then I think we would have to do something about the low volume. I think by using the three years of data, we're fixing a lot of the low-volume issues. But there still are -- even in our modeling found that there were just some hospitals that didn't have enough discharges for us to calculate any of the measures.

But I think, again, this three-year approach really does help include as many hospitals as possible.

DR. CROSSON: Marge.

MS. MARJORIE GINSBURG: I have a question about a
comment in the report where it said these actions would actually require legislation, which I haven't been on the Commission that long to know how many things have we proposed that actually require legislation, and whether you all have given any thought to how we make that happen and is there kind of a step-by-step process. It's a bigger hurdle than I think going to CMS.

Is that sort of the next phase? If we come to agreement on this, then there's the implementation plan, which is how do we actually get it to legislation and move on from there? So I don't know whether this is too early to ask the question about how do you do it.

DR. MATHEWS: Sure. So, Marge, I'll take a stab at this one. Once you've been around for a couple more years, you'll realize that a lot of what we do by way of recommendations are recommendations that are directed at the Congress because much of what we do will require a change in law.

The second thing I want to say is that you are not the first Commissioner to have expressed a little bit of impatience with the Congress at the rate of take-up of our recommendations, and I sense that. But at the same
time, our role is advisory, and we go where the analysis leads us. We recommend what we think is the best policy, and sometimes the recommendations lie fallow for a bit. But then as we continue to provide technical support to the Congress as they consider legislation, we are able to bring up these ideas and remind them of recommendations that we have made. And every once in a while, every several years, there is an opportune time when many of our recommendations get enacted into legislation.

So we play the long game here, but we are very cognizant of our role as advisory and support rather than proactive pushing -- "agenda" is too strong a word, but trying to make things happen.

DR. CROSSON: In the longer term, by way of examining what we do and the impact of it -- and this is rough, rough, but we end up with either Congress or the Secretary picking up our ideas or recommendations about 50 percent of the time. Sometimes it's not often, not exactly, but generally speaking -- and we're going to come up later in our update discussions with one very good example of that recently.

So, yeah. First of all, Congress does have to do
the updates, some update, and they either take our recommendation or they come up with a different idea, but in the policy arena, over a period of time, we think we're about one for two, something like that.

MS. MARJORIE GINSBURG: This one is very exciting. I mean, this is a biggie.

DR. CROSSON: I agree. Absolutely.

MS. MARJORIE GINSBURG: I don't know how else to say it, and so whatever we can do to foster its acceptance, I'm sure we will think of ways to do that.

DR. CROSSON: Absolutely.

Yes, Pat.

MS. WANG: I just want to sort of acknowledge Jon and Jonathan's comments because I really agree with them. I think the devil being in the detail and making sure that we have an open mind and don't just put pens down after this but continue to do work on quality -- the details of the quality metrics is very important -- and to try to help the government continue to refine that.

There are a lot of things that I like about this. We talked about the HVIP last time, and I think it's very elegant. I think that the peer grouping is terrific. We
mentioned all of that.

The precedent I think that we are kind of talking about here is to look at the update discussion differently by sort of breaking apart, as Jae mentioned, portions of what would otherwise constitute a straight across-the-board update and seeing if there are certain policy goals that we think are paramount, where the money should be, more directed and more focused.

I would like us to consider if this path is a good one that we consider in the future, trying to encourage the development of value-based organizations along the lines of ACOs or what have you using similar mechanisms. The Commission is really on record as saying that we think that this is critically important for the fee-for-service system and for the future viability of Medicare. So I think that that is a gigantic policy priority that we should keep track of.

The final thing, though, is I don't want to completely detach it from the conversation that we had just before lunch. The analysis of the efficient hospital margins, I think does need to be addressed, the relationship between what we saw there and what we're
proposing here. One of the thoughts was is there a way of
sort of modeling how the hospitals that were in that
efficient hospital category would perform in the HVIP
because if the money is somewhat related or targeted, then
I think we're kind of solving a couple of problems at the
same time.

DR. CROSSON: Right. Two birds with one stone or
something to that effect.

So, Jim, that is something we can address?

DR. MATHEWS: Yes.

DR. CROSSON: Try to address. It may not be
perfect, but I think we can get more information on that
between now and January.

Paul.

DR. PAUL GINSBURG: I just want to praise the
work that was done to develop this comprehensive approach
to value, and I think it's a big improvement over what we
have now.

And I also like the idea of integrating this with
the update recommendation. I think we'll have to decide
each time, but I think it's promising as a way to go in the
future to increase the richness and to really provide a
source of funding for new directions and policy that
promote quality and efficiency.

So I support the recommendations.

DR. CROSSON: Paul, thank you. I'd like to
second that in terms of compliment to Jim and the staff
because not only is this an exemplar of the good work that
the staff does, but I watched them doing this in a
relatively short period of time and very intensely. I know
there were some people not getting a full night of sleep as
a consequence, and we're very grateful for that.

Okay. I think we've come to the end of this
discussion. As we have mentioned several times, because
we're combining this with this morning's discussion, we
will be bringing this entire package back for a discussion
and vote in January.

Thanks very much, Ledia and Jeff. Appreciate it.

[Pause.]

DR. CROSSON: Okay. We're now going to take on
the question of payment adequacy for skilled nursing
facilities. Carol is here to take us through that
discussion.

DR. CARTER: Great. Good afternoon, everyone.
Before I get started, I wanted to thank Carolyn San Soucie for her help with this chapter.

First, a sketch of the industry. In 2017, there were about 15,000 SNF providers, and about 1.6 million fee-for-service beneficiaries used these services. Fee-for-service spending was $28.4 billion. Fee-for-service Medicare makes up about 11 percent of days but 19 percent of revenues.

I will be using our update framework to assess the adequacy of Medicare's payments shown on the slide.

Access to SNF services is adequate. In 2017, supply was steady at about 15,000 providers, and 89 percent of beneficiaries lived in counties with at least three SNFs and less than 1 percent lived in a county without a SNF. Occupancy rates were down slightly but remained high, at 85 percent.

Between 2016 and 2017, covered admissions decreased, consistent with a small decline in inpatient hospital stays that were three days or longer, which is a requirement for Medicare coverage. SNF stays were shorter, so total days declined. These changes are consistent with expanded participation in ACOs and alternative payment
models and are not a signal about the adequacy of Medicare's fee-for-service payments.

The marginal profit, a measure of whether providers have an incentive to treat Medicare beneficiaries, was very high, over 19 percent, a positive indicator of patient access.

For years we've reported on the growing intensity of therapy provision and how this trend reflects the biases of the payment system and not changes in patient characteristics. Since 2002, the share of days classified into the intensive therapy case-mix groups increased from 27 percent to 83 percent in 2017.

Changes in patient characteristics do not explain this growth. Rather, this growth reflects the design feature of the payment system, which uses the amount of therapy to assign patients to case-mix groups. Our work has found that as more therapy is furnished, providers' costs increase but payments increase even more, so providing more therapy is more profitable than providing less. The Commission first recommended revising the PPS in 2008.

CMS plans to implement a revised PPS in fiscal
year 2020. The redesign will base payments on patient characteristics, such as comorbidities, functional status, and cognitive impairment. CMS estimates that the new design will redistribute payments from high-therapy patients to medically complex patients. In response to the new PPS, providers are likely to change their mix of cases, service provision, and cost structures. The Secretary will need to recalibrate the relative weights of the case-mix groups to keep payments aligned with the cost of care.

CMS's redesign is consistent with MedPAC's recommended design and estimated impacts. CMS also noted in its final rule this year that the redesign will bring the SNF PPS closer to an eventual PAC PPS.

Turning to quality measures, performance was mixed, with small changes from 2016. We track three groups of risk-adjusted quality measures: discharge to community, potentially avoidable readmissions (both during and after the SNF stay), and changes in function. Because the function measures are provider-reported, the Commission is concerned that the information may not be reliable.

Between 2016 and 2017, the average facility rates of discharge back to the community improved. The
readmission rates were mixed. The during-stay rate remained the same as in 2016, but the rate of readmissions after discharge from the SNF worsened, and the function measures were essentially the same. Material in the chapter shows the variation in the rates, which suggests that there is plenty of room for improvement.

Because the vast majority of SNFs are also nursing homes, we assess the adequacy of capital for nursing homes. Industry analysts report that capital is generally available and expected to remain so in 2019. Buyer demand remains strong, fueled by aging demographics and the setting's lower costs compared to other institutional PAC.

Some lender wariness reflects three factors: low total margins -- that is, the margin across all payers and all lines of business are low; declining SNF use; and the increasing share of facility revenues from lower-paying payers, such as MA plans.

Investor reluctance does not reflect the adequacy of Medicare's payments; Medicare continues to be a payer of choice.

In 2017, the average margin for freestanding SNFs
was 11.2 percent, the 18th year in a row that the average was above 10 percent. These margins illustrate why Medicare is a preferred payer.

Across facilities, margins vary substantially. One-quarter of SNFs had margins of 0.8 percent or lower, and one-quarter had margins of at least 20.2 percent. There continues to be more than a 10 percentage point difference in Medicare margins between nonprofit and for-profit facilities, due in part to differences in their patient mix and therapy practices, but also differences in their economies of scale. Nonprofit facilities are typically smaller and have higher costs per day. Also in recent years, nonprofits have had higher cost growth compared with for-profit facilities.

To understand differences in performance and to evaluate the level of Medicare's payments, we identify a set of relatively efficient providers and compare them to other SNFs. Efficient providers are those that perform relatively well on both cost and quality metrics for three years in a row. The metrics are: standardized cost per day, rates of readmission during the SNF stay, and rates of discharge to community. In 2017, 987 SNFs, or about 9
percent of the over 11,000 providers that were included in the analysis, were relatively efficient.

Compared to other SNFs, relatively efficient providers had better outcomes: higher community discharge rates and lower readmission rates. Because relatively efficient SNFs were typically larger and had higher daily census, they achieved greater economies of scale. Their standardized costs were 8 percent lower than other SNFs.

On the revenue side, revenues were 11 percent higher, in part reflecting their higher share of the most intensive therapy case-mix groups. The combination of lower costs and higher revenues per day results in an average Medicare margin of over 18 percent, an indication that Medicare's payments are too high relative to the costs of treating beneficiaries.

We also look at the payment rates that some MA plans pay for SNF care. In three publicly traded companies that operate SNFs, fee-for-service payment rates averaged 21 percent higher than MA care payment rates. A survey of over 1,400 SNFs conducted by the National Investment Center for Senior Housing and Care found slightly higher differences between fee-for-service and MA rates. I think
it was 22 percent.

Our analysis of the characteristics of SNF users enrolled in MA and fee-for-service concluded that the users were not that different and would not explain these differences in payments. The publicly traded firms also report seeking managed care business, suggesting that the lower MA rates are attractive enough.

To project the average 2019 margin, we assumed that costs will grow between 2017 and 2019 at the five-year average annual increase.

To project payments, we updated the payments by the updates mandated by MACRA and the BBA of 2018. We also reduced payments in 2019 by the portion of payments retained as savings from the value-based purchasing policy. The projected average Medicare margin for freestanding SNFs in 2019 is 10 percent.

In considering how payments should change for 2020, indicators including access to care, access to capital, and quality are stable. The level of Medicare payments remain too high. For years, the Medicare margin has been among the highest of any sector. The wide variation in Medicare margins reflects differences in
patient selection, service provision, and cost control. The PPS has historically favored the provision of therapy and needs to be revised. CMS's proposed revisions are long overdue and should prompt providers to better align therapy with patient care needs and increase providers' willingness to admit medically complex patients.

This leads to the Chairman's first draft recommendation, and it reads: The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case mix groups to maintain alignment of payments and costs.

The implementation of a revised SNF PPS will increase the equity of Medicare's payments by increasing payments for medically complex care and decreasing payments for intensive therapy care that is not related to a patient's condition. The redesign would narrow disparities in financial performance across SNFs. The recommendation also calls for the Secretary to recalibrate the relative weights of the case-mix groups. The redesigned PPS is likely to alter the mix of cases treated, providers' cost structures, and the relative costs of different types of
stays. To keep payments aligned with the cost of care, the Secretary should recalibrate the relative weights each year.

In terms of implications, the recommendation would not affect spending; the revised PPS would be implemented to be budget neutral to the current level of spending.

For beneficiaries, access should increase for medically complex patients. Given the level of Medicare margins, we expect providers should continue to be willing and able to care for beneficiaries. A revised PPS should reduce the variation in Medicare margins across providers. The impact on individual providers will depend on their mix of cases and their current practice patterns.

The second recommendation addresses the level of payments, and it reads: The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

The level of Medicare's payments indicates a reduction to payments is needed to more closely align aggregate payments to aggregate costs. However, we expect the SNF industry to undergo considerable changes as it
adjusts to the redesigned PPS.

Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting some pressure on providers to keep their cost growth low. The Commission will continue to monitor beneficiary access, quality of care, and financial performance and may consider future recommendations based on industry responses to the new payment system.

In terms of implications, spending would be lower relative to current law. Given the high level of Medicare's payments, we do not expect adverse impacts on beneficiaries. Providers should continue to be willing and able to treat beneficiaries.

As required by PPACA, we report on Medicaid trends in nursing home spending, their spending, their utilization, and financial performance, and that information is in the chapter, and I won't go over it now. I'll put the Chairman's draft recommendations up, and I look forward to your discussion.

DR. CROSSON: Thank you, Carol. Very clear.

Clarifying questions? David.
DR. GRABOWSKI: Thanks, Carol. This is great work. I wanted to start by asking you about this big change we're going to see in fiscal year 2020, the patient-driven payment model. Do you have any sense -- it's like pressing "reset" for the sector, shifting from paying for therapy to paying for patient characteristics. Do you have any sense what that's going to do to margins? I know it's going to totally change incentives, but I'm trying to just think about going forward, what does that look like in terms of --

DR. CARTER: Well, the margin should change -- should remain the same because it is going to be budget neutral. At least that was what was in the proposed rule and final rule for this year, but it's to be implemented next year. I haven't heard discussions about whether it will continue to be implemented budget neutral, but I think that's the expectation.

There will be some redistribution, and I would suspect that the difference between for-profits and nonprofits will narrow, and between freestanding and hospital-based. So the narrowing of the distribution -- but it won't eliminate it. I should emphasize the cost
differences are real between nonprofits and for-profits.

So this payment system's not going to correct that, but the
narrowing will happen.

DR. GRABOWSKI: That was going to be my second
question, so let me get to my third and final question,
which was: Have you ever calculated the all-payer margins?

Medicaid is such an important payer in this sector --

DR. CARTER: Yes.

DR. GRABOWSKI: -- and it differs quite a bit
across states in terms of its generosity.

DR. CARTER: Yes.

DR. GRABOWSKI: Have you ever calculated sort of
state-by-state margins and show they're much higher in
these high-payment states --

DR. CARTER: No, I haven't done that.

DR. GRABOWSKI: No? Okay. That might be
interesting --

DR. CARTER: Yeah, I would expect them to differ.

DR. CROSSON: I'm sorry. For SNFs or nursing
homes?

DR. GRABOWSKI: For SNFs that also care for these
long-stay nursing home residents.
DR. CARTER: Right.

DR. GRABOWSKI: So they do both. These aren't only caring for Medicare --

DR. CROSSON: No, but which -- okay.

DR. GRABOWSKI: I wanted to look at the all-payer margins for SNFs.

DR. CROSSON: For the facilities, or for the SNF patients?

DR. GRABOWSKI: For the facilities. Sorry, for the overall nursing home --

DR. CARTER: For the facility, so it includes the nursing home business, and actually our total margin also includes if they have a home health business and outpatient, sort of all business, all payers, yeah.


MS. BUTO: Carol, do you know why the total margins went down -- are lower for for-profits versus not-for-profit nursing homes? Apparently, they were pretty comparable until 2017, but something happened. Do you know what that --

DR. CARTER: I haven't looked at that. It's possible just given what's happening with their payer mix
for MA plans that there's different mixes across for-
profit/not-for-profit, so you would see that in the total
margin. I haven't looked at that, though.

DR. CROSSON: Okay. Seeing no more questions,
we're going to move on to the discussion. The
recommendations are there. We'll hear discussion about
support or lack thereof or other ideas with respect to the
recommendations. Yeah, David?

DR. GRABOWSKI: I'll just say very quickly I'm
very supportive of these recommendations. I'm also struck
both in this discussion and our hospital discussion how
Medicare doesn't pay in a vacuum, and we pay alongside
other payers in these sectors. And when it comes to
hospitals, the dollars run from commercial payers to
Medicare. Here Medicare is cross-subsidizing Medicaid, and
I think that's a really important point, and there is some
text in the chapter around that's not the most efficient
way to cross-subsidize Medicaid. I very much agree with
that, yet these are all Medicare-eligible individuals.
They're dually eligible. They're Medicaid. But I just
want to make that point, that Medicare's not just an
important payer in this sector for kind of post-acute care;
it also is an important payer for Medicaid. And I'm not advocating that we kind of incorporate that into how we make our decisions going forward, only that there's some interdependence there, and we've got the good side of that with hospitals. Here we're seeing the other side of that coin that dollars are flowing the other direction. So I just wanted to make that point. But I'm very supportive of the recommendations.


DR. PAUL GINSBURG: I also support the recommendations. You know, following up on what David was saying, we just have a very complex thing that -- I mean, unlike hospitals where commercial payers and Medicare and Medicaid are paying different prices for pretty much the same thing, here we have a situation where the Medicaid is paying for different services, lower-acuity, custodial services, but still, you know, the reality -- and I was talking to Carol during the break about this -- is that it seems as though SNF and the custodial Medicaid services seem to really go in the same nursing homes, and that few have been successful in separating out the SNF and having a SNF-only business. So that makes it complex.
I have a sense that, Medicare being the better payer, as long as Medicare continues to be the better payer, states likely will respond by paying even less for their patients because they can. And if Medicare, you know, pays less generously, I think states will ultimately have to pay more. And it's important to keep this in mind as we contemplate this decision.

DR. CARTER: I guess the one thing I would follow on to that is people often look at the Medicaid rate and the Medicare rate, and they are really buying different packages of services. When I look at the relative weights of the Medicaid patient versus the Medicare patient, they're sort of orders of magnitude different. So if Medicare were paying for that same package of services, its average payment would be much lower also.

DR. CROSSON: Good point. Okay. Thank you. I'm looking around. I'm not seeing any signs of objection to the recommendations, so we will bring this forward in January in the expedited mode. And, Carol, thank you once again.

[Pause.]

DR. CROSSON: Okay. We'll move on to the next
presentation. Welcome back, Craig. Craig and Dana are
going to take us through the update for inpatient
rehabilitation services.

MR. LISK: Good afternoon. Glad to be back.

So after illness and injury or surgery, many
patients need intensive rehabilitation care, including
physical, occupational, and speech therapy. Sometimes
these services are provided in inpatient rehabilitation
facilities. Today I will briefly review Medicare's payment
system for IRFs, including some concerns we have about the
payment system, and then I will present our payment
adequacy analysis.

In 2017, Medicare spent $7.9 billion on care
provided in about 1,180 IRFs nationwide. There were about
380,000 Medicare fee-for-service IRF stays in 2017, and on
average, Medicare paid a little more than $20,300 per case.
Per case payments to IRFs vary depending on
patient's condition, level of impairment as measured by the
IRF, age, and comorbidity. Medicare accounted for about 58
percent of IRF discharges in 2017. The average length of
stay in an IRF was 12.7 days.

To qualify for an IRF, facilities must meet
Medicare's conditions of participation as well as several additional requirements outlined in your paper. In addition, for a stay to be covered, there are certain patient requirements that must be met as well. We will be happy to discuss these on question.

The Commission has made two observations about the IRF payment system that raise concerns. First, we have observed that high-margin IRFs have a different mix of cases than other IRFs do. This suggests that some case types may be more profitable than others.

Second, the Commission has found evidence to suggest that patient assessment may not be uniform across IRFs. We, for example, found that patients in high-margin IRFs were less severely ill during the preceding hospital stay compared with patients in low-margin IRFs. But once patients were admitted to and assessed by the IRF, the patients were coded as being more impaired on average.

At any level of severity in the acute-care hospital, high-margin IRFs consistently coded for a higher level of impairment than did low-margin IRFs. What is important to remember is how IRFs code affects payments and that we currently rely on IRFs to assess patients'
functional status that helps determine their payments.

I'll turn now to our review of payment adequacy for IRFs. We've used our established framework that you have seen in earlier presentations today. We will start by considering access to care.

We first looked at the supply of IRFs. In 2017, there were just under 1,180 IRFs nationwide, a slight decrease from 2016. However, despite this decline in number of facilities, the total number of IRF beds edged up slightly, with a little more than 37,000. As you can see in the facilities column on the chart, only 24 percent of IRFs were freestanding, but freestanding IRFs tend to be bigger, so they accounted for slightly more than half of Medicare discharges in 2017. And even though the total number of facilities declined in 2017, the total number of freestanding facilities actually continued to grow.

Overall, 33 percent of IRFs were for-profit, accounting for 54 percent of Medicare fee-for-service cases. The number of for-profit IRFs also continues to grow steadily.

We next move on to beneficiaries' access to care, and in 2017, we find a slight dip in the volume of Medicare cases and the number of cases per fee-for-service
beneficiary. However, payments per case continue to rise along with Medicare expenditures for IRFs. If we look at marginal profit, we see that it is a robust 40.9 percent for freestanding IRFs and 19.4 percent for hospital-based IRFs, meaning that both sets of providers have an incentive to serve additional Medicare beneficiaries, assuming that they qualify for IRF-level care.

We also looked at the quality of care furnished in IRFs using risk-adjusted measures developed for MedPAC. Overall, we find some improvement since 2012 in our quality measures. The risk-adjusted rate of potentially avoidable readmissions during the IRF stay was 2.6 percent in 2017 and was 4.7 percent during the 30-days after discharge, both improving slightly from 2012.

Now, these rehabilitation rates -- these rehospitalization rates are low compared with those of other PAC settings, in part because IRF patients must be able to tolerate and benefit from intensive therapy, which means they tend to be less frail than, say, SNF patients. In addition, IRFs are certified as hospitals, so they may be in a better position to handle cases that have problems during the stay.
We also saw improvements in the share of patients discharged to the community, rising from 74.3 planning in 2012 to 76 percent in 2017. And we also saw improvements on gains in motor function and cognitive function over this period. But remember that function scores are provider-reported and affect payments, so should be viewed with some caution.

Turning now to access to capital, as I noted earlier, more than three-quarters of IRFs are hospital-based units which access needed capital through their parent institutions. As you heard this morning, hospitals maintain good access to capital. Hospitals with IRF units also had a strong all-payer margin which stood at 7.0 percent in 2017. Please note that we cannot calculate an all-payer margin just for the hospital's IRF line of business.

But if we look at hospitals with units and we look at their Medicare margins, we see their relative Medicare inpatient margins and overall Medicare margins were higher than for hospitals that did not have IRF units.

As for freestanding IRFs, close to half of the providers in the freestanding IRF category are owned or
operated by one large chain. Market analysts indicate that this chain had good access to capital, the company has continued its pursuit of vertical integration by expanding its business to include the purchase of home health agencies and hospice providers, and entering into joint ventures with acute-care hospitals to build new facilities. The all-payer margin for freestanding IRFs is a robust 10.4 percent.

We now move on to discuss payments and costs. As this next slide shows, the green line -- shows payments, the green line had been increasing faster than costs since 2009 with payments rising a cumulative 20.8 percent and costs rising a cumulative 14.5 percent. You will note that the cost growth was particularly low from 2009 to 2015, averaging just 1.5 percent per year.

These differences in per case costs and payment growth led to a steady rise in aggregate Medicare margins for IRFs, which climbed from 8.4 percent in 2009 to 13.8 percent in 2017. So for the past three years, aggregate IRF margins have remained above 13 percent.

Financial performance continued to vary widely across IRFs. The aggregate Medicare margin for
freestanding IRFs was 25.5 percent in 2017. In contrast, hospital-based IRFs had an aggregate margin of 1.5 percent. We also see wide differences in margins for for-profit and nonprofit IRFs. The primary driver in these differences in margins is costs, which tend to be lower in freestanding and for-profit IRFs.

So why do we see such a disparity in margins and costs as one of those factors between hospital-based and freestanding facilities? We think there are a number of factors.

First, hospital-based IRFs are more likely than freestanding IRFs to be nonprofit, and so they may be less focused on reducing costs to maximize returns to investors. They also may have fewer economies of scale.

Hospital-based IRFs tend to be much smaller than freestanding IRFs, and they have fewer total cases. Their occupancy rates are also somewhat lower.

Hospital-based IRFs also tend to have a different mix of cases. It's not clear why this is the case. As we mentioned earlier, some case types may be more profitable than others, resulting in higher margins for facilities that admit a larger share of those cases.
Finally, hospital-based IRFs may assess and code their patients differently, contributing to differences in payments for similar patients.

Next we will move on to our analysis that examines relatively efficient IRFs. This is the first year the Commission has completed an analysis to look at the financial performance of relatively efficient IRFs.

Efficient provider analysis had been part of the update framework for many of the other sectors, such as hospitals and SNFs, for many years. The approach we take for examining efficient providers in IRFs is similar to what we do for the other sectors. We examine IRFs with consistently low costs and high quality. In our analysis, we used three years of data -- 2014 to 2016 -- to categorize IRFs as efficient. We required that over the three-year period they be in the top third performance on costs or quality every year for one of these metrics and that they do not have poor performance, bottom third, on any of these metrics over the three-year period. We then assess the efficient hospital groups' performance using 2017 data and compare it to other IRFs.

What we find is that the relatively efficient
IRFs had better performance on quality metrics with readmission rates that were 9 percent lower and discharge rates to skilled nursing facilities that were 35 percent lower than for other IRFs. Relatively efficient IRFs also were larger and had higher occupancy rates than other IRFs, leading to lower costs. Payment rates, however, were similar between both groups but, as I mentioned before, with large cost differences. Medicare margins were much higher in the relatively efficient group, 16.5 percent in 2017 compared with 1 percent for other IRFs. The mix of cases was also different, and as we have discussed before, relatively efficient IRFs had a smaller share of stroke cases and a higher share of other neurological condition cases. Freestanding and for-profit IRFs were disproportionally represented in the relatively efficient hospital group here, but there were hospital-based facilities in the efficient group, and they represented about half of the facilities in that group. With that, we will move on to discuss our projected margin for IRFs in 2019. We expect that cost
growth is likely to exceed payment growth in 2018 and in 2019, and so we have projected that aggregate margin will fall to 11.6 percent. Payment growth will be limited because payment updates for fiscal year 2018 and '19 were set in statute at below market basket levels, 1 percent and 1.35 percent, respectively. And though cost growth in the industry was low from 2009 to 2015, cost growth was higher in 2016 and 2017, and we expect this higher cost growth to continue with costs rising faster than the payment updates in both '18 and '19.

So, to summarize, we observed capacity that appears to be adequate to meet demand and that providers should have an incentive to take more Medicare beneficiaries that qualify for IRF-level care given the strong marginal profits for both freestanding and hospital-based facilities. Our risk-adjusted quality outcome measures have improved slightly over time. Access to capital appears adequate. In 2017, the aggregate Medicare margin was 13.8 percent and the projected margin for 2019 is 11.6 percent.

And so that brings us to the update for 2020. We have started from the Chairman's draft recommendation from
last year, and it reads: The Congress should reduce the fiscal year 2020 Medicare payment rate for inpatient rehabilitation facilities by 5 percent.

To review the implications on spending relative to current law, Medicare spending would decrease. Current law would give an update of 2.7 percent, for your information.

On beneficiaries and providers, we anticipate no adverse effects on Medicare beneficiaries' access to care. The recommendation may increase financial pressure on some providers.

The Commission's standing recommendation to expand the outlier pool may increase payments to providers that treat more high-cost cases, which would tend to go to hospital-based and nonprofit facilities.

So, with that, I'd be happy to answer any questions. We'd be happy to answer any questions, and I'll look forward to your comments.

DR. GRABOWSKI: Thanks for this work and presentation. Could I ask you about Slide 9, the relative growth in payment and cost? What happened? What sort of took off and changed? Was there a policy change in there?
I just want to better understand --

MR. LISK: I think cumulative cost growth was being held down substantially, and I think profits had gone up so much they probably felt -- even in hospital-based facilities, the profits had started going up a little bit, even though it's relatively low compared to the freestandings. And so probably cost pressure wasn't there to hold down costs as much, so costs went up a little bit.

DR. GRABOWSKI: Maybe I'm not reading this correctly, but in 2009-2010, payments and costs per case are pretty tight there, right? Am I -- cumulative growth --

MR. LISK: This is cumulative growth.

DR. GRABOWSKI: Got it, okay. So this is relative margins.

MR. LISK: Yes, yes.

DR. GRABOWSKI: Thank you.

DR. CHRISTIANSON: Jon.

DR. PERLIN: Let me add my thanks for a terrific presentation. I just have a couple clarifying questions. First, we're talking about fiscal year 2020 in terms of the recommendation, but we also have
simultaneously something in motion, if my recollection is
correct, that we're switching in terms of the risk
adjustment or case-mix methodology from FIM to IRF PAI.
And I was just wondering what your assessment of how that
impacts this going forward is and how should we view that
in terms of our deliberations?

MS. KELLEY: Yes, so they're moving to the Care
measures that -- and moving off some of the FIM measures.
That's true. We expect that those will -- that will move
some money around. It will have no impact on aggregate
payments, of course, and we expect that it will
redistribute payments somewhat, but it shouldn't have --
it'll redistribute payments towards nonprofit and hospital-
based facilities, but I think the impact will be relatively
small.

DR. PERLIN: Okay. And the second question is:
Just in terms of trying to understand the dynamic of
utilization differently, how does MA influence the IRF use?
What do we know about that?

MS. KELLEY: So MA -- IRFs are required to submit
IRF PAI assessment forms for their MA patients. We don't
know -- however, since there's no connection with payment
on the fee-for-service side, there's no way of knowing how complete those reports are. But assuming we do have complete data, when we look at MA use of IRFs, what we see is generally lower use and much -- patients tend to be in particular case types. There's more use of IRFs for patients with stroke as opposed to neurological conditions, and the lengths of stay tend to be shorter. But we have not -- when we do that analysis, we have not controlled for -- what's not clear is whether or not areas that have IRFs are more or less likely to have high MA penetration, so that's something we haven't controlled for in that analysis.

So it's something we looked at in the past, but we don't have complete confidence in our findings.

DR. PERLIN: Thank you very much.

DR. CHRISTIANSON: Brian and then Paul.

DR. DeBUSK: First of all, thank you for a great report. It read really well. I had a question on page 3 of the presentation. You mentioned that the patient assessment may not be uniform across IRFs. This has a little bit of the whole MA coding issue feel to it in that, you know, are these patients at least in certain situations
being upcoded to realize larger payments. Do you have a feel and can you get your hands around the upcoding effect? And could you speak to the -- maybe focusing on program integrity and getting the coding right, or properly coded, versus the 5 percent payment cut? Could we realize the 5 percent cut or even more if the assessments were done correctly? That's what I'm trying to get a feel for.

MR. LISK: So there are some issues about how the assessments are done and some talking -- it was discussed I think last year and stuff where we looked at -- and some of it's a question whether some of the requirements to just do the assessment at the greatest level of impairment the person has. And so that's one -- kind of maybe one of the tricks that may go on, but it's kind of what focus places really have in learning how to do the assessments, too. So it's kind of like if everyone's assessing consistently, that would be an issue, but I think there's kind of a question of whether people are assessing fully how impaired a person is and what level of effort they put into it and what effort they learn to those assessments, too. So it can go both directions.

So some of the issue is whether hospital-based
facilities, for instance, are not putting as much effort into judging that assessment and the training. On the other cases, you know, they may be waking the patient up where an assessment will not be as productive for the patient, too.

DR. DeBUSK: That is what I was just trying to get at because, again, something needs to be done. I think there's no question you've made that case.

I was just wondering if you did the 5 percent cut and then, say, program integrity worked on this and we tried to get the assessment right, if the people who were doing the coding correctly in the first place, we're going to disproportionately suffer from the cut, and I just wondered how much emphasis we should put on adjusting the rate versus ensuring that the assessment is done correctly.

MS. KELLEY: So I think there's probably room for both things to be done.

About the assessments, I will say that I think Craig characterized correctly that it's not clear exactly what is going on. In a way -- well, from the sort of 10,000-foot view, it doesn't really matter what's going on. If we can't rely on the assessments, the payment system is
not moving money around to the patients who need or who have the higher resource needs.

When we dig down and try to think about how to fix the problem, I think there's a great deal of research about the reliability of the IRF PAI assessment tool, but I think a lot of that research was done before Medicare started paying on it. And I think as a payment tool, what we have seen or what we are starting to wonder about is whether or not we can rely on how much a provider's assessment of a patient really can vary and whether or not there's enough in the medical record that can actually support particular assessments, whether the medical record can provide the background information that one would need to check.

And Carol and Ledia are going to come back to us in the spring to talk about this issue of patient assessment and how reliable it is and whether or not -- to what extent we need it to make appropriate payment for post-acute care cases.

DR. CROSSON: Okay. I have Paul and then Kathy.

DR. PAUL GINSBURG: Yeah. Well, a really good job on this report. I learned a lot.
On Slide 14, it struck me as tautological saying that this efficient group of IRFs had better than average quality and lower than average cost, but that's how you chose them for that list. I suspect that that's not what you did, but that's what it seemed to me.

MR. LISK: I mean, in some ways, that is because we are requiring them to have two of the quality measures to be better on quality for those here. So, in some ways, yes, we're looking at places. We have had consistently low cost and consistently low quality, but we're looking at that at an earlier period, and we're looking to see how they're doing in 2017.

So they are performing well, and I think there's a lot of consistent -- in this group compared to even other groups, there's a lot of consistency. When we do this analysis, we have a large share of IRFs actually in a relatively efficient group compared to other settings. Even though we're requiring a third, we have about -- almost a quarter of the IRFs are in that efficient -- relatively efficient group.

But I think what's actually important to remember about that analysis too is that what we're finding now is,
even though we see the low margins in hospital-based IRFs, we are finding that half of those hospitals in the efficient group are hospital-based units. So we do know that hospital-based units can be relatively efficient in making those lower cost --

DR. PAUL GINSBURG: An idea is that you might do the analysis a little differently. First of all, look at the group that qualified based on low costs, and look at their quality compared to the other IRFs. And then do the same thing, the ones that qualified through your filter on high quality. Look at their costs. I think that might be meaningful.

MS. KELLEY: So that would be interesting. That might be something we could take a look at. We've tried to keep our approach to the efficient provider analysis consistent across the different sectors, and so maybe that's something we could consider, a change in the future. But for this first attempt at this analysis, we kept it consistent with what we've done in other sectors.

DR. PAUL GINSBURG: It's possible, then, that my question really applied to all the analyses, then.

[Laughter.]
DR. CROSSON: Kathy.

MS. BUTO: So I have a question about the Chairman's draft recommendation to reduce the 2020 payment rate update by 5 percent. I have two thoughts. One is, is some of that money being used to fund the outlier pool? Is that the reason that you went for 5 percent?

And then I looked back on SNFs, and I realized that for SNFs, which have a similar, not quite as high -- I guess it's a 10 percent Medicare margin projected for 2019, and this is 11.6. That we essentially recommend no increase or no payment updates.

So I'm just trying to understand the difference, and maybe this is partly a question for Carol. It might have to do with the transition they're going through in 2020, but it struck me that we for a long time said SNFs were really needed to face a reduction as well, maybe to keep the pressure on. I just wondered why this disparity.

DR. CROSSON: Kathy, it is exactly what you said, which is what Carol.

MS. BUTO: Transition.

DR. CROSSON: Yeah, transition.

MR. LISK: And the only other thing I want to say
is that for IRFs -- and we didn't put this slide in -- that
when we look at what the Commission has done from 2009
through 2015, the Commission recommended zero update. For
2017 and 2018, the Commission had recommended -- in our
2017 and '18 reports, we recommended a minus 5. So this is
consistent. This recommendation is consistent with what
the Commission recommended last year too.

MS. BUTO: This looks out of whack with SNFs, I
guess, in my view.

MS. KELLEY: Right. And so the change that we're
anticipating in the SNF case-mix system will.

The other thing you asked about, the outlier
pool. No, this would be separate from -- our standing
recommendation is to increase the outlier pool from 3
percent to 5 percent. This would be separate.

DR. CROSSON: Jon.

DR. CHRISTIANSON: That is actually what I was
going to ask about. It seems odd to have that sentence in
there, "As an implication of the Chairman's
recommendation." It's not an -- it would be true, no
matter what the Chairman's recommendation is, right, this
outlier pool in effect?
MS. KELLEY: That is true, and our discussion in
the report will reflect it in that way.

This was a way for us to remind you that we have
that standing recommendation out there and that if the two
recommendations were done simultaneously, this is what
would happen.

DR. CHRISTIANSON: Yeah. I think that's probably
better in the chapter than in the implications of this
particular recommendation, if it isn't.

MS. KELLEY: Okay.

DR. CROSSON: Okay. Seeing no further questions,
we'll move on to the discussion period. We have a draft
recommendation before you. The discussion should focus on
the recommendations, support, not support, other ideas, et
ce tera.

Seeing one.

[Laughter.]

DR. JAFFERY: So let me make sure that I
understand because this is to Congress, right?

DR. CROSSON: Yes.

DR. JAFFERY: So this is a little bit different
than some of our other recommendations?
DR. CROSSON: No. We've only had one recommendation that goes to the Secretary. That's the next one.

DR. JAFFERY: Okay. So that's the outlier.

All right. I'm going to withdraw my questions.

DR. CROSSON: Okay. The reasons is -- and everything except for -- what is it? IRFs? Long-term care hospital. Sorry. We have a standing congressional current law that we react to, and in the case of long-term care hospitals, there is none, although it's a little more complicated than that because it's actually the Secretary that sets the rate, but there is some guidance in MACRA as well. So it's kind of a mixed case, but it still goes to the Secretary.

DR. JAFFERY: Okay.

DR. GRABOWSKI: Jay?

DR. CROSSON: Yeah, David.

DR. GRABOWSKI: So I'll say I support the draft recommendation. I wanted to make one small comment, which is after reading this chapter, it really reaffirmed my support of site-neutral payment for post-acute care. That really came across in reading this. I'll leave it at that.
DR. CROSSON: Okay.

DR. GRABOWSKI: I think this would be Exhibit 1 and why we need site-neutral payment.

Thanks.

DR. CROSSON: Okay. I'm getting a sense that there is a consensus in support of the recommendation.

Thank you very much.

We'll bring this through expedited voting in January.

Craig, thank you, and Dana.

We'll move on to the final presentation for the day.

[Pause.]

DR. CROSSON: Okay. The last one for today's session is an assessment of the payment adequacy and recommendation for update for long-term care hospitals.

Stephanie, you've got the mic.

MS. CAMERON: Thank you. Good afternoon. Today we are here to discuss how payments to LTCHs should be updated for fiscal year 2020. Using the established framework, we will evaluate the adequacy of Medicare payments in LTCHs. As you will recall from our September
and November meetings, the Commission has been asked to assess changes in response to the implementation of a dual-payment structure for LTCHs, which is due in June. We plan to incorporate any relevant information from today and our January presentation into this report, as applicable.

Today I start by summarizing some background information that was included in your mailing materials. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay for certain Medicare cases of greater than 25 days. Care provided in LTCHs is expensive. The average Medicare payment in 2017 was over $38,000 across all cases and close to $46,000 across the cases meeting the criteria specified for payment under the LTCH perspective payment system that I will discuss momentarily.

As you will recall, the Pathway for SGR Reform Act of 2013 changed the way LTCHs are paid, and established a dual-payment rate structure. Cases meeting the criteria are those that are preceded by an acute care hospital discharge and either spend three or more days in the ICU of the referring acute care hospital or receive prolonged
mechanical ventilation in the LTCH. These cases are paid under the LTCH PPS and will be the focus of a lot of the analysis I will walk through. All other cases, those not meeting the criteria, are paid a lower site neutral rate. The policy began in fiscal year 2016 and is being phased-in over four years. Until 2020, cases that do not meet the criteria are paid a rate equal to 50 percent of the site-neutral rate and 50 percent of the much higher standard LTCH payment rate.

I will now turn to the question of how payments to LTCHs should be updated for fiscal year 2020. To determine the update recommendation, we review payment adequacy using our established framework consistent with what you've seen in other sectors throughout the day today. While we apply this framework on the prior slide in the same manner for LTCHs, we expect substantial changes from the implementation of the dual-payment rate structure given the financial disincentive for LTCHs to continue taking Medicare beneficiaries not meeting the criteria. Because of the reduction in payment, the extent to which LTCHs are better able to alter their admission patterns toward cases meeting the criteria will determine
facilities' financial performance under Medicare.

Because some LTCHs have dramatically altered their admission patterns in response to the policy consistent with the goals of the dual-payment rate structure, we isolate some of our analyses to the LTCHs with more than 85 percent of their cases meeting the criteria. I will specify when we consider this subset of providers during this presentation.

Now with that, we have no direct indicators of beneficiaries' access to needed LTCH services so we focus on changes in use, capacity, and occupancy. As you will recall, most beneficiaries receive this level of care in a short-term acute care hospital.

We are going to start with use. We find the number of LTCH cases declined starting in 2012. The reduction in volume has not been consistent across case types over the last six years. Although the volume of cases meeting the criteria decreased slightly from 2012 to 2015, which is before the policy started, starting in 2016, following the implementation of the policy, the volume of cases meeting the criteria increased, as expected.

In contrast, cases not meeting the criteria
declined more rapidly from 2015 to 2017, compared with prior years. As a result, the share of LTCH discharges meeting the criteria has increased since 2012. Just over half of LTCH cases met the criteria prior to the implementation of new dual-payment rate structure and aggregate. However, this share increased to about 64 percent in 2017.

As you know, historically, this product has not been well defined and the absence of LTCHs in many areas of the country and the variation in availability of LTCHs across markets makes it particularly difficult to assess the adequacy of supply. Although the number of LTCHs has been decreasing since 2012, there was more than a 4 percent reduction in supply from 2016 to 2017, with additional closures occurring in 2018.

In 2017, LTCH occupancy rates averaged around 64 percent, a 2 percentage point drop from 2016. This suggests that LTCHs have excess capacity in the markets they serve.

Medicare marginal profit across all LTCHs was 14 percent in 2017, down from close to 20 percent in 2016.

The marginal profit for LTCHs with a high share of Medicare
beneficiaries meeting the criteria was 16 percent. Therefore, we contend that LTCHs have a financial incentive to increase their occupancy rates with Medicare beneficiaries who meet the criteria.

Moving to quality, not unexpectedly, given differences in patient severity, unadjusted rates of direct LTCH to acute care hospital readmissions, death in the LTCH, and death within 30 days of discharge from the LTCH varied depending on whether or not the case met the criteria, but were all stable over time.

In 2017, for cases meeting the criteria, 10 percent were readmitted to the acute care hospital directly from the LTCH, 16 percent died in the LTCH, and 13 percent died within 30 days of discharge from the LTCH. This means that, combined, close to 40 percent of LTCH cases meeting the criteria in 2017 were readmitted or died within 30 days of LTCH discharge. By comparison, cases not meeting the criteria have lower rates of readmission and mortality.

CMS has published two years of data for several outcomes measures including new or worsening pressure ulcers, 30-day all-cause unplanned readmissions, catheter-associated urinary tract infection, and central line
bloodstream infection.

In 2017, the pressure ulcer rate was relatively low, around 1.3 percent. The risk-adjusted 30-day readmission rate was about 25 percent in 2016. This rate differs from the unadjusted rate I previously mentioned because of differences in methodology. The standard infection ratios for catheter-associated urinary tract infection and central-line associated bloodstream infection were lower than expected after adjustments for certain risk factors.

Moving now to access to capital. Access to capital allows LTCHs to maintain and modernize their facilities. However, given the last decade of policies that have limited industry growth, including moratoria on new facilities, and the implementation of the dual payment rate structure, the availability of capital is limited across the industry. Major chains have been diversifying their portfolios and have been strategic in their purchase, sales, and closure of LTCH facilities in more competitive LTCH markets, also reducing the need for capital.

LTCHs' access to capital also depends on their all-payer profitability which was 0.2 percent in 2017, down
from 3.1 percent in 2016, resulting from reduced payments for cases not meeting the criteria. LTCHs with more than 85 percent of their Medicare cases meeting the criteria had an aggregate all-payer margin of 4.2 percent in 2017.

LTCH cost per case increased by about 2 percent per year from 2012 through 2015 across all LTCHs, including those with a high share of Medicare beneficiaries meeting the criteria as of 2017. However, after the phase-in of the dual-rate payment structure began, the trend in cost growth diverged. In aggregate, growth in cost per discharge was low from 2015 through 2016, and negative from 2016 to 2017.

However, cost growth remained robust for LTCHs with a high share of Medicare cases meeting the criteria. Cost per case increased by 5.4 percent from 2015 to 2016, and by 5.6 percent from 2016 to 2017. These increases in costs are expected, given the increase in case mix and patient acuity associated with treating the higher severity of patients meeting the criteria. For this group of LTCHs, the share of cases meeting the criteria grew tremendously, by close to 30 percentage points in aggregate. We expect changes in cost growth over time will become increasingly
In 2017, the aggregate Medicare margin fell to -2.2 percent, down from 3.9 percent in 2016. However, the aggregate Medicare margin for LTCHs with more than 85 percent of their Medicare cases meeting the criteria was 4.6 percent, reflecting a 1.6 percentage point reduction from 2016. Consistent with LTCHs' financial performance in aggregate, differences still exist by facility ownership, even across LTCHs with a high share of cases meeting the criteria. We see a 13 percentage point difference in the margins between for-profit and nonprofit facilities, with for-profit LTCHs accounting for 87 percent of Medicare cases in this group.

Looking more closely at the characteristics of established LTCHs with the highest and lowest margins, this slide compares LTCHs in the top quartile for 2017 margins with those in the bottom. More than half of the LTCHs with the highest Medicare margins in 2017 also had more than 85 percent of their Medicare cases meeting the criteria. Therefore, many, although not all, of the attributes of the highest-margin facilities overlapped with those of LTCHs with a high share of cases meeting the criteria.
As you can see, high margin LTCHs tend to be larger and to have higher occupancy rates, so they likely benefit more from economies of scale. Low margin LTCHs had standardized costs per discharge that were 30 percent higher than high margin LTCHs. High margin LTCHs have fewer high cost outlier cases and are more likely to be for-profit.

We project that the 2017 Medicare margin for LTCHs with a high share of cases meeting the criteria will decline in 2019. Our projection of the LTCH margin for fiscal year 2019 focuses on LTCHs with more than 85 percent of Medicare cases meeting the criteria. This includes about 30 percent of LTCHs and aligns with the goals of the dual-payment rate policy, encouraging LTCHs to admit the most medically complex cases requiring specialized services.

We expect significant changes in LTCHs' costs as the dual-payment rate structure is fully implemented and continue to increase their Medicare admissions toward cases that meet the criteria. However, once an LTCH has reached a threshold of Medicare cases that meet the criteria, we expect the changes in cost will become increasingly stable.
and reflect cost growth levels consistent with those prior to the implementation of this policy in 2016. Using historical levels of cost growth, we project a 1.2 percent Medicare margin for LTCHs with a high share of cases meeting the criteria for 2019.

In sum, occupancy rates across the industry have decreased by 2 percentage points. Although growth in the volume of LTCH services per beneficiary declined, this decline is in large part from the implementation of the dual-payment rate structure and LTCHs admitting more patients meeting the criteria, which aligns with the goals of the policy.

In terms of quality, unadjusted mortality and readmission rates appear to be stable. While certain adjusted measures appear to be better than expected, it is likely too soon for a time-series analysis for other publicly reported measures. The effect of fully implementing the dual-payment rate structure will continue to limit industry growth and access to capital in the near term. Our projected Medicare margin for LTCHs with a high share of cases meeting the criteria in 2019 is 1.2 percent.

CMS historically has used the market basket as a
starting point for establishing updates to LTCH payments. Therefore, we make our recommendation to the Secretary. And with that, the Chairman's draft recommendation reads, 
The Secretary should eliminate the fiscal year 2020 Medicare payment update for long-term care hospitals.

Eliminating this update for 2020 will decrease federal program spending relative to the expected regulatory update. We anticipate that LTCHs can continue to provide Medicare beneficiaries who meet the criteria with access to safe and effective care.

And with that, I will turn it back to Jay.

DR. CROSSON: Thank you, Stephanie. Actually, I have a question myself. So in this particular case does the 1.2 percent projected 2019 margin, does that assume something about like a market basket update? It does.

MS. CAMERON: Yes. So the Secretary has historically provided a market basket update for LTCHs, and, in fact, there an LTCH-unique market basket that is produced annually. However, the Secretary is not under statute required to use that. The expectation is that he or she will apply it and then that market basket is
subsequently reduced by what’s in statute, and right now, for 2018 and 2019, that is a productivity adjustment downward, an additional adjustment that was mandated by the ACA. In 2020, that additional adjustment goes away and then it would be -- what would be expected is the market basket minus productivity. However, that is not in statute. The market basket piece is not in statute, and therefore, technically up to the discretion of the Secretary.

DR. CROSSON: Right. But that's built into the 1.2.

MS. CAMERON: That's correct. Yes.

DR. CROSSON: Okay. All right. Thanks.

Okay. Questions. Amy?

DR. BRICKER: What do you believe is driving the facilities to get out of the business, given the margins that we've highlighted? What's the driver? There's so few, right? Is it 398 now?

MS. CAMERON: Yes.

DR. BRICKER: So few.

MS. CAMERON: So few that have left?

DR. BRICKER: No. In total facilities.
MS. CAMERON: Oh.

DR. BRICKER: I mean, the same expenditure, when you look at the surgery centers, right, the same exactly expenditure. There are 5,800 of those. There's only 400 of these. I'm just curious, if the margins are as rich as I believe I understood them to be, then what's driving them to get out of the business?

MS. CAMERON: So I think in the past the margins have been significantly higher. So last year the margins for all facilities for Medicare were 3.9 percent, and this year they're down to -2.2 percent. And a lot of what we focused on today were the facilities that were taking a large share of cases meeting the criteria, thinking about the underlying goals of the policy and wanting to kind of transition to think, for the LTCHs that are aligning with those goals, what is their payment adequacy and thinking about it in that manner.

I think for the other LTCHs they've had quite a large reduction in their margin and they've seen a fairly large reduction in payment. And for LTCHs that have, you know, lower rates of admissions for patients meeting the criteria, their Medicare margins are quite low. And we
have found that because Medicare accounts for often more than half of an LTCH business, if that Medicare margin is quite negative the all-payer margin also goes down considerably.

And I think there have been a significant number of closures, although it's less clear based on the methodology we use in this report. You know, a gross number of closures is about over 40, and that's kind of using the most up-to-date data. That's not thinking about kind of the timeline of just up through 2017 that we typically use for this report. And that's 10 percent of the industry. So I think when you look at it that way, there have been a significant number of closures, and those closures did have fairly low Medicare margins before they closed.

DR. BRICKER: Yeah. I don't want to bleed into round two. I just -- I know we've had robust discussions about the role of these facilities. I think that there's not a consensus that I've felt overwhelmingly that the Commission holds about then. But if you have seen that they do serve, you know, a specific purpose around the most complex and critically ill, although only 100,000
beneficiaries, based on this information, why we would not
give them an update to payment, why we would recommend a
zero percent update.

MS. CAMERON: So is your question why is the
Chairman's draft recommendation zero?

DR. BRICKER: I guess I should turn --

MS. CAMERON: I think -- well --

DR. CROSSON: Yeah. So I think the thought here
is that -- and actually I was going to say something. I'll
say it now. Marge asked the question earlier, which is,
you know, does anybody listen to us, and I think this is a
good example of not only a recommendation of ours, with
respect to the dual payment system having been picked up
and passed into legislation, but once that happened then
the industry itself began to be reformatted in a way that
we see, where the facilities that were treating patients,
who arguably didn't need the expertise of the facility, are
now unprofitable. And so facilities who were, you know,
kind of using that as a business model are the ones who
appear to be dropping out. And those who are focusing, as
we would have wished, more appropriately on patients who
meet the criteria and who really need that type of care,
those facilities are doing much better. So I think that transition is expected to continue and has led us to the recommendation that at least at this point extra money is not needed. But that's for this Commission to decide.

MS. CAMERON: And if you will recall, there has been a long history of very rapid growth in this sector, especially following the implementation of the PPS, where really, since 2002, we've seen costs skyrocket. We've seen payments increase. We've seen the use of the facilities grow quite rapidly, and we've seen the facilities grow quite rapidly. So I think there is kind of a long history to go along with what you said, Jay, that kind of supports wanting to maintain a certain level of cost pressure on these facilities, given their relative responsiveness to payment policy, historically.

DR. CROSSON: Right. And again, I think the other piece of it is the recognition that these services can also be supplied, and are being supplied in many parts of the country, by acute care hospitals quite well. So it's not, you know, that if we see some facilities who are basing a business model on inappropriate provision of
services fall out that there's no other option for Medicare beneficiaries. At least that's the logic.

Paul.

DR. PAUL GINSBURG: To continue this discussion, I think the fact that there are a lot of departures from the industry, you know, I think we're comfortable with that, because of the change in structure of payments, what it was trying to achieve. But was still surprised with projecting a 1.3 percent margin for the types of long-term care hospitals that we want to keep, presumably the ones where most of their patients meet the criteria, why we would be recommending such a low margin for them.

You know, everything we've talked about today either had a margin that was very high -- you know, 10 percent or in that area -- or something that was negative, and we haven't really had occasion to discuss, well, what should an appropriate margin be, somewhere between negative and 10. And, you know, I guess the key thing is that we understand that this industry is still shaking out. There should be departures, but isn't there a subclass of long-term care hospitals that we want to keep, and it seems as though with a 1 percent margin we're not supporting that.
DR. CROSSON: Okay. Marge.

MS. MARJORIE GINSBURG: This information raises, to me, the question, are these facilities dinosaurs? Are we holding onto them because they still do serve some purpose somewhere, for some people, and they are providing some value? But looking ahead, do we really think we're going to have them? Are they still going to be here 5, 10 years from now? And if we think they shouldn't be dinosaurs, that we really -- regardless of how many there are, they plan an important role, then perhaps we should send the message that we value them and want to continue to see them function.

So, anyway, my main comment was really the dinosaur one.

MS. CAMERON: And so one of the things to keep in mind as we move forward, and this goes into the work that we've done and the Commission has done on the unified PPS, is looking at these services being provided, and, you know, the question of down the road, transitioning toward a much more kind of patient-centric payment model that is across all setting. You would see patients who may now currently be in an LTCH perhaps seen in different settings, but all
the payment would be kind of leveled out across those
settings for that same patient.

So I think, you know, maybe, Marge, you're
thinking more ahead of, you know, are the silos, maybe is
that the dinosaurs and it's moving towards a unified PPS
that we're really after.

DR. CROSSON: Yeah. Thank you. But in that
interim period of time we still have these facilities, and
I think it's our responsibility to decide whether we think
this is an update that's adequate or not. And I want to
hear more discussion about that.

Jonathan and then Kathy.

DR. JAFFERY: Yeah. So I think generally I am
supportive of the draft recommendation. I have a concern
about the criteria, and I think that actually may be very
relevant if we go to a unified system and where patients
have the opportunity to go to other places.

But I recall that there was something -- it might
have been in some previous reading from a prior meeting,
but it also drives as my own personal experience with these
organizations -- that they have increasingly tried to
increase their catchment area in order to improve the
number of -- you know, fill their beds, which is understandable. But, you know, that means that they're reaching out to smaller -- likely reaching out to smaller hospitals, community hospitals and other places, in a broader area.

And when I think about these two criteria -- so mechanical ventilation while in the LTCHs, prolonged mechanical ventilation seems like a pretty clear proxy for severity -- it's not as clear to me that three days in an ICU, from the referring acute care hospital, is always a mark of very high severity, especially as you're getting into different facilities. ICU stays in a small community hospital can look very, very different from other facilities.

And so if we're baking those criteria into what will be a significantly higher payment for LTCHs, or potentially for other post-acute settings, or even acute care settings, as outlier payments or whatnot, I wonder if we should be thinking about a different proxy for severity, or if that one, in particular, is adequate.

DR. CROSSON: Okay.

MS. CAMERON: So the Commission, in their
recommendation on our recommendation in March of 2014, we actually had an eight-day criteria, to partially get at the issue that you're talking about. I think three days in an ICU, the Commission has been, in the past, and obviously continues to be concerned with, given that it almost comprises about a quarter of current acute care hospital users have at least a three-day stay in an ICU. So I think there is a fairly large pool of potential LTCH candidates, if you're only looking at ICU use, whereas if you moved to an eight-day you're getting 5, 6 percent-ish of patients instead, and that's obviously a much higher severity, I think, type of patient who would be eligible for LTCH care. So the Commission remains on record with an eight-day ICU stay recommendation.

There has been a significant amount of work trying to distinguish LTCH patients or patients appropriate for LTCH, and how do we define the most chronically critically ill. The literature, you know, has provided a wide range of descriptions, but I think the difficulty is finding that data and having descriptions that also match claims data, or data that can be used to define the patient in a clear way. And the ICU days has been one of the
actual data points that does seem to distinguish patients. Now whether 3 days is too little, I think the Commission has been in agreement, but I think the measure itself seems to be one of the more solid ones that's out there.

DR. GRABOWSKI: So just to follow up, I appreciate that. The length of the ICU stay doesn't really change this potential issue of what an ICU stay looks like in different kinds of acute care facilities. And so it also appears that there is a particular expertise that comes on LTCHs often, which is around prolonged ventilation and difficult-to-wean patients and patients who are on ventilators with other conditions, for whatever reason, so that they become prolonged. And so I'd encourage us to think about looking at the criteria more in the future.

DR. CROSSON: Kathy and then David.

MS. BUTO: So, Stephanie, remind me what the number is again of individuals who are discharged from an LTCH, the mortality rate. Is it 30 percent, 40 percent, within 30 days, something like that?

MS. CAMERON: Right. The measure you're looking at -- so I think I mentioned almost close to 40 percent and that was a readmission plus a death in the LTCH, plus
mortality within 30 days of discharge.

MS. BUTO: Thirty days.

MS. CAMERON: So it's kind of the adverse event that occurred between being in the LTCH and 30 days post-discharge.

MS. BUTO: Okay. So I think it's probably 29 percent, 30 percent, something like that, for death, as I recall.

MS. CAMERON: Yes. I think that's right.

MS. BUTO: And so when I was reading this material I started thinking, the LTCH feels lot like a hospice for people with respiratory failure. There are a lot of individuals on ventilators in the LTCH, and those clearly are not as easily, I guess, treated, or there's not as much a specialization in maybe other settings. So at least in my mind, there was that issue. But I wanted to just check that with you, since we're in round one, before drawing any conclusions. Is that right? Are they a lot of respiratory failure patients?

MS. CAMERON: Absolutely, and as you look toward the facilities that take a larger share of patients meeting the criteria, the ventilation, you know, obviously you
would expect those to be more respiratory in nature. And so, you know, the LTCHs have been experts, I think, in a lot of ways, at vent weaning, and for the respiratory population, the population that has respiratory needs, a place for treatment.

That said, I don't have offhand, but I could provide additional information on certain respiratory conditions and the mortality and readmission rates for those specifically, if you think that would be a helpful statistic to have, thinking about just kind of the respiratory DRGs and how that looks.

MS. BUTO: I just think it would be helpful to us as we think about the unified PAC to think about what is the niche that LTCHs may or may not be able to play in that post-acute care unified PAC world, to know a little bit more about that set.

MS. CAMERON: Right, and I think the LTCHs, because they have an average length of stay requirement, they are not looking -- their preference is not trying to find patients they think are going to die in their facility or soon thereafter. I mean, death is very, very hard to predict. I think even under the best circumstances it's
very difficult. But the LTCHs, you know, have to make
sure, or do their best to ensure that patient is strong
enough to make it, because, you know, these are not large
facilities. They have very long lengths of stay. And if
there are a handful of patients that die within a week of
their stay, their average length of stay can really be
reduced, and I think then there's a problem on the facility
with its certification.

So, you know, it's not -- I worry about thinking
of them as a hospice, with all due respect, because they're
doing a lot of interventional care and their goal is to,
you know, to provide --

MS. BUTO: To prolong life --

MS. CAMERON: -- curative care.

MS. BUTO: -- et cetera. Yeah. No, I wasn't
actually trying to label them as hospices. I was just
trying to understand, you know, because they are among the
most expensive, you know, institutional settings that
exist. In fact, the downside for them is being paid at a
DRG level. So it just helps to think about where they fit
in the overall continuum.

MS. CAMERON: Sure.
MS. BUTO: Thanks.

DR. CROSSON: Okay. I'm not sure who was first.

I had Pat and then Sue. Sorry. On this point, Sue?

MS. THOMPSON: On the point, and I think the comment that Kathy made about this feels like we're talking about pre-hospice. If we just step back, this whole business -- and I need my clinical friends here to help me with this discussion -- but it strikes me that the fact that we have Medicare patients that end up in need of LTCH care, in many cases could be addressed if we were more proactive and intentional to have conversation about folks' intentions, what they would want. I can assure you, when you look at the kinds of quality measures, pressure ulcers and urinary tract infections and bloodstream infections, these all end up in sepsis, and that is not -- and ventilator dependency, that is not the way -- and I know we weren't going to bring Mom up again, but that would not be the way I would want my mom to see her demise.

And I think the fact that we are in this conversation about LTCH is a comment on our ineffectiveness in a health care industry to address getting upstream here a bit, and having the conversation with folks about their
intentions, so that they don't, in many cases -- and in some cases they do. This is their intention and it is their want. But in many cases they would not desire to be in this situation.

So the comment that you make about hospice, Kathy, I think it resonated with me and I would ask other clinicians to comment on that. And I don't know that there's anything to do with payment update, in terms of a policy recommendation, but it just strikes me that it just smacks of an inadequacy, and I'm guessing this is a round two comment. But I had to comment while Kathy made that question about hospice care.

DR. CROSSON: Okay. Thank you, Sue. Pat.

MS. WANG: Can you remind us what happens to this class of providers under the unified PAC-PPS?

MS. CAMERON: I'm sorry, what?

MS. WANG: What happens to this group of providers under the unified PAC-PPS --

DR. CROSSON: Go ahead, Carol.

MS. WANG: -- relative to the current -- if the projected margin -- and I'm going to put you on the spot.

DR. CARTER: No, but I know the answer to this
question. Yeah. So there wouldn't be a specific payment
adjustment based on setting, but what we're trying to do
are define the types of patients and patient
characteristics that zero in on care needs. And so, for
example, payments would increase for severe wound care, for
medically complex, for patients with five or more body
system conditions, for ventilator dependence, and each one
of those adds payments.

So, I mean, those are patients that probably are
LTCH -- the poster child for an LTCH patient, but it's
defining the patient characteristics as opposed to the
setting.

Does that help?

MS. WANG: It does. Is it possible to say, under
the modeling that you did, that if you took one of these
efficient LTCHs that Stephanie has identified, whose
projected margin in 2019 is 1.9 percent, if the unified
PAC-PPS were fully in place, what would their margin be?

DR. CARTER: I don't know what their margin would
be but we did look at separating out the impacts on
payments between LTCH patients that meet the criteria and
patients who don't. And payments for all LTCH patients go
down because most of these patients are also treated in other much lower-cost settings. But the payment reduction for LTCH qualifying cases is much smaller than the reduction for non-qualifying cases, and it's because the non-qualifying cases are predominantly treated in SNFs, which is a much lower-cost setting.

So we didn't -- and we might have done the facility change in payments for LTCH that have a preponderance of LTCH qualifying stays. I can't remember -- criteria. But in general, the payments go down for all LTCH patients, but for the qualifying they go down less.

MS. WANG: Okay.

DR. CARTER: And we are trying to capture directing payments to patient criteria that are sort of the heavy care, medically complex patients.

MS. WANG: Okay. I find that clarification really helpful to put into context the transition of this particular group of providers, so thank you.

DR. CROSSON: It was very helpful, because I think it suggests -- and I'm not sure how this is going to play out in the second part of this discussion, but it suggests that LTCHs, even those who are caring for the
patients who meet the admission criteria, are going to be in more financial straits as we move forward here. So seeing no further questions, let's take a look at the --

MS. CAMERON: Can I just make a quick clarification?

DR. CROSSON: Yeah. Go ahead.

MS. CAMERON: I just want to be clear that the providers that have greater than 854 percent of their cases meeting the criteria, we have not classified them as efficient or not. That is, we don't do that analysis for LTCHs because of historical issues with some data, and now this giant payment change that's occurring.

So, you know, we have not looked at them based on quality. We do know their costs are actually a tad higher, which could result from the different care that they are providing. But just to be clear, that's not an efficiency measure.

DR. CROSSON: So thank you, Stephanie. Without putting you on the spot, because I realize that we're talking about Secretary discretion, but you do have a track record of what the Secretary has done in the past.
1 Realizing the fact that the Secretary is now dealing with
2 some requirements in law, can you make an educated guess as
3 to what the Secretary's decision might look like for 2020?
4
5 MS. CAMERON: Yes. I believe it's 2.8 percent.
6 I think it's similar to the hospital.
7
8 DR. CROSSON: And that includes the reduction for
9 -- okay.
10
11 MS. CAMERON: That's right.
12
13 DR. CROSSON: All right. Okay. So let's have a
14 discussion about the recommendation as it stands, and I
15 think the issue on the table is one of payment adequacy
16 pretty much. It's not a policy issue here per se.
17
18 Paul.
19
20 DR. PAUL GINSBURG: I'll start off and just say
21 that I haven't heard a case so far, you know, for not
22 having an update, and I'm open to hearing a case but I
23 haven't heard one.
24
25 DR. CROSSON: Other comments. Amy.
26
27 DR. BRICKER: Yeah. I think based on the
28 discussion thus far if we can focus on ensuring that the
29 criteria is there to promote this qualifying patient -- I
30 remember so many conversations that we've had, at least in
the last three years, around these facility types, and specifically around mechanically ventilated patients and their ability to wean. I'm just sitting here thinking if I had a choice in a community between, you know, my hospital or a facility like this for a loved one, you know, where would I rather be, if that were my medical situation.

So I just want to make sure that we're thinking about the value that these facilities, those that should be in operation, if we have done a good job of ridding ourselves of those that maybe shouldn't, I just want to protect them, because I think that unless we can hear some other rationale, they do serve a critical purpose in the ecosystem, and I'd like to continue to protect them. So I'm not as compelled, with this facility type, to not provide the update.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: I'm not opposed to giving them an update but I think the argument -- just to respond to Paul and Amy -- would be if you look at those LTCHs that are treating 85 percent or greater of cases meeting the criteria, they do have a margin here of 4.6 percent. And so those are relatively healthy.
And to Carol's point, if those who don't meet the criteria should really be receiving treatment in a SNF, then these are exactly the LTCHs that we want to reward with, you know, going down the road, and they do seem to be fairly healthy. Once again, we can argue whether 4.6 percent is a good margin.

DR. PAUL GINSBURG: Well, actually, I think the only difference between us, presuming you are on Slide 14 -


DR. CROSSON: That's 2017 and we're talking about projected.

DR. GRABOWSKI: Sure. Sure.

DR. CROSSON: We're talking about projected margin.

DR. PAUL GINSBURG: Yeah, but the projection for these is 1.2.

DR. CROSSON: Okay. Yeah, Pat.

MS. WANG: You know, I respect what people have said, but then what does that -- does that call into question our embrace of the unified PAC-PPS, because it sound like that's going to make the situation worse for
these organizations. They're going to get cut. So if there's concern about preserving them as part of the infrastructure of the health care system, you know, how do you reconcile these two things -- payment update and then unified PAC-PPS, payment decrease?

DR. CROSSON: And remind me. Unified PAC-PPS is 2022? Carol, is that right, 2022? Okay. And we're talking about -- sorry.

DR. CARTER: Do you mean what the Commission --

DR. CROSSON: Yeah, what we've recommended, 2022.

DR. CARTER: Yes. Right.

DR. PAUL GINSBURG: We don't know when it's actually going to be implemented.

DR. CROSSON: Right. Right. You know, I have the sense here that we're of two minds on this particular issue, and I have some discomfort myself, to be frank, after listening to the discussion. So I'm going to suggest that we come back in January for reconsideration of this issue, with perhaps -- can we do options in this regard?

DR. MATHEWS: Why don't we talk after the meeting?

MS. BUTO: Get a little more data on how some of these prevalent conditions in LTCHs might be already being managed in SNFs, for example, and maybe IRFs, but I don't think IRFs because of the severity of illness. In other words, it would help to know how much capability there is in other settings, even as they move toward the 2020 changes, are SNFs going to be taking on more of these patients? I think that would help us understand the context.

DR. CROSSON: Yeah. I mean, my own sense, and it's based on no data, is that there's plenty of capability, because as Amy pointed out, there are not many of these in the country. So we've got patients being cared for in acute care hospitals and SNFs as well. If we could get more quantitation of that.

DR. MATHEWS: Yeah. And, in fact, isn't the strong majority of those kind of patients are being treated in non-LTCH settings?

MS. CAMERON: That's right.

DR. CROSSON: Right. And the cost differential?

MS. CAMERON: It's quite significant. I mean, the average LTCH payment, as I showed earlier, you know,
$40,000, close to. The SNF payment is $18,000, on average. You know, we haven't adjusted that at all by condition, but, you know, it's an order of magnitude difference.

DR. CROSSON: So this is a policy tension here, because, you know, I understand the notion here of providing an update that is adequate for the best of these facilities to continue. On the other hand, one would say what are we doing if, in fact, this is very much more costly than other settings? Because I guess then the argument comes down to whether or not the specialized services, knowledge, expertise of these facilities is sufficient to justify the extra cost.

DR. MATHEWS: And one other thing to add there, and, Stephanie, this is memory refresh exercise. When we made the original recommendation regarding eight days in the ICU to identify qualifying cases, wasn't there a companion part of that recommendation that said the savings from this part of the recommendation should go to fund outlier payments in acute care hospital, or am I missing something?

MS. CAMERON: Nope. That's exactly right.

DR. MATHEWS: Yeah. So it was an explicit
recognition of the fact that acute care hospitals are
treating the majority of these cases and would benefit from
the additional money due to their high cost.

DR. CROSSON: Paul and then Jonathan.

DR. PAUL GINSBURG: Yeah. I mean, is it correct
that we have a report to Congress in June, due in June --

MS. CAMERON: Yes.

DR. PAUL GINSBURG: -- on long-term care
hospitals?

MS. CAMERON: It is correct.

DR. PAUL GINSBURG: So that might be a time to
consider, you know, do they really have a role in Medicare.
It seems to be premature starting to use no updates to sort
of getting there until we've actually come to the
conclusion and submit it to Congress, which, you know,
maybe will happen.

So, I think, I mean, it's one thing for us to
decide they shouldn't really have a role. We've been
working on them for a long time, and, therefore, this is
one of the things that should happen to diminish their
role. And then we'd have a justification for recommending
no update. But without doing that it's kind of hard to --
I don't see a justification for that at this point in time.

DR. CROSSON: I understand the point you're making but I just want to be clear. That's not the point we're making here, and the update recommendation is, you know, let's make the update so small that all of these facilities go out of business. That's not what we're recommending. I think it's legitimate to contest whether or not this particular recommendation of 0 versus 2.8 is the right recommendation. I think that's fair enough.

DR. MATHEWS: Or any point in between those two.


DR. JAFFERY: Yeah. I guess I just -- this has come up a couple of times now and I want to emphasize this point, a point. So we're talking about this moving towards being an element of a unified post-acute care payment system, and LTCHs are at one end of that, and it's not clear to me -- and I think it's not clear to lots of people all the time, because this keeps coming up -- that they're always, or maybe predominantly, in the post-acute care space. They may really be more in the acute-care space, in fact. That's part of their name, right?
So, you know, and I'm thinking about Amy's comment about if I needed this type of care I'd want this in my community so I could go. Well, so maybe that depends on if you're faced with there's a nursing home that doesn't have great capacity for this or great experience, but not comparing it to the acute care hospital that maybe could do this more effectively or as effectively.

So I'm not sure, to me, this totally fits entirely in the post-acute care space. And, you know, that's not going to impact this recommendation right now, but I think we need to think about that.

DR. CROSSON: Bruce.

MR. PYENSON: Yeah. I support the recommendation as written, and I think what convinced me is some of the discussion around the historical elasticity of this segment to adjust. And I think that's an important characteristic to look for in the transformation of the system. Thank you.

DR. CROSSON: Okay. So I think it should be obvious that this doesn't fit the criteria for coming back with an expedited vote in January. So I think there have been an number of good points here, and not just points but
values. We've got some competing values going on here, which I think deserve some more explication. So I'm going to suggest to Jim -- I already have -- and to Stephanie and others that we come back in January and we lay out some of these issues. How is this care provided? Where is it provided? What's the financial impact on the Medicare program of various sites? If we can, with some of the implications of the recommendations on unified PAC, would that take place? So we have a little bit better grounding.

And then as part of that, perhaps thinking again of what the updated recommendation might be. I have to talk to Jim about whether we can -- you know, in keeping with our practices, whether we can actually have options for, or we just need to bring forward a recommendation based on some more thought.

Does that sound okay to everybody?

[No response.]

DR. CROSSON: Okay, good. Thank you. Thanks very much.

So that's what we'll do, and that bring to the end the discussions for today.

DR. CROSSON: We now have time for a public
comment period. If there are any of our guests who would
like to make a public comment, now is the time to stand up
and be recognized.

[No response.]

DR. CROSSON: Okay. Seeing no one come forward,
I would -- before we close I did neglect this morning to
ask about discussants for the Medicare Advantage chapter
tomorrow. Does anybody want to raise their hand on that
one? Pat, okay.

So we are adjourned then until 8:00 tomorrow
morning -- 8:00 tomorrow morning -- 8:00 tomorrow morning.

Thanks very much. Thanks you.

[Whereupon, at 4:05 p.m., the meeting was
adjourned, to reconvene at 8:00 a.m. on Friday, December 7,
2018.]
MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, NW
Washington, D.C. 20004

Friday, December 7, 2018
8:00 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
MARJORIE GINSBURG, BSN, MPH
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
SUSAN THOMPSON, MS, RN
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B&B Reporters
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DR. CROSSON: This morning, we have three updates to do and then our annual review of the Medicare Advantage program. We're going to start out with outpatient dialysis services. Nancy and Andy are here.

Nancy, are you going to start out? Okay.

MS. RAY: Good morning.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2017, there were approximately 394,000 Medicare fee-for-service dialysis beneficiaries treated at about 7,000 facilities. Total Medicare fee-for-service spending was about $11.4 billion for dialysis services.

Moving to our payment adequacy analysis, as you have seen, we look at the factors listed on this slide which include examining beneficiaries' access to care, changes in the quality of care, providers' access to capital, and an analysis of Medicare's payments and providers' costs.

We look at beneficiaries' access to care by examining industry's capacity to furnish care, as measured
by the growth in dialysis treatment stations.

Between 2016 and 2017, growth in dialysis treatment stations, at about 3 percent, grew faster than fee-for-service beneficiary growth, at about 0.4 percent.

Between 2016 and 2017, more facilities opened than closed. There was a net increase of about 250 facilities. Few facilities closed in 2016. There was a net increase in for-profit freestanding facilities as well as facilities located in rural and urban areas.

The roughly 40 facilities that closed were more likely to be hospital-based and nonprofit compared to all other facilities. Few patients, about 0.3 percent, were affected by these closures. Our analysis suggests that affected patients were able to obtain care elsewhere.

Another indicator of access to care is the growth in the volume of services. We track volume growth by assessing trends in the number of dialysis fee-for-service-covered treatments and fee-for-service dialysis beneficiaries.

Between 2016 and 2017, the total number of fee-for-service dialysis beneficiaries, total Medicare-covered treatments, and non-annualized treatments per beneficiary
remained steady. This is a little different than historical trends that show small positive growth for these measures.

There are a couple of reasons that may explain this trend. First, overall ESRD incidence is decreasing. Second, the share of ESRD patients in MA plans is increasing; and third, there has been greater uniformity in paying for three dialysis sessions per seek, as explained in more detail in your briefing materials.

Looking at the marginal profit, the 17 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

We also look at volume changes by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of care.

Since the PPS was implemented in 2011, dialysis drugs have been included in the payment bundle. Consequently, providers' incentive to furnish them, in particular the erythropoietin-stimulating agents, ESAs, has changed. ESAs are the leading dialysis drug class in terms of utilization.

Before start of the PPS in 2011, there were both
clinical and financial reasons for their overuse. As anticipated, after the PPS, ESA use went down significantly.

Between 2010 and 2017, the use of ESAs declined in aggregate by 58 percent. This outcome was expected and desired and has occurred, according to researchers with some positive changes to beneficiaries' health status.

In early years of the PPS, 2011 and 2012, ESA use per treatment declined substantially. In more recent years, the decline has moderated somewhat. However, since 2015, we see substitution among ESAs for the lower-cost product, which is also consistent with the goals of the PPS.

Next, we look at quality by examining changes between 2012 and 2017. One indicator that measures how well the dialysis treatment removes waste from the blood, dialysis adequacy, remains high. Mortality, admissions per beneficiary, and the percent of hospitalized beneficiaries with a readmission are trending down.

The percent of dialysis beneficiaries using home dialysis, which is associated with improved quality of life and patient satisfaction, has modestly increased. These
are all good trends. On the other hand, the percent of
dialysis beneficiaries with at least one ED visit in a
given month has increased under the PPS.

Regarding access to capital, indicators suggest it is robust. An increasing number of facilities are for-
profit and freestanding. Private capital appears to be available to the large and smaller-sized multi-facility
organizations.

Since the start of the dialysis PPS, the two largest dialysis organizations have had sufficient access
to capital to each purchase other organizations. The 2017 all-payer margin was 23 percent.

Moving to our analysis of payments and costs, in 2017, the Medicare margin is negative 1.1 percent. The biggest difference across freestanding facilities is based on location.

The aggregate Medicare margin for rural facilities, which accounts for about 20 percent of facilities, is negative 5.5 percent. The lower Medicare margin for these facilities is related to their capacity and treatment volume.

Rural facilities are on average smaller than
urban ones. They have fewer stations, and they provide fewer treatments. And smaller facilities have substantially higher cost per treatment than larger facilities, particularly overhead and capital costs.

So now let's review the factors that the 2019 projected Medicare margin is based on, the 2018 factors include the statutory update to the base payment rate of 0.3 percent. Regulatory changes by CMS that are expected to increase total payments, and a small estimated reduction in total payments due to the ESRD quality incentive program.

The 2019 factors include a statutory update to the base rate of 1.3 percent, regulatory change by CMS expected to increase total payments, and a small reduction in total payments, again, due to the ESRD QIP.

Applying these factors, the 2019 projected Medicare margin is negative 0.4 percent, a small increase from the 2017 margin.

There are a couple of policy changes that will occur in 2020. This includes the statutory update of the base payment rate. There will also be an estimated small reduction in total payments, again, due to the ESRD QIP,
and in addition, in 2020, CMS will begin to pay facilities separately for all new dialysis drugs, including biosimilars and generics for a two-year period without any offset to the PPS-based payment rate. We expect this will increase Medicare payments to dialysis facilities.

So here is a quick summary of the payment adequacy findings. Access to care indicators are favorable. Quality is improving for most measures. The 2019 Medicare margin is projected at negative 0.4 percent.

Here is the Chairman's draft recommendation. For calendar year 2020, the Congress should update the calendar year 2019 Medicare ESRD PPS base rate by the amount determined in current law.

So with respect to the draft recommendation's implications, in terms of spending, this draft recommendation has no effect on spending relative to current law. No impact to beneficiaries is expected. Given that there is no change in current law, we would expect no effect on providers' willingness and ability to care for Medicare beneficiaries.

With that, I give it back to Jay.

DR. CROSSON: Thank you, Nancy.
I actually have one question myself. If we do the math here, it looks like commercial margins are relatively robust. Do you know is there as much spread in commercial margins between urban and rural and between large and small dialysis centers as there is with respect to Medicare?

MS. RAY: I don't know that.

DR. CROSSON: Okay. Thanks.

Questions?

Bruce.

DR. PYENSON: Thank you very much, Nancy. I know you're an expert in end-stage renal disease and have been following it for a while.

Just a couple of questions, one of them taking up from Jay's question. Do you know what portion of revenue is commercial or is non-Medicare versus Medicare fee-for-service? Because it's striking how the very healthy margins of the industry compare to the Medicare reimbursement.

MS. RAY: So I know that number, but it's back in the office.

DR. PYENSON: Okay.
MS. RAY: I can definitely get that to you.

DR. PYENSON: A related question, in the materials, it mentioned that 31 percent of all enrollees, of Medicare enrollees, are in MA; 19 percent of people with end-stage renal disease or classified as end-stage renal disease in Medicare are in MA. Because they're not allowed to enroll after beneficiaries are certified, this suggests that people join either right before they get end-stage renal disease or they've developed the disease while they're a member.

DR. JOHNSON: I think that's right, but was there a specific question? Or is that -- I think that assertion is --

DR. PYENSON: Well, I'm leading to another question. There have been suggestions in the oncology world that individuals who know they will need cancer treatment might disenroll from Medicare Advantage. There have been suggestions on that.

I'm wondering if the opposite is true of people who are going to need dialysis, and that's because the Medicare Advantage plans are paying much, much more than Medicare rates very often to the end-stage renal disease
providers, and I'm wondering if that's something that you've looked at or could look at.

DR. JOHNSON: I don't think we've looked at. I think a complicating factor is that the ESRD is a reason for Medicare entitlement for people who are younger than 65 as well, so there's sort of a split in the population of people who are on Medicare and are using dialysis.

DR. PYENSON: So do you think that's a hypothesis, a reasonable hypothesis, that individuals who are already enrolled in Medicare might be encouraged to enroll in Medicare Advantage because the providers will be much higher reimbursed?

DR. JOHNSON: I guess you would have to expect that you might be heading towards end-stage renal disease, that you have an earlier chronic kidney disease stage and would plan in advance. We haven't looked at that, but I'm thinking of ways that we might be able to.

DR. CROSSON: Marge, on this point?

MS. MARJORIE GINSBURG: Actually tied to this question. First of all, it said in the report that people with end-stage renal disease are not allowed to enroll into Medicare Advantage plans, if this happens, but that that
law was changing and that they will be.

So that I think might be related to Bruce's question. I'm curious why they were not allowed. My theory -- and it may be wrong -- was that the cost is so steep for caring for patients with end-stage renal disease that in fairness to Medicare Advantage plans, they basically gave them an out by saying, "Don't worry. We won't have people enrolled," unless they were already patients within that system, in which case they stay in the system.

So was that true? Was it because they were trying to -- and if that was true, then why is that now flipping and people will be able to enroll with end-stage renal disease now?

And I would question whether -- and this is pure fantasy -- whether patients would be so forward-looking that they would say which of these two systems is going to treat me best. I don't think Medicare beneficiaries --

DR. PYENSON: Oh, for sure, but I think the providers are so forward-looking.

MS. MARJorie GINSBURG: The providers. But some providers are both MA and fee-for-service. So you're
saying that you think a provider might encourage a patient
to move from original Medicare to MA that they're also a part of? So they wouldn't be losing their physician network? Is that what you're saying?

DR. PYENSON: And if not today, certainly when the rules change, I think that's a real potential because my understanding is that the market leaders are not accepting Medicare rates from Medicare Advantage. They're accepting commercial rates, which are much higher. So I think there's sort of the flip side of what people have talked about with oncology is potentially an issue.

MS. MARJORIE GINSBURG: Mm-hmm.

MS. RAY: I think one --

MS. MARJORIE GINSBURG: Well, so go back to the original question, why did all this --

MS. RAY: Right. Just a couple of points, and I hope this can help address your question.

Number one, for the under-65, if you're in a state in which you're not permitted to buy Medigap and if you're already in a plan, then you can stay in that plan.

Did I get that right?

DR. JOHNSON: If you're in the plan, you can stay
in the plan.

MS. RAY: Yes, yes, yes. So there's that working here in this trend.

In terms of the background as to why there is a statutory bar, I'm not sure of the exact history of that. I do believe that the cost of these patients was a factor, however; but on the other hand, there are other expensive patients in MA plans who are permitted to enroll, patients with multiple sclerosis and Parkinson's, et cetera.

The Commission has a longstanding recommendation that the Congress lift the statutory bar and permit Medicare ESRD patients to enroll.

MS. MARJORIE GINSBURG: Has there been a response from MA plans about the right lifting of the bar? Have they been happy or unhappy?

DR. JOHNSON: I don't know that there's a consensus either way.


DR. PAUL GINSBURG: I just want to reimburse what Bruce said about the very powerful role of the providers of dialysis services to influence patients as to what they enroll. It's been a major issue with marketplace plans set
up by the Affordable Care Act, of so-called foundations
paying the premiums for ESRD patients to enroll in private
coverage and allowing the providers to get much higher
commercial rates instead of Medicare rates. So this is
somewhat of a unique area.

   DR. CROSSON: Yeah, Jonathan.

   DR. JAFFERY: A little different type of
question. So in the meeting material there was some
discussion about the -- I forget what it was called --
kidney disease education payments, I think under MIPPA,
that doesn't sound like they had very much take-up. And
you mentioned a minute ago that obviously there's two ways
to get onto -- to get Medicare for dialysis. You can
already have Medicare and then be over 65 and develop
dialysis or be under 65.

   And so I wondered, do you have any information
about other payers and if any of them have developed
similar education program type payments, because it does
strike one that it's hard for a clinic to set up -- it's
less easy or less straightforward from the setup of that
program to start charging people for that if it's just a
small subset of patients.
MS. RAY: I am aware of other payers that have set up such programs and we could come back to you in the future to discuss that. I'm also aware of some dialysis providers who are, I think, working with payers to implement such programs as well.

DR. JAFFERY: I just want to clarify one thing. So we're talking about providers here.

MS. RAY: Facilities. I'm talking about dialysis facilities.

DR. JAFFERY: Right, so that's come up a few times. And so as we're getting into this idea of kidney disease education and pre-end-stage renal disease.

MS. RAY: Right.

DR. JAFFERY: Ultimately if we want to save -- improve beneficiaries' lives and save money there's a prevention opportunity here. So for those providers, we're only talking about the nephrology community, dialysis, although there are -- even the big dialysis centers are starting to think about chronic kidney disease -- pre-end-stage chronic kidney disease, but just for everyone to recognize that there's a big distinction there between providers and when and where they interact with patients.
DR. CROSSON: Karen.

DR. DeSALVO: Fantastic job on this chapter and it sparked a lot of new things for me. So I just want to get a little clarification about the outcomes and quality measurement component to this, to make sure I understand. What we know mostly is from the fee-for-service outcomes. We don't know very much about the MA outcomes, or is that included in what you all know?

MS. RAY: So mortality would be based on all dialysis patients, regardless of payer. The hospital admissions, readmissions, ED visits, adequacy hemoglobin levels in the paper, that would be specific to the fee-for-service population. Thank you. I apologize for that.

DR. DeSALVO: That's okay. And medication use as well?

MS. RAY: Medication use is for fee-for-service.

DR. DeSALVO: Okay. And then just a follow-up question about the strategy around moving this part of the market to value, that looks like HHS is pretty active in a few areas. And I think the reason I was interested in that particularly was because of the hospitalization rates starting to tick up, and I wondered if, Nancy, you all had
any perspective on what the cause of those hospitalizations were and whether that was one of the drivers to try to create ACO-type models or other models that are more coordinated for dialysis patients.

MS. RAY: Right. Just to clarify. Admissions per beneficiary has been trending down.

DR. DeSALVO: Okay.

MS. RAY: That is consistent, I think, with overall decline in fee-for-service admissions going down. All that being said, they are still hospitalized, you know, more than non-dialysis beneficiaries, and I think that that has -- and I don't have the exact percentage here but a relatively large component of all of the costs of a dialysis beneficiary -- dialysis, admissions, post-acute -- but admissions is a fair share. And I do believe that that was a driving force in the creation of the ESCOs for dialysis providers to take risk for these patients in trying to decrease hospital admissions, ED visits, and other -- and to improve outcomes.

DR. CROSSON: I have Kathy, Brian, Pat.

MS. BUTO: My question is about the -- remind me whether last year we recommended the current law update for
ESRD. We did, right?

MS. RAY: Yes, we did.

MS. BUTO: And I'm looking at the new provision that allows pass-through payments for new drugs. So we can't estimate yet what the increase will be in terms of revenue to dialysis centers as a result of that, but clearly that's going to be additional revenue, assuming there are new drugs that come along. And I just want to -- I'm looking to you for any sense of do we know anything about projected new drugs in this space.

MS. RAY: I think there are a couple of new drugs that are expected to come out, to be launched. I would expect that after January 1, 2020. CMS, in their proposed and final rule did not estimate the impact of this new change, saying that, you know, they basically did not know, you know, the pricing and the exact timing of the launch of these products.

MS. BUTO: Okay. And are they ESAs, do you know?

MS. RAY: I believe that there is one ESA biosimilar coming out. There is also a product for itching of dialysis patients, which can be severe in certain patients, and it's -- I think it is also expected to be
launched.

MS. BUTO: I know this is not the place to take this on but this issue of pass-throughs for some drugs in a category and not for others that are already in the base I think is an issue we need to take a look at down the road. But that's sort of a round two comment.

DR. CROSSON: Nancy, can you remind us what the base -- what's the formula for payment for these pass-through drugs?

MS. RAY: They will be paid at ASP, 100 percent of ASP.

DR. CROSSON: Okay. With no add-on.

MS. RAY: No add-on.

DR. CROSSON: Okay. Thanks.

DR. JOHNSON: [Speaking off microphone.]

MS. RAY: And no adjustment to the base rate.

Thank you. No adjustment to the base rate.

DR. CROSSON: Right. Right. Right.

MS. RAY: They will be paid for two years at 100 percent of ASP, and then they will be included into the base rate with no adjustment.

DR. JOHNSON: And all the --
DR. CROSSON: Is it reasonable to surmise, then, that, once again, the larger facilities, particularly the national chains with more negotiating power may have a significant advantage here as well?

DR. BRICKER: I would just venture that you would be incented to use the new products, not those that are included in your bundles, right?

UNIDENTIFIED SPEAKER: Already paid for those.

DR. BRICKER: You paid for those. Then you get additional value through the new products, whether or not they're better products, or, yeah.

DR. CROSSON: And if -- okay. Well, I'm speculating. Brian, on this as well as --

DR. DeBUSK: Yeah. To clarify one more time, and this is part of where I wanted to go with my question but then I have a separate one, so I could take an existing patient, existing procedure, everything, quit using the ESA that I've used for years, use a new ESA, receive an ASP payment. Clearly it's in their economic best interest to do a switch, even if the new ESA is more expensive than what they're using. It seems like a huge hole in the system.
DR. JOHNSON: And it would get the full base rate bundle as well as the ASP rate.

DR. DeBUSK: Okay. And if I can ask a related question on that too. I mean, first of all, that's sort of glaring. The second question is, I know that -- and I asked this two years ago so it hopefully may have changed. You always want to ask. The ESAs that we have also are --

I think they're Part B drugs as well. They have codes --

MS. RAY: Yes.

DR. DeBUSK: -- they would have codes.

MS. RAY: Yes, they do have codes.

DR. DeBUSK: And do we have enough information, say, from the cost report or from other information to where we could crosswalk what the same drug, under the Part B fee schedule, versus what it sells for to a dialysis clinic?

MS. RAY: Yeah. You know, the way that -- that would be a slightly tricky analysis, and I can talk to you offline about it. But the way that the -- I'd have to go back to the cost reports. And if all ESAs are reported in one column then that would be -- and if a facility used more than one ESA, that would be difficult to do.
DR. DeBUSK: Okay. I was just wondering, because I know Kathy had advocated, when we had a Part B discussion two years ago, was talking about packaging more drugs into the procedures, and it seems like this would be a good opportunity to test that.

MS. BUTO: We're going the other direction on this one.

DR. DeBUSK: Yes.

MS. BUTO: Or unpackaging it.

DR. DeBUSK: Yes.

DR. CROSSON: Okay. Brian, was that your question or do you have another one? Okay. Pat.

MS. WANG: I just wondered whether there was any information yet on the progress, I guess, or achievements of the ESCOs or other efforts to coordinate. It was also unclear in the written materials. Are these organizations primarily being administered or initiated by the dialysis providers or are some of them in coordination with like hospital ACOs, et cetera?

MS. RAY: Okay. So the ESCOs are -- have been developed by the dialysis organizations with nephrologists.
We have the first-year analysis of the results show that they did save money. They were returned money from the government, right?

DR. JOHNSON: All of the ESCOs saved money in the first year and all but one saved enough to get a shared savings payment back.

MS. RAY: Right. Thank you. And the contractor's analysis show that admission significantly decreased. And I think that was the biggest decrease in terms of utilization of services.

DR. CROSSON: Jon.

DR. JAFFERY: It may be a related question. So do you have any data of the Medicare fee-for-service beneficiaries who, on dialysis, how many are either in ESCOs or ACOs, separate ACOs?

MS. RAY: Right. I don't have the number that are in ACOs. The number that are in ESCOs, I did not determine it. It was based on what I found according to CMS and in an article. And I'm looking for it. So according to other sources, there are approximately 16,000 beneficiaries in the first performance year and it increased to roughly 55,000 in the second performance year.
DR. JAFFERY: It might be interesting at some point, if there are enough numbers, to compare performance or outcomes between, you know -- you could have four categories: MA, Medicare fee-for-service who are not part of any value-based contract, Medicare fee-for-service in an ESCO, and Medicare fee-for-service in some separate ACO, and then even think about pushing out some shared learning.

MS. RAY: Agreed. I think that would be super interesting.

DR. CROSSON: Karen.

DR. DeSALVO: And just as a follow-up, as you're looking at it, is it possible to also look at geographic for the beneficiaries, because I would imagine that those in rural areas are less likely to have access to coordinated care models through MA or ACOs or ESCOs. There would be differential impact.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Nancy and Andy, I know you've used the Medicare cost reports from the end-stage renal disease facilities in your analysis, and that involved splitting the Medicare costs from the non-Medicare costs. And that's an issue of concern I have of how that's done and the
validity of the cost reports for some of the purposes that we're using them.

I wonder if you have an opinion about that.

Yesterday we discussed a similar issue with the ASCs that today don't have cost reports and how to do that right. So I wonder if you have any thoughts on that and how that might extend to other areas.

MS. RAY: I'd like to think about that question and follow up with you in the future about that. What I will say is that we recommended, I believe it was in 2014, or 2013 or 2014, that CMS conduct audits of ESRD cost reports. The statute -- Congress took up our recommendation, appropriated money to CMS for this, and we're still awaiting the results of that audit.

DR. CROSSON: Okay. I think we're ready to move on to the discussion period. We've got -- put the recommendation up. So we've got the recommendation there, to the current law update. I'd ask you to comment on support for the recommendation, no support, suggested changes.

Kathy.

MS. BUTO: So I support the recommendation. I do
want to say that the pass-through for new drugs is troublesome and we don't have enough data to say how troublesome it is. But for next year -- and I think I really urge that we put some language in this year's update, saying that we're going to be looking at that -- maybe take us a year and a half to really look at it -- but looking at the data on expenditures for new drugs to see whether, number one, we would recommend that provision be repealed, or two, we would recommend that updates subsequently would be either no update or negative to account for the inflation in costs.

So I'd like to see us take that on a little more directly than just to lay out that this is an issue and da-da-da-da-da.

DR. MATHEWS: Yeah, we can obviously do that and we will track the effects of the pass-through payments going forward. And I believe --

MS. BUTO: Will we have it for next year, though?

DR. MATHEWS: Pardon?

MS. BUTO: Will we have it next year?

DR. MATHEWS: Maybe not.

MS. RAY: It doesn't begin until 2020.
MS. RAY: Yeah.

MS. BUTO: Oh, okay. So we're not going to --

DR. MATHEWS: But one thing that we could do --
correct me if I'm wrong -- we took a fairly strong position
with respect to this proposed policy in our comment letter
this past summer. Is that correct?

MS. BUTO: Did you? Okay.

DR. MATHEWS: And so I think there was language
we can export from that comment letter --

MS. BUTO: Right.

DR. MATHEWS: -- and give it some prominence in
this year's chapter, just to put a marker down, if that
would help address your concern here.

MS. BUTO: I think that would help.

The other thing I would say is just -- speaking
of markers -- I think the Commission has to look at pass-
through payments, period, because these distortions that
we're talking about, a small change, not just for drugs but
for other things that are pass-through, a small change that
qualifies as a new whatever -- technology, procedure, drug
-- can really distort what's provided. And that can go for
imaging. There are a number of areas where I think we
haven't taken that on directly. I just think it's an across-the-board issue that creates distortions in payment. So I think it's totally within our bailiwick to look at that.

DR. CROSSON: Other thoughts? Brian did you raise your -- no. Okay. So Paul and then Bruce.

DR. PAUL GINSBURG: I support the recommendation. I'm very glad that Kathy brought up this issue of pass-through drugs. One word that we should be sure to use, which hasn't come up in our conversation is the fact that many of these drugs are substitutes for drugs in the bundle, and that's what makes it so problematic.

DR. CROSSON: Bruce.

MR. PYENSON: I think we have an opportunity here to encourage the coordinated care approach, that I want to make sure we don't miss. So it's seems as though over 10 percent of end-stage renal disease beneficiaries are in -- have entered one of the new programs, and the evidence in the first years is startling that everybody has saved money, at least by how the benchmarks were set, and most of those have saved enough to actually earn back. So I think this is -- without -- of course, there could be distortions
in how that was calculated, but this suggests that that's really, really powerful.

And so I would suggest that we provide no update to the rates, that that be our recommendation, because we see an alternative which is the coordinated care approach, and that's been consistent with MedPAC's philosophy and direction. So I think we have an opportunity to do that by putting pressure on this sector. The margins are impressive for the industry as a whole, and so given the experience that we've seen with other sectors that pressure encourages efficiency, and because we have a vehicle that seems viable, I'd offer that as an alternative.

DR. CROSSON: Okay. Jon.

DR. PERLIN: You know, I'm glad Karen asked the question earlier about quality measures. It strikes me that across the different programs we ought to have a coherent philosophy of how we measure quality. And, you know, I liked the sort of rubric we invoked in HVIP, and one wonders whether there isn't an analog here, where, you know, there were a set of hospital-acquired conditions, dialysis-acquired complications, admissions to hospital, you know, things that were problematic there, spending per
beneficiary to help compare across programs, you know, a direct correlation there. Infection, obviously, is a consistent risk. And in terms of quality there are any number of markers, including the adequacy of the dialysis. You can dialyze a patient much faster and technically complete the dialysis. It's absolutely miserable for the patient and it leaves them with confusion and, you know, some metabolic dysfunction after that.

So I just want to put a sort of placeholder there. It doesn't have to be a bold-faced recommendation but I think we should work toward a set of coherent, balanced measure that are comparable across programs, and particularly to Bruce's point, as we try to assess the impact on patients across different arrangements of reimbursement for these services.

DR. CROSSON: Yeah. And I think Jim may want to comment but we do have kind of standing policy that that's the direction we're trying to move across all payment areas.

Karen.

DR. DeSALVO: So, first, I agree with Jonathan, and it would be with Jon's recommendations about being more
structured including, as you all point out in the chapter, that even within the dialysis program between the Stars and the QIP, there's different ways that we're measuring success. And that could be confusing. So there's opportunity there.

I actually feel a little equivocal about the recommendation for some of the reasons that Bruce mentions. That it seems to have robust margins overall in the industry, and that there seems to be opportunity when pressed, when there's pressure, for savings.

In addition to these ACO models, with MA stepping into the space and ACOs growing and taking on the total cost of care longitudinally, there may be some opportunities in the coordinated care, value-based care world to really offset some of the negative outcomes for the patients and maybe even, Kathy, some of the cost choices about the drugs.

I mean, if you're responsible for total cost of care, then it's not necessarily a pass-through. It might encourage providers to be more thoughtful about not only outcomes but also costs.

That's sort of a newbie thing for me about how we
look at total margin and Medicare margins, so I'll just have to work my head through it, but it feels like there's still opportunity to improve the total cost and outcomes without an increase.

DR. CROSSON: And, truthfully, I think over the years, we've been a little bit dualistic in this regard in the sense that now we're about Medicare and we're interested in what Medicare is paying and whether it's equitable and adequate and the like.

On the other hand, sometimes -- and this is a case, I think, in point here where it's kind of hard to do that and totally ignore the other part of the equation, particularly in a situation where it's undergoing change; in this particular case, where there may be a new mechanism coming in place, which could tend to exacerbate that situation because I think -- I mentioned this already, but I do think that the difference in Medicare margin between the large commercial for-profit dialysis organizations and some of the smaller organizations which serve certain communities in the country, it may very well grow larger as a consequence of this particular drug policy.

Let's see if there are more comments. Yeah. Jon
and then Pat.

DR. CHRISTIANSON: Yeah. I approve the recommendation.

I'm wondering whether in the chapter there couldn't be a little more discussion of the rural issue. I don't know if we have an access problem for beneficiaries living in rural areas. We do have lower margins on Medicare, smaller facilities -- have a sense whether that's adequate.

We worry about rural access issues for a lot of things, and I would like to see something in the chapter that would discuss whether that's an issue here, whether we need to think more creatively about the need or not to maintain access to dialysis for people living in remote rural areas.

DR. CROSSON: Pat and then Jon.

MS. WANG: I agree with much of what has been said, and again, if there needs to be further endorsement of taking a really concerned look at the pass-through payment policy, I would just add my voice to that.

I have to say I'm ambivalent about the update as well, just because, Jay, as you point out, we just spent
time looking at negative margins for efficient providers, and we're not really doing anything extraordinary there to address that situation. I realize that it's an expensive price tag when you're talking about hospitals.

But in this case, the fact that the overall margin is so high and that the coordinated care approaches have been so successful, whether it's because it's the start of the program or benchmarks or what have you, when ACOs started, the benchmarks were all over the place. And there was varying levels of success -- suggest that there is a lot more efficiency to be gained in providing these services. It feels like the wrong approach just to reflexively say here's a fee-for-service across-the-board update when it seems like there's some other story lurking behind there and opportunities to lower cost through a coordinated approach. It seems like there's a lot of opportunities there, actually.

So I'm a little ambivalent. It's like between zero and the update that is in law.

I appreciate Jon's comment about it's going to fall differently in different parts of the country. I don't know what to do about that exactly, but I'm a little
uncomfortable about just kind of blasting an update out there.

DR. CROSSON: Okay. I've got Jonathan, and then I saw Amy and then Kathy and Marge.

DR. JAFFERY: So I'll also add I've got some ambivalence, but I think on balance, I agree with Jon that I support the recommendation for that particular reason. It's not clear to me where this falls out for small particular rural providers.

I think this issue around -- we've seen a clear demonstration that organizations can move towards value and have improvement. It is encouraging and exciting, but I'm a little bit uncomfortable saying that means we should just no longer give updates based on that because there is a fair discrepancy in terms of where that exists in terms of who the providers are that are delivering it.

I think the question of we've also got people on ACOs -- I think there's a little bit of confusion about who's getting the payments for this and where the incentives are. So if you're running an ACO and you have a substantial population of patients on dialysis, this payment actually does not impact you at all, either way.
So I'm not sure that that's clear enough yet. And I guess I ultimately -- I don't want to lose sight of the fact that end-stage kidney disease is an undesired outcome here for every conceivable reason, and we've got -- I think it's beyond the scope of payment update to dialysis providers. But we do have an opportunity to think about, in going forward, are there ways to use Medicare payment policies to incent better pre-ESRD, chronic kidney disease care in order to prevent the need for dialysis or transplantation.

DR. CROSSON: Amy.

MS. BRICKER: I want to just add additional concern that other Commissioners have already mentioned around the update.

Is there a mechanism for us to provide update only to rural facilities versus all? Is that an option?

DR. CROSSON: Of course, it's up to us what we do, but as we mentioned yesterday when we were talking about hospitals, for the most part, we have made across-the-board update recommendations. To develop a policy which is different from that is something that we could do, but it's not something we can do in the short term.
Just as you saw the complexity of what we were doing yesterday with hospitals, my guess is it would require us at least to think about this for a year and make sure we've examined all the ramifications of departing from our usual track.

I understand exactly what you're trying to get at, and I have the same concern. But I don't think it's something that we could do, let's say, by next month.

MS. BRICKER: Okay, that's fair.

So I think potentially -- and we're talking about 1 percent or 1.3 percent. The thing I wouldn't want us to encourage is further consolidation of these types of providers to those that are able to essentially drive the all-payer margins that are in question, so continuing to have those facilities that are servicing populations that are underserved today. That's important.

And if we aren't able to -- and your point is well taken -- make a shift to focus on those specific facilities that are servicing those populations, I'm in support of the recommendation for that sole reason.

I think this industry is presenting -- is leaning into a number of tailwinds. I think that the margins will
continue to improve as a class, but as the individual provider level, I'm not sure that that's the case, especially these smaller facilities that aren't able to have the leverage over the commercial payer MA market. So I'm in support with -- come full circle.

Thanks.

DR. CROSSON: I understand. I kind of agree.

Okay. So, Kathy.

MS. BUTO: Yeah. And I could actually go either way on this. I support the recommendation, but I am sympathetic to the view that zero update might be the stronger signal to send.

I do have a question, though, that I think we should be aware of, both a question that Bruce originally asked about the mix between commercial and Medicare because I think the vast majority of payments is not -- in other words, commercial margins are not a major source of payment for ESRD, although I know over the years, Congress has allowed more commercial payment because they've bumped up the time you're eligible for ESRD. You have to stay on private insurance for longer.

So I do think that's important as we consider
that issue, commercial versus Medicare.

The other thing I think is important to think about is I believe the facility rate sets the ceiling for how much home dialysis paid for. Is that still correct?

MS. RAY: For adults, for adult dialysis patients, there is no difference in the payment rate for in-center versus home dialysis.

MS. BUTO: Right. So anything we do on in-center could impact the availability of home dialysis is my point. We just need to be aware of that because there has been a greater shift to home dialysis, and I think we're really focusing on the facility aspect of this.

DR. CROSSON: Kathy, on the commercial margin piece, I think that we'll find -- I think we're going to come back on this in January. I think it's pretty clear. I think we'll find that the number of Medicare beneficiaries -- sorry -- the number of dialysis patients who are on the commercial side may not be very large, but the commercial margins are so large that when you're looking at dollars, I think we'll be surprised at how large that is.

MS. BUTO: I'd like to see that.
DR. CROSSON: Yeah. Okay.

DR. JAFFERY: Can you explain a little bit what your concern was about the home dialysis payment?

MS. BUTO: I just want us to be aware that this sets essentially a payment level for home dialysis as well, and I think in people's minds, home should be cheaper than facility. But it's really the opposite in many cases, not all cases, but it can be more expensive.

I know this because some years ago, HCFA was sued because it turned out the agency, Medicare, was paying a lot more for home dialysis, and essentially, Congress put a cap on that. And the reason it was there was a loophole, paying based on charges.

So I'm just saying I think we ought to be aware. There's a greater desire to have home dialysis be an option and that anything we do on facility has an impact on what payment rates are available for those services.

DR. JAFFERY: Thanks.

DR. CROSSON: Marge. I think that's it.

MS. MARJORIE GINSBURG: I share everyone's ambivalence, and I appreciated Jon's comment and others about the status of the rural programs, since those seem to
be the ones that are now more often falling by the wayside, and their Medicare margins is so much worse than the others. I worry that if we don't keep an eye on what's happening with rural, we'll end up losing more and more of them, and I really think that's unfair to Medicare beneficiaries to have to drive 30 miles or more in order to get their dialysis done.

I want us to be aware of those folks and sort of keep an eye on what's actually happening there and if we need to make adjustments in the recommendations that will support the rural facilities.

DR. CROSSON: Okay. I agree with that.

We have a short-term and a long-term issue. The short-term issue is we have to figure out what we're going to do for this cycle, and I think we have a split opinion here. In addition, a number of good thoughts have been brought up. So we will be coming back for a fuller discussion in January. Maybe I don't have all the issues here, but I think the notion of what could be done to encourage more value-based arrangements is one.

This question of access in smaller, particularly not-for-profit, especially rural, more information there,
to the extent that it's possible. It may not be.

Perhaps a little more thought about the
differential impact of these pass-through drugs, but in the
end, we're going to need to come back with another
recommendation. We'd leave that to Jim and the staff to
absorb this commentary and come back with a recommendation
in January for the update.

Is everybody okay that? Okay. Thank you very
much.

We'll move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. The next presentation for
this morning is on hospice services, recommended update,
and Kim is here.

MS. NEUMAN: Good morning. So next we'll be
talking about hospice services.

In 2017, nearly 1.5 million Medicare
beneficiaries used hospice services, including more than
half of beneficiaries who died that year. Approximately,
4,500 hospice providers furnished care to Medicare
beneficiaries, and Medicare paid those providers about
$17.9 billion.
So first I will review a couple of facts about hospice. The hospice benefit provides palliative and supportive services for beneficiaries with terminal illnesses who choose to enroll. To be eligible, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course.

At the start of each hospice benefit period a physician must certify that the beneficiary's life expectancy meets this criteria. There is no limit on how long a beneficiary can be in hospice as long as they continue to meet the life expectancy criteria.

A second requirement of the hospice benefit is that the beneficiary agree to forgo conventional care for the terminal condition and related conditions.

So before we walk through our indicators of payment adequacy, I'm going to remind you about some recent changes to the hospice payment system.

So first, back in 2009, the Commission reviewed the hospice payment system and found that it was misaligned, with long stays in hospice more profitable than short stays. And this was because Medicare generally paid a flat daily rate for hospice while hospice services tend
to be more frequent at the beginning and end of a hospice episode. So the Commission recommended changing the daily rate for routine home care, the most common level of hospice care, from a flat payment per day to a payment that's higher at the beginning and end of the episode and lower in the middle.

In 2016, CMS changed the payment structure for routine home care in a way that was directionally consistent with the Commission's recommendation. There are now two daily payment rates, one for the first 60 days, which is higher, and a lower payment rate for days 61 and beyond. In the last seven days of life, hospices receive additional payments for registered nurse and social worker visits on top of the regular daily rate.

CMS' new payment structure was designed to be budget neutral in the aggregate but modestly redistribute revenues across providers, so it was expect to increase revenues for providers that had fewer very long stay patients, that is, provider-based, nonprofit, and rural hospices.

So this brings us to our payment adequacy analysis, and like in the other sectors we use our standard
First, we have a chart showing the growth in the number of hospice providers. The green line is the total number of hospice providers, and that total number of providers has been going up for almost two decades, and it increased by 2.4 percent in 2017. The other three lines show the number of providers by type of ownership. Yellow is for profit providers, and you can see that the net growth in provider supply has been accounted for entirely by for-profit entry. As of 2017, nearly 70 percent of hospice providers are for-profit.

The next chart shows growth in hospice use among Medicare decedents. The share of Medicare decedents who used hospice crossed the 50 percent threshold in 2017, reaching 50.4 percent. Over the years, hospice use has grown most rapidly among the oldest beneficiaries. In 2017, more than 60 percent of decedents aged 85 and older used hospice.

As we've seen in past years, minorities and beneficiaries in rural areas continue to have lower hospice use than other beneficiaries, but use has generally been increasing for these groups as well.
So this next chart gives more details on utilization growth. The number of hospice users grew about 5 percent in 2017, to nearly 1.5 million. With growth in the number of hospice users, we also saw growth in the total number of hospice days, reaching 106 million in 2017. The bottom of the chart shows hospice length of stay among decedents. Average length of stay among decedents increased slightly in 2017, as we observed an increase in length of stay at the 90th percentile, while median length of stay was unchanged, at 18 days.

Another indicator of access to care is marginal profit. Different from other sectors, for hospice we have marginal profit in 2016 because the 2017 margin information is incomplete. In 2016, marginal profit, which is the amount Medicare payments exceed the marginal cost of treating an additional Medicare patient, was 14 percent, which is a positive indicator of access.

So next we have a chart showing that length of stay varies by observable patient characteristics like diagnosis and patient location, so that hospices that choose to do so have an opportunity to focus on patients likely to have long stays that may be more profitable.
Consistent with that, for-profit providers had substantially longer lengths of stay than nonprofits in 2017, 109 days versus 67 days, on average. And as discussed in the paper, over the years the Commission has expressed concerns about very long stays and the profitability associated with those stays. The Commission has also expressed concern about very short stays in hospice, which may not offer patients as much benefit as if they had enrolled earlier. Your mailing materials discuss what we know about early experience with a couple of initiatives that might have potential to influence hospice enrollment -- the CMMI Medicare Care Choice's model, and the coverage of advanced care planning visits under the physician fee schedule.

So next, on to quality. Limited data are available on hospice quality. Currently, Hospice Compare includes seven process measures that gauge whether hospices performed certain activities appropriately at hospice admission. Scores on the process measures are extremely high for most hospices, and given that these measures appear to be topped out, CMS may want to revisit the measures and consider whether retirement is warranted.
In 2018, for the first time, Hospice CAHPS data became available for individual hospice providers. CAHPS surveys family members of hospice patients after their death to get information about the care that was provided to those patients. Scores were generally high on the CAHPS measures but there was more room for improvement and variation than the process measures.

Although not a traditional quality measure, live discharge rates also are a potential indicator of poor quality or program integrity issues. The rate of live discharge has been stable over the last three years, although as we note in the paper there is substantial variation across providers.

So next we have access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall access to capital appears strong. We continue to see growth in the number of for-profit providers, which increased about 5 percent in 2017, suggesting that capital is accessible to these providers. Also, reports from financial analysts suggest that the hospice sector is viewed favorably by private equity investors and by other health care companies seeking mergers and acquisitions. We
have less information on access to capital for nonprofit freestanding providers, which may be more limited. Provider-based hospices have access to capital through their parent providers, who have adequate access to capital.

Next, we have Medicare margins. As I noted earlier, different from other sectors, we have the margin data through 2016, because 2017 margin data are incomplete. In 2016, the aggregate Medicare margin reached 10.9 percent, its highest level in more than 10 years.

A couple things to note. Consistent with other sectors, we exclude non-reimbursable costs from our margin calculation, which means we exclude bereavement costs and the non-reimbursable portion of volunteer costs. If those costs were included, it would reduce our margin estimates by at most 1.7 percentage points.

Next we have margins by category of hospice provider. In 2016, freestanding hospices have strong margins, about 14 percent. Provider-based hospices have lower margins than freestanding hospices. This was partly due to their shorter stays and the allocation of overhead from parent providers.
The chart also shows margins by type of ownership. For-profit hospices have substantial margins, 16.8 percent. The overall margin for nonprofits is 2.7 percent. Looking just at freestanding providers, the nonprofit margin is higher at 6.4 percent.

This table also shows, at the bottom, margins for providers that are above or below the aggregate cap. As you will recall, that the aggregate cap limits payments to hospices with very long stays by capping the average payment per beneficiary a hospice can receive. In 2016, the cap was about $28,000 per beneficiary, and it applied in the aggregate, not at the individual patient level. Hospices that exceed the cap in 2016 had about a 20 percent margin before the return of overpayments and a 12.6 percent margin after the return of overpayments. Below-cap hospices had a slightly lower margin, at 10.7 percent.

Next, we show what's underlying some of the margin differences. Here we have the relationship between length of stay and hospice margins. Providers with longer stays had higher margins in 2016. Providers in the lowest length of stay quintile had a -5 percent margin compared to a 20 percent margin for providers in the 2nd highest length
of stay quintile. These margins include the effects of the new payment system in 2016, and although the new payment system narrowed the variation in margins by length of stay modestly compared to 2015, there is large variation that remains.

So next we have our 2019 margin projection. To make this projection, we start with the 2016 margin, and we take into account the net payment updates that occur in 2017 through 2019, and we assume cost growth consistent with historic trends. With that, we project a margin of 10.1 percent in 2019.

Before we discuss the payment update it's worth noting some broader concerns about the payment system. First, the payment rates by level of care are out of balance. Routine home care appears to be paid substantially more than its costs, while the payment rates for the other three less frequent levels appear to be below providers' costs. Second, the new payment system has had only a modest effect on the variation in profitability by length of stay. Providers with the most long-stay patients continue to have high profit margins. And third, the percentage of hospices exceeding the aggregate cap has been
increasing, and for the first time in 2016, above-cap hospices had higher margins than below-cap hospices, even after the return of overpayments.

In light of these issues, the Commission could consider approaches to rebalance the payment system in the future.

So, in summary, our indicators of access to care are positive and there are signs that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. The number of hospices increased, driven by entry of for-profit providers. The number of beneficiaries enrolled in hospice, the number of hospice days, and average length of stay increased. The rate of marginal profit was 14 percent. Access to capital appears strong. Limited quality data are available.

The 1016 aggregate margin is 10.9 percent, and the projected margin for 2019 is 10.1 percent.

So that brings us to the Chairman's draft recommendation. It reads: The Congress should reduce the fiscal year 2020 Medicare base payment rates for hospice by 2 percent.
Given the margin in the industry and our other payment adequacy indicators, we anticipate that the aggregate level of payments could be reduced by 2 percent in 2020 and would still be sufficient to cover providers costs. So this draft recommendation is not expected to have an adverse impact on beneficiaries' access to care.

Consistent with the Commission's principle that it is incumbent on Medicare to maintain financial pressure on providers to constrain their costs, this draft recommendation would increase financial pressure on providers but it is not expected to affect their willingness or ability to care for beneficiaries.

So that concludes the presentation.

DR. CHRISTIANSON: [Presiding.] Thanks, Kim. Do we have clarification questions for Kim?

Jonathan.

DR. JAFFERY: Yeah, thanks for a great report.

Going back to the -- regarding the payment rates by level of care being out of balance, and in the material Table 14 lays it out pretty nicely, and it's pretty striking, actually, do you have any information about some of these subcategories, the freestanding or the for-profit versus
not-for-profit and who delivers all these services? And am I correct that not all facilities provide inpatient care, for example?

MS. NEUMAN: So under the conditions of participation, hospices are required to have the capacity to furnish all four levels of care. What we see in the data is that there are some hospices that do not appear to provide, particularly the continuous home care. There is a big chunk that don't seem to providing continuous home care, and then there are some that also don't provide general inpatient care. It's always been hard to know, especially if a provider is small, whether they didn't have a patient that needed that service or whether they don't furnish it. But we definitely see providers who have, you know, no days in these categories.

In terms of by category who's furnishing it versus not, so I would say that freestanding providers -- let me just back up a second. For-profit providers provide a little bit less of the higher acuity levels of care than nonprofits, but it's not by much. I mean, the main level of care is, on average, about 98 percent of the days across the industry, and the for-profits are doing routine home
care at 99 percent of the days. So we're talking a
percentage point difference. But there are some
differences in that.

Also, the provider-based tend to provide a little
bit more, again, a percentage point or so more of high-
acuity care than the freestanding providers.

DR. CHRISTIANSON: Kathy, did you -- okay.

Anybody?

DR. GRABOWSKI: Yeah. Thanks, Kim, for this work. I wanted to ask you about the access to capital, and there's been a lot of media reports of kind of acquisitions of hospice companies by private equity groups and other health systems. And I'm just curious, is this just that it's a really profitable sector? Is this part of trying to move towards a greater system of care? I just wanted to try to unpack a little bit of your understanding, because it hasn't been clear to me from all the kind of different media stories around all this activity that hospice is really hot right now. It would seem, from these stories, and I just wanted to get a little bit more color on that.

MS. NEUMAN: Yeah. So I think it's all of the things you've mentioned. I think that the sector is viewed
favorably as having potential profit opportunities and
being stable, and the fact that the payment system changes
were quite modest. That is often cited. I also think that
there is sort of thoughts about, you know, sort of having
an ability to offer the full continuum of care and the idea
of moving to systems where we're less focused on inpatient
and more focused on treating people in the community, and
sort of changing how we care for people. And I think
that's part of it too. I think it's both things.

DR. GRABOWSKI: I can't help myself. I also have
to ask about it, that at the end of the chapter you have a
table on the margins that hospice delivered in assisted
living and nursing homes, and I wondered there, too. You
have some explanations about some of the economies around
potentially delivering hospice in an institutional setting,
or at least a facility-based setting.

I'm curious. Is that the whole story there? Is
there something about kind of ownership by nursing homes of
hospice? Is there more sort of going on, and is this
something we will want to think about going forward, about
payment hospice in the community versus hospice in kind of
these institutional settings?
MS. NEUMAN: So this is something that the Commission has kind of looked at over time and something that we could come back to if we look at the payment system in greater detail in upcoming cycles. There are a few things going on. As we've talked about, there are potentially economies of scale, treating people in a facility, versus going to individual homes. With nursing facilities there's the idea that there's potentially a duplication of services, that there are aides in facilities and then there are hospice aides, and so there could be some economies that way.

Patients in these settings also tend to have longer stays, and so there are, you know, sort of that dynamic that's throughout the payment system also plays out in that setting. But it seems to be more than just that. And, you know, people always do talk about the idea that there could be some ownership issues going on between nursing facilities and hospices, and so there could be -- that could be generating some profitability, and that could be something to look at certainly.

I think there are also providers that may not be affiliated with the nursing home itself but that focus on
those patients or focus on assisted living facilities, and
it's kind of almost a different business model. And so
there's all of those things going on.

DR. DeBUSK: I have a question about the 2
percent cut, sort of the source of the 2 percent cut, and I
was noticing on Chart 13 of the presentation you were
looking at the providers who went above their cap, and even
after they returned the payments they still came out right
at about two points ahead of the people who didn't exceed
their cap. Is that correlated to the 2 percent cut in any
way? I mean, where did the 2 percent come from?

MS. NEUMAN: I don't think that the cap piece was
sort of driving that 2 percent number. I don't know.

Should I --

DR. CROSSON: This is hard to admit, but -- well,
I'm kind of out there right now.

[Laughter.]

DR. MATHEWS: I could pull you back in, if that -

DR. CROSSON: These update recommendations are an
exquisite composite of science and judgment, and sometimes
the judgment is easily traceable to the science, the
numbers, and sometimes it's not. And that's why we have a
Commission.

DR. DeBUSK: Thank you.

[Laughter.]

DR. DeBUSK: Well, again, at the risk of encroaching on round two territory, when I saw the minus 2 in the draft recommendation and then I realized that if you get caught going above your cap and have to give that revenue back up, if you took that 2 percent, that's sort of the differential there.

The other thing I was going to get at is they're providing those services and then having to surrender that revenue, a portion of that revenue. So would this -- and this, again, is not rhetorical. It is a question. Does this suggest, though, that we're still overpaying for the middle of the stay?

Back to our original, MedPAC original recommendations, it appears that we've addressed it some, but does this mean we haven't fixed it if you can still surrender all of your revenue above the cap and still come out 2 points ahead of someone who didn't exceed their cap?

MS. NEUMAN: I think that all of the data that we
have to this point, the cap, as well as just what we're seeing about margins by length of stay, suggests that the payment system effects have only made a modest difference, and that the underlying concerns that we've had about profitability by length of stay remain.

DR. DeBUSK: So we should just steepen -- the adjustment was directionally correct, then, in your opinion. We just need to steepen the adjustment?

MS. NEUMAN: The Commission originally had a steeper suggestion than what CMS implemented, and so that is one way to go, to think about steepening it, and we could think about rebalancing it more in general as well.

MS. MARJORIE GINSBURG: [Speaking off microphone.]

MS. NEUMAN: Right now, days 1 to 60 is one rate, and days 61-plus is another rate. The costs actually look much more like this. It's not like this, and so you could think about whether the structure should be a little bit different. That's one possibility.

DR. CROSSON: Jim.

DR. MATHEWS: So just to try and add a little bit more rationale behind the 2 percent reduction that is on
the table for this sector, in contrast to other sectors,
IRF and SNF -- or I'm sorry -- IRF and --

DR. CROSSON: LTCH.

DR. MATHEWS: No. Let's stick with IRF for a moment, where we are recommending at minus 5 percent.

MS. BRICKER: Home health?

DR. MATHEWS: Pardon?

MS. BRICKER: Home health?

DR. MATHEWS: Home health.

Where in those sectors we've seen very pronounced trends of very strong margins in many instances, year-over-year increases and we have been able to point to specific program integrity issues or potential program integrity issues and specific payment system changes that we think need to be brought into play, and that has resulted in a more aggressive recommendation of minus 5 percent, here we definitely see strong financial performance under Medicare. And we don't see Medicare's payments as being an impediment to access to care or any signal of payment adequacy concerns.

But we're not 100 percent sure that the signals we are getting warrant as deep a cut as we have recommended
for home health and for IRF. We've kind of gone not as far
here.

DR. CROSSON: Paul, I think I had.

DR. PAUL GINSBURG: Yeah. I just want to note
that a number of the write-ups on the topics we've been
covering sometimes point to private equity interest as an
indicator that this is extremely profitable, and I think
it's really more mixed.

And this came up at a -- I run a Wall Street
Comes to Washington meeting each year, and it came up this
year in the area, and that sometimes private equity
identifies often nonpublic companies that are doing very
well and could grow a lot faster with more capital. But
sometimes it's also used for particularly some of these
public companies that are struggling, which in a sense --
and there's a perception that they could be profitable, but
they're going to need better management. They're going to
need to do tough things. So they go private for a period
of years to do that, with the hope that then they can be
returned.

So we just need to be careful not to say private
equity means extremely profitable, but go a little deeper
into what's drawing the interest to private equity.

DR. CROSSON: Thank you. Good point.

Okay. So I think we'll now move on to the discussion period. We have the recommendation, Kim. The recommendation is for 2 percent reduction.

Again, let's hear comments about the recommendation.

[No response.]

DR. CROSSON: Seeing none, I'm taking this as an indication that the recommendation is supported. So we will bring this forward in expedited fashion in January.

Thank you very much, Kim.

We'll move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. The next presentation is on payment updates for home health services. Evan is here, and you've got the microphone.

MR. CHRISTMAN: Good morning.

Now we will review the indicators for home health using the framework you've seen in other presentations.

As an overview, this presentation will cover the basics of the benefit, the current issues the Commission
has identified, and the bulk of it will review the payment adequacy framework and present the draft recommendation.

As a reminder, Medicare spent $17.7 billion on home health services in 2017. There were over 11,800 agencies, and the program provided about 6.3 million episodes to 3.4 million beneficiaries.

In terms of the payment system, the Commission has noted two problems. The first issue is the high level of payments. Medicare has overpaid for home health since the PPS was established. The fact that home health can be a high-value service does not justify the excessive overpayments.

As discussed in the paper, Medicare margins have averaged better than 16 percent in the 2001-to-2015 period. These overpayments do not benefit the beneficiary or the taxpayer.

The second issue is an incentive in the current system. The current PPS uses the number of therapy visits provided in an episode as a payment factor. Payments increase as more therapy visits are provided in an episode. This incentive and the fact that more profitable HHAs tend to favor therapy episodes raised concerns that the
financial incentives of the payment system may be influencing the type of care provided.

The Commission recommended the removal of therapy as a payment factor in 2011.

Major revisions to the PPS will be implemented in 2020. The first is a policy that addresses our recommendation to eliminate the therapy thresholds. The second is the implementation of a 30-day unit of payment, and concurrently, CMS also plans to revise the home health PPS with a new case mix system and payment adjustors.

These will be the most significant changes to the PPS since it was implemented.

These changes are intended to be budget-neutral but will redistribute payments among providers. Estimates of the redistribution have some uncertainty because agencies have a history of changing coding and operational practices when the PPS is altered, but based on current patterns, CMS estimates that payments for nonprofit, facility-based, and rural agencies will increase, and for-profit, freestanding, and urban agencies will decrease.

As a reminder, here is our framework, and again, it's the one you've seen in earlier presentations.
We begin with supply. As in previous years, the supply of providers and the access to home health appears to be very good. Eighty-four percent of beneficiaries live in an area served by five or more home health agencies. Ninety-seven percent live in an area served by at least one home health agency.

In turning from access to supply, the number of agencies was over 11,800 by the end of 2017. There was a decline of about 3 percent, or slightly under 400 agencies in 2017, relative to the prior year, but overall, the supply of agencies has increased about 57 percent since 2004.

The recent decline is concentrated in a few areas, such as Texas and Florida, that have been the targets of efforts to reduce fraud, and these areas experience rapid growth in prior years.

Next, we look at volume. Overall, the volume of episodes and the number of beneficiaries declined in 2017 relative to the prior year. Cumulatively, however, the volume of services has increased substantially, and the number of episodes is about 54 percent higher in 2017 compared to 2002. The number of users is over 35 percent
higher, and total spending is up over 80 percent.

This substantial growth coincides with a period of high payments under Medicare, and margins for home health have ranged between 10 and 23 percent since the advent of PPS in 2000.

The marginal profit in 2017 was 17.5 percent, indicating that home health agencies had substantial incentive to serve additional beneficiaries.

Our next indicator is quality. I've split the quality measures into two groups. The first group of measures on the left are based on provider-reported data collected by home health staff at the start and end of home health care.

The group of measures on the right are claims-based measures that use Medicare claims to detect the incidence of hospitalization or emergency care use for home health patients.

As you can see, the first group shows that the frequency of patient improvement in walking or transferring has generally steadily increased from year to year.

In contrast, hospitalization and ER use rates have had a mixed annual trend but have not changed.
significantly in most years and certainly do not show the same substantial improvements as the functional measures. The contrast in these two groups of measures is striking, and though many factors may explain them, it is important to keep in mind that differences in the methods of data collection may account for some of the divergent trends.

Next, we look at capital. It is worth noting that home health agencies are less capital incentive than other health care providers, and relatively few are part of publicly traded companies. But overall, financial analysts have concluded that the publicly traded agencies have adequate access to capital.

We have seen a recent uptick in mergers and acquisitions, and it appears that some firms are increasing their capacity in this sector. And the all-payer margins equaled 4.5 percent in 2017.

Turning to Medicare margins for 2017, we can see that the margins for this year were 15.2 percent. The trend by type of provider is similar to prior years, with for-profits having better margins than nonprofits and urban agencies having higher margins than rural, but the
differences are relatively small. And, again, these
margins did not change substantially from the 2016 level.

The high margins in 2017 are notable because the
Patient Protection and Affordable Care Act mandated 4 years
of payment reductions in 2014 through 2017. However, the
PPACA offset these reductions with an annual market basket
update. The net effect was that payments were reduced by
less than 1 percent in each year, and the Commission has
long expressed that the PPACA reductions would not
significantly lower margins.

And as you can see, the margin results for 2014
through 2017 bear this out. Margins in all years of
rebasing have exceeded 10 percent and in the last three
years have been almost 3 percentage points higher than the
margins in 2013, the year before the PPACA reductions went
into effect.

The net effect is that despite the PPACA
policies, average payment per full episode in 2017 is 5
percent higher than the average payment in the year before
rebasing began.

This year, we also examined the performance of
relatively efficient home health agencies. Recall that we
define "relatively efficient providers" as those that are in the lowest third of providers in cost or the best performing third of providers for quality, without having extremely low performance on any measure. About 7 percent of agencies met this standard.

Compared to other agencies, efficient providers have lower hospitalization rates. They typically have higher patient volume. Their standardized cost per episode were 15 percent lower than other home health agencies, likely reflecting economies of scale from their larger size.

On the payment size, average payment per episode was 5 percent higher; the efficient providers' average margins of almost 26 percent.

We estimate margins of 16 percent in 2019. This is a result of several payment and cost changes. For payment changes in 2018, we included the payment update of 1 percent, which was offset by a coding adjustment that CMS implemented in this year.

For 2019, we included the payment update of 2.2 percent.

Cost growth has been historically low in home
health, and we assumed cost growth of 0.5 percent a year, which is above the long-term average.

Before I summarize our indicators and turn to the draft recommendation, I want to explain a payment reduction for 2020 that is required by the Bipartisan Budget Act of 2018. Recall that three changes are happening as a consequence of the Bipartisan Budget Act: a new unit of payment, removal of therapy as a payment factor, and a new case-mix system.

Statute requires that these changes in 2020 be budget-neutral. CMS has projected the behavioral responses by home health agencies to the new policies will increase payments by 6.42 percent in 2020, which would equal about a $1 billion increase in payments.

Consequently, CMS plans to implement a 6.42 percent reduction in 2020. Again, this reduction is necessary to offset the spending spike in 2020 due to the behavioral changes. It does not address payment adequacy.

Our analysis suggests that payments for 2019 will be more than adequate, and the planned 2020 reduction, since it is budget-neutral, should not substantially change provider margins.
Turning back to our framework, here is a summary of our indicators. Beneficiaries have good access to care in most areas. The number of agencies has declined slightly but remains high. For quality measures, we saw trends consistent with earlier years. The rates of hospitalization or ER use are unchanged, and the functional measures showed improvement in 2017, with the caveat I mentioned earlier.

Access to capital is adequate, and the financial performance of the sector under Medicare is strong, and these are the highest margins of any provider you have seen in this update cycle.

This brings us to the draft recommendation for 2020. That Congress should reduce the calendar year 2020 Medicare base rate for home health agencies by 5 percent. This recommendation reflects that payments in 2017 are more than adequate, and that significant action is necessary to reduce payment.

In past years, we have recommended a two-year rebasing to follow immediately in the year after a 5 percent cut. While it is likely that significant reductions after 2020 will be necessary, the payment
changes being implemented in 2020 would make it problematic
to pursue a rebasing in 2021.

Ideally, data for a rebasing should reflect the
mix and level of services HHAs provide under the new
payment policies for 2020, but this data will not be
available until mid-2021. As a result, our recommendation
today only addresses payments for 2020.

The impact of this change would be the lower
spending relative to current law. In terms of beneficiary
and provider impacts, it should be limited. It should not
affect access to care for beneficiaries or provider
willingness to serve beneficiaries.

This completes my presentation. I look forward
to your questions.

DR. CROSSON: Thank you, Evan.

Questions for Evan? Paul.

DR. PAUL GINSBURG: Evan, a really great
presentation.

Do you have any data on how commercial rates for
HHAs compare to Medicare?

MR. CHRISTMAN: So what we hear on average is
that the rates are lower. I think this majorly comes up
with Medicare Advantage, and what we understand is that in some cases -- I think this has gotten better in recent years, but in general, Medicare Advantage pays less per visit and provides fewer -- and ends up with fewer visits in an episode.

DR. CROSSON: Jon.

DR. CHRISTIANSON: I guess two questions. One is do we have -- is the data that you present on the quality measures, is that from fee-for-service or from Medicare Advantage and for example?

MR. CHRISTMAN: Those numbers are fee-for-service patients only. My examination of this has not suggested that the MA looks that different.

DR. CHRISTIANSON: Okay. So I think we need to be clear when we introduce the data on the quality measures that we don't have data we're reporting on Medicare Advantage --

MR. CHRISTMAN: Okay.

DR. CHRISTIANSON: -- which is a third of our beneficiaries.

The other thing about the quality measures is I think we've had this discussion before, and, Evan, you can
remind me. We've probably put this in other chapters and
not in the update.

I like your observation that the provider-reported
functional status measures -- you don't say it this way,
but make us a little nervous about the validity of them.
To me, it would help clarify that whole discussion if we
kind of started out by saying what we want is to know if
the functional status of beneficiaries improved due to
their home health care.

We have two ways of getting at it. One is a very
crude, very high-level claims analysis of ER admissions and
so forth, which really doesn't do the job, and the other is
the provider-reported functional status measures, which we
question whether that does the job. So the bottom line
here for me is that we really don't know a lot about
whether quality has improved because of the shortcomings
and the two different ways we go about doing it.

To me, that's the bottom line here. I don't know
whether you agree with that or whether we've probably gone
into this issue in greater detail and I'm forgetting about
it in past work.

MR. CHRISTMAN: I guess I would say two things.
Yes, I think we do have concerns about whether the functional measures accurately reflect the experience of patients, and I think we can sharpen that a little bit in the discussion.

I think the other point is a piece of this is also obviously being explored in the project that Carol and Ledia are leading sort of looking at the use of the functional data in general, and so I think a lot of what you're talking about will also get teased out in that work.

DR. CHRISTIANSON: And I think it's worth saying that. Again, to reiterate my point, I don't think -- the way it's laid out now, we have these measures, and they're going up or they're going down. My feeling about it is we really don't know, not nearly to the degree we would like to know, and I think that needs to come through in that discussion.

DR. CROSSON: Jon.

DR. PERLIN: Thank you, Evan, for a really thoughtful report.

One of the things that would be interesting just to understand, almost less in terms of the specific recommendation than in terms of thinking about post-acute
generally, is you noted an increase in the volume of utilization of home health services. Are you able to tease apart what percentage of that is attributable to patients who are enrolled in bundles, the incentives to otherwise get patients to the most efficient level of post-acute service?

MR. CHRISTMAN: We haven't looked at that specifically, but I can think of three experiences that probably inform your question. One is a general theme and things like CJR and BPCI is that for some patient populations, it's definitely been true that they have sent more patients to home health.

Obviously, those demonstrations are a fraction of the volume, and then the groups within that, that I'm talking about, are a fraction. So whether it's enough to really show up in national-level statistics, I think would be interesting.

The other experience is the ACO performance, and the ACO performance, I guess I think of -- I keep three facts in mind when I think about them. In aggregate, the work has shown a decline in home health use, but you have to keep two things in mind. The work that has split home
health utilization into episodes immediately preceded by a hospitalization have actually gone up just a tiny tick. Those episodes not preceded by a hospitalization -- we kind of call them "community-admit" -- have actually gone down significantly.

So if you look at it in an aggregate, you will see that home health utilization probably has gone down in ACOs, but it's because of that community admit piece and not the hospital piece.

And then the third fact to keep in mind is that generally the ACO studies show the hospitalization going down. We haven't pulled this all together, but it's quite possible that there might have been a slight uptick in the use of home health after hospitalization.

DR. CROSSON: Thank you.

David.

DR. GRABOWSKI: Thanks, Evan.

This was hard to unpack, given we're not just thinking about a payment update, but CMS is also shifting the method of payment for this sector with the patient-driven groupings model.

You had mentioned CMS has estimated sort of a 5
percent behavioral decrease, and I wondered if you could
say more about that. How do they estimate that? Do you
sort of trust that?

I've done some of these estimates, and they're
based on a lot of assumptions. It's really challenging
work. So I'm curious what you think of that approach and
in general whether we think going forward that that change,
along with our payment update, where that's going to leave
us at the end of the day.

Thanks.

MR. CHRISTMAN: Sure. So, yep, 2020 is a big
year. That's a lot going on. And so there's -- I want to
put this in -- I want to take this in two buckets. One is
the changes will be redistributional within the industry,
and the general way to think about those changes is that
it's going to move money from home health agencies that are
doing more therapy today, which tend to be more profitable,
to agencies that are doing relatively less therapy, which
tend to be less profitable. So, in a sense, the agencies
with lower average margins today are going to see money
redistributed towards them, and the ones with average
margins today are going to see money redistributed away.
So that's one thing. That's the budget neutral piece -- the case mix redistribution. Excuse me.

The other piece is how the aggregate coded case mix of this population will change in 2020. CMS is implementing a new system that uses 432 payment group set payment, and CMS has estimated that agencies will change their behavior in a way that will cause the reported case mix to go up by 6.42 percent without the severity of the patients changing. And breaking that 6.42 percent apart, the biggest part of it is they expect that agencies will be aggressive about, frankly, changing their clinical coding so that fewer patients are in the lowest-paid category. And, you know, that's about two-thirds of that effect.

The other sort of 2 points come from expecting agencies will be more aggressive about coding comorbidities, because comorbidities will count in a way that they don't today, so there will be more reported comorbidities. And the threshold for moving from a small, short-stay outlier payment to a full episode payment is going to be lower. So there's a sense that agencies may add one or two visits to pick up another $1,000, basically.
If you look at the 6.42 percent that CMS has set for 2020, and what has happened in the past when CMS has made changes, you know, I appreciate that, you know, as Yogi Berra said, predictions are uncertain, especially about the future, you know, when they implemented the changes in 2008 to a new system, payments in that year went up between 3 and 5 percent, and that is a much smaller set of changes than what we had before.

I think that there is a sense that, you know, the industry is pretty nimble. There are a lot of examples I could provide. But, you know, to their credit, what the law does is it requires CMS to implement all of these things in a budget-neutral way, and CMS has laid down the 6.42 percent. But the law also requires them to look back, and if they've figured out they've taken out too much, they're required to put the money back in.

DR. CROSSON: Okay. Thank you. Seeing no more questions we'll move on to the recommendation, which is for a 5 percent reduction for home health services. Discussion with respect to the recommendation?

Karen.

DR. DeSALVO: I missed round one so I'm going to
bridge. Is that okay? Because I just had a question --

I'm sorry, but I just had a question for you, Evan, about when you're thinking about number of providers or agencies, when there is consolidation in the market, how do you reflect that? I see that you say that there's beneficiary access, but I'm just wondering if that continues, how we're going to know it's not just a declining industry. It's just that there's M&A.

MR. CHRISTMAN: Right. Okay. So there's a lot going on there. I think just to be clear, so that we're clear, you know, when we report numbers those are the number of licensed Medicare agencies. And in general, in my experience when they buy a new agency, for a variety of reasons -- licensing and whatnot -- they don't consolidate a lot of provider numbers.

DR. DeSALVO: Mm-hmm.

MR. CHRISTMAN: So I haven't seen consolidate itself really have a serious effect on the overall number of reported agencies on the Medicare side. But I would take your point as this, that part of the challenge with measuring the home health supply is that agencies vary widely in their size, and it's across within a state and
across states. And so that point is taken. You know, we
have agencies that provide hundreds of thousands of
episodes a year and agencies that provide 20. And, you
know, I think there's one agency in the state of New Jersey
that provides 30 percent of all the episodes in that state.

So it's a little difficult. I guess what I also
just track on is the other aggregates, the number of users
and the number of beneficiaries.

DR. DeSALVO: Okay. Thank you. I support the
recommendation. I did want to make a comment about the way
we think about this part of the sector, particularly
wearing my doctor hat, which is to say that home health is
kind of, for me, in some ways, the poster child of a siloed
fee-for-service marketplace. And what I hope to see is
that, over time, home-based care is more a part of the
continuum of care in models like ACOs, as an example, or
MA, simply because of the importance of connecting that
really critical post-discharge often part of care with my
patient who is acutely ill, very nearly.

And I think what most doctors would tell you in
the field is that we're not as encouraged, or we don't have
opportunity, for whatever reason, to tightly communicate
with home health. And so I think the incentive structure, financially and from a quality standpoint, to really drive the system and coordinate that transition of care, to really think about helping the person stay at home is something that I'd love to see us focus more on.

You had this one section in the chapter about the value-based care attempt for home health, which I appreciate in and of itself wasn't success. But I would like for us to paint a picture in the chapter that we don't think that this is an opportunity for value-based care. I just had a sense from the chapter that maybe we think that -- not that we think this but I would like to try to find a way to shape the message that this is part of the care continuum and that better care coordination, there may be opportunities for efficiencies but also for better outcomes in quality of care. That's kind of how I read some of the quality numbers.

The other thing I just wanted to mention, for future thinking, is the -- Jon, you're right. Right now we're using claims and physician or clinician assessment, but there's an opportunity to think about the individual's assessment, whether that's through CAHPS or through other
measures like NPS or Healthy Days.

So I don't know where CMS is going with their quality measurement but I'd love to see the incentives aligned, both in terms of health outcomes and finances, so that this was better connected to the rest of the care system.

DR. CHRISTIANSON: Evan reminded me that Ledia and -- who was the other person? I'm sorry.

MR. CHRISTMAN: [Speaking off microphone.]

DR. CHRISTIANSON: Yeah, were working on that.

DR. CROSSON: Sue and then Bruce.

MS. THOMPSON: Evan, thank you for this chapter, and I, too, simply want to say that I was really conflicted as I read this chapter, not with the data, not with the methods, but with what home health represents and has contributed to our work in ACOs and looking to the future of that platform in terms of being able to move more care out of our expensive hospitals and long-term care hospitals into a home environment. I mean, I think if we looked ahead five years, seven years, we are going to be marveling at the kind of technology we're going to take into the home, and that's going to require an organization, a
platform of providers that are very, very comfortable working in home environments.

And so there's a tone in the chapter, which I know relates to bad actors in this business. I mean, there are program integrity issues. We have lots of evidence where folks have taken advantage of, this is a part of the industry where you can be nimble, and you can move quickly. But I just really -- there is a part I just have to comment on that has something to do with the tone that we send about how important this element is to our continuum, and where, in the future, we're going to look to be able to provide care in a less-expensive environment.

So I just want to add that to my comments. I can support the recommendation but with that caveat.

DR. CROSSON: And I think we can look at that balance.

Bruce.

MR. PYENSON: I look back at the MedPAC recommendations from last year and it was also a 4 or 5 percent reduction. I think the reality was that CMS actually had an increase, I think. So if that's the case I would suggest we think about more than the same reduction
that we suggested last year. And I'm not sure if that -- I
didn't look up if that should really be for two or three
years. I think we've been making a similar reduction.

DR. CROSSON: So, Bruce, you don't support the
recommendation?

MR. PYENSON: Well, I think the 5 percent is a
minimum reduction. I should have asked the question, is
the -- was there an increase last year.

MR. CHRISTMAN: Yes. Yeah. They've gotten an
increase of around 2 percent.

MR. PYENSON: Yeah. I think our assumption from
last year was 1 percent.

MR. CHRISTMAN: Yeah. I guess if I had to go --
when you say last year I don't want to -- yeah, so in 2018
it was -- they were basically -- excuse me. In 2018, they
were basically level because they had the 1 percent going
in and the case-mix adjustment coming out. So that was
basically flat. For next year they're going to get a 2.2
percent increase.

MR. PYENSON: Okay. So then I'm fine with the 5
percent. I just want to keep in mind the consistency of
our recommendation. I do support the recommendation.
DR. CROSSON: Okay. Thank you. Marge.

MS. MARJORIE GINSBURG: Just as a matter of full disclosure I actually was a home care nurse at some point earlier in my career. I do support the recommendation, but I also support, I can't remember whose comment, about how closely the work of home care is linking to other aspects of the care they're getting from their physician and their health care system.

And I don't know, Evan, whether you have any information about how home care services are communicated. I mean, I can remember the olden days about how we communicated, which has no relevance to today, but I would imagine that home care nurses have their tiny little iPads or laptops and they actually record right into the patient's medical record. Is that right?

MR. CHRISTMAN: Sure. I think I would say two things. You know, in part because of the patient assessment requirements in home health, home health agencies frequently use some sort of point-of-care system for their own medical records, and some, I think, do offer that data in a portal for physicians to access.

But my understanding of how a lot of the
communication happens, Marjorie, is that it will probably not be that different in that, you know, it's calling physicians, faxing, talking, trying to get to the office. My impression is that -- as other Commissioners have mentioned -- this still remains a flash point in the benefit. You know, there are some physicians who know the setting very well and work closely with their agencies, but my understanding is that those are more the exception. And, you know, sometimes I hear the words "said it and forget it."

So I wish I could say that it had changed more.

MS. MARJORIE GINSBURG: And just to reinforce, at least my expectation and hope, is that, in fact, the work of the home care staff really becomes integrated and part of the entire comprehensive care that patients are getting and not seen as just isolated ancillary services that have no relevance to the care they receive. And I don't know what it takes to make that happen more convincingly.

DR. CROSSON: Okay. Thank you. Seeing no further comments it's my judgment that there's broad support for the recommendation. Therefore, we will bring it forward in January as an expedited voting process.
Thank you, Evan. Nice job. We will move on to the final presentation for the December meeting.

[Pause.]

DR. CROSSON: So the final presentation today is our annual update on the Medicare Advantage program. There are no recommendations here but I anticipate a vigorous discussion. Scott, Carlos, and Andy are here, and it looks like, Andy, you're going to be beginning? Oh, Scott. Sorry. Go ahead.

DR. HARRISON: Good morning. I am going to present our analysis of the Medicare Advantage enrollment, plan availability and bids for 2019. Then Andy will give you an update on risk coding intensity, and, finally, Carlos will talk about MA quality.

Let me briefly summarize the MA payment system. Plans submit bids each year for the amount they think it will cost them to provide Parts A and B benefits. There is a separate bid for Part D drugs, but the MA plans just get paid for D as if they were stand-alone Part D plans. Each plan's bid is compared to a bidding target or "benchmark." CMS sets county benchmarks based on the fee-for-service spending in each county. These benchmarks
range from 115 percent of fee-for-service in the lowest-spending counties to 95 percent of fee-for-service in the highest-spending counties. A plan's benchmark is the risk-adjusted average of the county benchmarks of its enrollees. Quality bonuses can increase plan benchmarks by up to 10 percent. Carlos will discuss these plan quality bonuses shortly.

If a plan bids below its benchmark, as plans almost always do, Medicare pays the bid plus a rebate which is calculated as a percentage of the difference between the bid and the benchmark. The rebate percentage ranges from 50 percent to 70 percent, depending on the plan quality ratings. The rebate must be used to provide extra benefits. If a plan bids above its benchmark, Medicare pays the benchmark and beneficiaries make up the difference with a premium.

Enrollment in MA plans continues to grow rapidly. In 2018, MA enrollment grew 8 percent to 20-and-a-half million enrollees. That growth is about the same as the average annual growth over the last 12 years. Plans project double-digit enrollment growth for 2019, presumably based on both an increase in the number of plans bidding

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and the extra benefits being offered. By plan type, enrollment in HMOs grew 7 percent while local PPOs grew by 16 percent. Regional PPOs, however declined slightly. Thirty-three percent of Medicare beneficiaries are now enrolled in Medicare Advantage plans.

Medicare beneficiaries have a large number of plans from which to choose and MA plans are available to almost all beneficiaries.

For 2019, 99 percent of Medicare beneficiaries have at least one plan available, 97 percent have an HMO and/or a local PPO available, 90 percent have a zero-premium option available that includes the Part D drug benefit, and that is up from 84 percent in the previous year.

As I mentioned, there is a large increase in the number of plans bidding. The average number of plans available in each county increased to 13, from 10 in 2018.

Weighting by the number of beneficiaries in each county tells us the number of plan choices available to the average beneficiary, and that increased to 23 plans, up from 20.

Finally, the average rebate that plans have
available for extra benefits in 2019 has increased to $107 per member per month, a record high. Note that these record levels have developed over a period when PPACA reduced the benchmarks. Plans were able to respond to fiscal pressure by increasing the efficiency of their bids.

For 2019, we estimate benchmarks, bids, and payments, including quality bonuses, will average 107, 89, and 100 percent of fee-for-service, respectively. These numbers have been stable over the past three years as the PPACA benchmark reductions were completed in 2017. So we are now in a period where on average nationally, per capita spending to plans, are roughly equivalent to spending on fee-for-service Medicare beneficiaries, and 2 to 3 percent of those MA payments are attributable to quality bonuses.

The plan benchmarks, however, include an average of 4 percent for quality bonuses and an average of a total of 107 percent of fee-for-service, on average.

Looking at the bids column we see plans, especially HMOs, are usually able to bid below fee-for-service costs, averaging 89 percent of fee-for-service overall and 88 percent for HMOs. The other plan types bid higher and local PPOs are bidding 96 percent of fee-for-
Bear in mind that all the numbers on this slide assume that risk differences are properly accounted, but next Andy will say that not all risk is properly accounted for. If we incorporated the uncorrected coding intensity differences, we would say that 2019 payments would average 101 to 102 percent of fee-for-service.

I have one last slide before I hand it over to Andy. This chart shows how much plans bid relative to fee-for-service for service areas with different ranges of fee-for-service spending. As expected, plans bid high relative to fee-for-service in areas with low fee-for-service spending and bid low relative to fee-for-service where fee-for-service spending is high.

If you look at the left-most column which shows the bids for plans with service areas concentrated in counties in the lowest spending quartile where the benchmarks are set at 115 percent of fee-for-service, you will see that the median bid is 99 percent of fee-for-service. This means that most plans in these counties, which were presumed to be the most challenging for MA plans to compete in, are bidding below local fee-for-service.
spending.

That has not always been the case. As benchmarks have declined over the past few years, the median bid for these areas has decreased from 111 percent of fee-for-service in 2013. However, the increased efficiency of plan bids in these areas have not translated to Medicare savings. For 2019, Medicare is still paying an average of 111 percent of fee-for-service in these areas, because the benchmarks average 118 percent of fee-for-service when you include the quality bonuses the quality bonuses.

Now Andy.

DR. JOHNSON: Medicare payments to MA plans are unique to each enrollee and are the product of two factors. The first is a base rate that Scott described earlier. The second is a beneficiary's risk score, which is a standardized measure of expected spending. A risk score adjusts the base rate by increasing payment for beneficiaries who are more sick and therefore expected to have greater health care expenditures, and vice versa.

The risk model includes demographic information and certain medical conditions, identified by diagnosis codes and grouped into HCCs. Risk scores are the sum of
the relative spending amounts for each component in the
model. The more HCCs indicated for a particular enrollee,
the larger the risk score and the larger the Medicare
payment will be for that enrollee.

The risk model is estimated using fee-for-service
data, and therefore relative spending amounts reflect the
spending and diagnostic coding practices in fee-for-service
Medicare. There is little incentive to document all
diagnoses in fee-for-service Medicare, as most HCCs are
documented on claims paid based on procedure codes rather
than diagnosis codes.

In MA, however, there is a significant financial
incentive to document all diagnoses as payment is tied
directly to the number of HCCs identified. The difference
in fee-for-service and MA coding intensity causes
beneficiaries of equivalent health status to have higher
risk scores and to generate greater Medicare spending when
enrolled in MA.

Our analysis of 2017 data found that MA risk
scores were 7 percent higher than fee-for-service
beneficiaries with comparable health status. Each year,
CMS applies an adjustment that reduces all MA risk scores
to account for the impact of coding differences. The adjustment was 5.66 percent in 2017. The remaining difference of 1 to 2 percent generates payments to MA plans in excess of what fee-for-service Medicare would have spent to care for the same beneficiaries. Through 2015, our analysis found that the overall impact of coding differences was increasing each year, but this difference has decreased in the past two years.

We believe three factors contribute to the reduction. First, CMS implemented new versions of the risk score model that are less susceptible to coding differences. Second, fee-for-service risk scores grew faster during the past two years than prior years, nearly matching annual MA growth rates. The fee-for-service growth rate may have been influenced by the transition from ICD-9 to ICD-10 diagnosis codes, as well as other factors. Finally, MA risk scores were reduced slightly by the use of encounter data in risk adjustment.

Although we have seen a reduction in the overall impact of coding intensity, the coding adjustment policy continues to generate significant inequity across MA contracts. The coding adjustment is shown by the yellow
line. Each black columns shows one MA contract's coding intensity relative to fee-for-service.

This graph shows significant variation in coding intensity across MA contracts. Considering that the coding adjustment reduces all MA risk scores by the same amount, contracts on the left of the dashed line are penalized by the coding adjustment, and contracts on the right are overpaid despite the coding adjustment.

In 2016, the Commission recommended a three-part approach that would make the coding adjustment more equitable across MA contracts and would account for the full effect of coding differences.

I will now turn it over to Carlos.

MR. ZARABOZO: As Scott mentioned, MA has a quality bonus program that provides bonus payments to highly-rated plans. Plans are rated using a 5-star system and contracts with an overall average rating of 4 stars or higher receive bonuses. The bonus takes the form of a 5 percent increase in MA benchmarks, and in some geographic areas a 10 percent increase. Using the most recent star ratings, 75 percent of MA enrollees are in contracts with a 2019 star rating of 4 stars or higher, with expected
expenditures of about $6 billion for bonus payments in 2019.

One aspect of the quality bonus program is that plan sponsors can use contract consolidations to move non-bonus contracts to bonus status. The plan sponsor can merge a contract that has a rating below 4 stars with a contract at or above 4 stars and choose to have the higher rating apply to the newly formed combined contract. This consolidation process is occurring in the current cycle, with 550,000 enrollees being moved to bonus status under merged contracts. Over the last 5 years, nearly 5 million enrollees have been moved to bonus status through consolidations.

Beginning next year, the policy applied in contract consolidations will change so that rather than allowing one contract's star rating apply to the merged contract, the star rating will be determined based on the weighted average quality results for the contracts being merged. However, under the new rules, a plan sponsor would still have the opportunity to obtain unwarranted bonuses by designing mergers where the averaging method results in an overall rating that is at 4 stars or higher.
The contract consolidations that have occurred over the last 5 years have affected our ability to judge quality in MA and changes in the level of quality over the years. As we discussed at the November meeting, because of consolidations, MA contracts can cover wide, disparate geographic areas. As a result, since star ratings are determined at the contract level, star ratings are not a good indicator for evaluating quality. Even if we examined individual measures in MA, many quality measures are based on small samples drawn at the contract level, regardless of the size and geographic reach of the contract. So results examined at the measure level also may not be a valid representation of quality in MA.

To summarize the status of the MA program, the program is doing well, as evidenced by the growth in enrollment, increased plan offerings and extra benefits that are at a historically high level. As Andy explained, certain policies have helped reduce the impact of coding differences between MA and fee-for-service.

For the immediate future, we plan to continue looking at issues with the MA quality bonus program, looking at ways to account for continued coding differences.
between MA and fee-for-service and how to address those
differences in a complete and equitable way, and ensuring
the completeness and accuracy of encounter data.

Going forward, the Commission may wish to look at
MA payment policy from a broader perspective. When the
PPACA payment reforms were instituted that reduced MA
program payments, there was some concern about whether MA
would continue to grow and attract Medicare beneficiaries.
The fiscal pressure did not have the effect that some had
predicted. Instead, bids have come down in relation to
fee-for-service. This is true, as Scott mentioned, even in
areas where sponsors might have found it challenging to
operate successful plans, such as in areas where MA
benchmarks are at 115 percent of fee-for-service.

On average across the nation, MA payments are
nearly at parity with fee-for-service expenditure levels,
consistent with the Commission's support of equity between
the two programs. A reasonable question to ask, though, is
whether 100 percent of fee-for-service is the right
yardstick for evaluating the efficiency of the MA program,
given that we would expect plans to be more efficient than
fee-for-service.
In setting payment policy in fee-for-service, the Commission tries to have a level of fiscal pressure applied to providers to promote the efficient provision of care while maintaining good access. Fee-for-service payment policies of that nature have an effect on MA payments because MA benchmarks are based on FFS expenditure levels. In the future, the principle of parity can encompass the concept of achieving an equal level of cost and quality pressure between MA and FFS.

That concludes our presentation. Thank you.

DR. CROSSON: Thank you. Very good update. We now open for clarifying questions.

Jonathan and then Marge.

DR. JAFFERY: Thanks for a great update. I guess I have two questions. I guess these are for Andy, and the first one may not be easy to answer. Can you explain at all how the coding adjustment factor is determined? And the second part is, I think you mentioned that Commissioners in the past made, I think, three recommendations regarding addressing issues with coding adjustments. Can you remind us what those are?

DR. JOHNSON: So the coding factor is set in
statute to increase each year. I think it started in 2014, and it will level out starting in 2018 at about 5.9 percent. The Secretary has authority to go above that amount. It's a minimum adjustment amount but to date has not applied a higher factor.

And the second question was about our three-part recommendation. The first part was to remove health risk assessments as a source of diagnosis for risk adjustment, so that only diagnoses that were documented on assessment but not had any care provided outside of that assessment would be removed. And we think that is associated a little bit with the graph that shows that there is wide disparity in coding intensity across contracts.

The second part of the recommendation was to use two years of diagnostic data, both in MA and fee-for-service, and that would decrease some of the disparity between MA and fee-for-service coding rates. And the last part was to, after implementing those two, identify the remaining impact of coding intensity and apply either an across-the-board adjustment or afterwards we discussed separating that out into groups of low, medium, and high adjustments to address the rest of the coding impact.
DR. JAFFERY: Thanks.

DR. CROSSON: Marge, and then Jon.

MS. MARJORIE GINSBURG: This is a real basic question, I guess. So the goal of maintaining equity between the two ways Medicare beneficiaries get their services, original Medicare and Medicare Advantage, why? I think it's been shown that folks in Medicaid Advantage plans use services more efficiently, I think have better health outcomes. It should be a less expensive way, and probably better way, to provide care for seniors.

So what is the philosophy behind maintaining equity in how much money the government spends on these two services? Thank you.

DR. CROSSON: Go ahead.

DR. MATHEWS: So this notion of parity between MA and fee-for-service goes back quite a few years and has been one of the standing principles of the Commission that the Commission should be indifferent with respect to, you know, financial incentives regarding a beneficiary's choice of MA versus fee-for-service. And so for the better part of at least a decade now that has been the Commission's principle, that as long as it is neutral to the program the
beneficiary should be able to select the delivery model that is of most, you know, interest and utility to the beneficiary.

But as the presentation articulated, now that we have, you know, reached parity, putting aside, you know, any potential residual coding differences, the question for the Commission's discussion is, you know, is that sufficient, or do we want to look at ways to impose additional financial pressure directly on MA the way we do through the fee-for-service sectors. And so that's the question that's under discussion.

MS. MARJORIE GINSBURG: Because I, I mean, in my mind, you know, a major function of the Commission is to keep an eye on how much the taxpayer is paying Medicare, and so if we're not particularly attentive to how dollars are being spent where they don't have to be spent, that's of high interest to me. Thank you.

DR. CROSSON: Did I see Pat? Oh, I'm sorry. Jon was first, then Pat. Go ahead, Pat.

MS. WANG: So the sort of observation that payments to MA are now about equivalent to fee-for-service is sort of like the top-line story, and underneath that, of
course, is because there are different benchmarks by county. It's a blend, that 100 percent equivalency is a blend of plans in lower benchmark counties bidding far below fee-for-service, by definition, because the benchmark is 95, and those that are bidding, you know, up to 115 percent of fee-for-service.

As I recall, one of the rationales behind kind of doing the tiers of benchmarks in that fashion was partly to try to attract MA to counties that had low fee-for-service spending and maybe they were rural areas, what have you. I'm thinking about Sue's comment yesterday, I guess -- it seems like a week ago -- yesterday, that, you know, in her area it's still difficult to get MA plans in, even though maybe she's in a 115 percent benchmark county.

I just wonder whether, with the passage of time, you have a feel for whether that strategy to put the benchmarks 15 percent or 7 percent above fee-for-service has worked in attracting MA into the areas, or whether there might be other strategies needed to bring MA in, like provider network, which Sue raised.

DR. MATHEWS: And Scott and Carlos, before you answer, can you scroll back to Slide 7?
DR. HARRISON: Thanks. That's where I was going to go.

So you still see that there are differences between the quartiles, but it has moved. Now I believe about 25 percent of rural beneficiaries are in Medicare Advantage, and that's quite an increase from what it had started at.

Most rural beneficiaries have access to plans, even multiple plans, and so, yes, certainly plans have shown up. They're still not everywhere. There's none in Alaska, and there's a few other counties, pockets of places where there aren't any. But for the most part, the plans have now established themselves.

Now the question would be -- yeah. What's next?

DR. CROSSON: Jon.

DR. CHRISTIANSON: First, a quick question on Slide 6. The $107 figure, I know you said this in the presentation, but I missed it. What's the time period for that? Is that a per-month figure or per-year figure?

DR. HARRISON: Oh, you mean -- I'm sorry. You mean the rebates?

DR. CHRISTIANSON: The rebates available for --
DR. HARRISON: That's per member per month. I'm sorry.

DR. CHRISTIANSON: Per member per month.

DR. HARRISON: Yeah.

DR. CHRISTIANSON: So there's $107 per member per month, plans have to spend on extra benefits for Medicare beneficiaries --

DR. HARRISON: Right.

DR. CHRISTIANSON: -- over and above fee-for-service. Okay.

The general comment, I guess is on the quality discussion. On a status report for the Medicare Advantage Program, for me on quality, the headline news would be how does the quality in Medicare Advantage plans compare to the fee-for-service system.

MR. ZARABOZO: And the answer would be we don't know.

DR. CHRISTIANSON: Well, that's not here, though, right? I mean, I think that's an important headline story to me, and I think you start with that and say, "Okay. We don't know how the quality compares for 33 percent of our beneficiaries in the Medicare Advantage plans versus those
that have elected to stay in fee-for-service." So that's an important first choice the beneficiaries make: Do I do a plan, or do I stay in fee-for-service?

Your focus on quality is if you choose to go to Medicare Advantage, can you compare the plans? So I think your conclusion there is that beneficiaries can't even do that reliably, given the information they have that's publicly reported in the Star ratings.

Are there other measures that allow us to compare these two that could be in this report, that allow us to compare plans?

MR. ZARABOZO: Well, the CAHPS measures, for example, on the Health Plan Finder, you can compare CAHPS results in fee-for-service with MA results.

DR. CHRISTIANSON: Yeah. So I think you focus in the status report on what the beneficiaries have available, which is appropriate and reflects your work that's been done, which is great. Is there something else we could report on what data are available that we could compare plans on in this status report?

MR. ZARABOZO: Again, other than the CAHPS, I would say not really, that we don't have a good basis for a
comparison.

DR. CHRISTIANSON: Okay.

MR. ZARABOZO: Now, as you know, we have a recommendation that says we would like to be able to compare fee-for-service and MA and have measures that are comparable between the two.

DR. CHRISTIANSON: Yeah. So I think a complete discussion of the status of quality needs to have those things in it. We are at a stage where 33 percent of beneficiaries have chosen Medicare Advantage plans, and we don't know whether quality is better or worse for those beneficiaries in aggregate. Plus, we don't have information that allows them to make choices between plans, if I understand your --

MR. ZARABOZO: Yes.

DR. CHRISTIANSON: That, to me, is the bottom line of the quality discussion is in terms of status of the MA program.

DR. CROSSON: On this point, Jon?

DR. PERLIN: Thanks.

I think Jon's point is really well taken, and it just drives me to the challenge and fundamentally in the
data. Without the adequacy of the diagnostic information and fee, you not only have a financial issue in terms of the benchmark setting, but you also have inadequate basis for a comparison of the fundamental health status of the beneficiaries to be able to then evaluate the quality outcomes.

DR. CROSSON: Okay. Further questions? Clarifying questions?

[No response.]

DR. CROSSON: Seeing none, we'll start the discussion about the report. We've heard some comments to that effect already.

Pat, I think you are going to lead off.

MS. WANG: I'll just kick it off.

I thought it was really a great chapter, so I commend you guys for all the work that you've done on this. Just a couple of things. Just starting with risk adjustment, reiterating the recommendations of the Commission in past, I think this is a really small technical thing, but just on the recommendation of excluding HRAs, HCCs obtained on HRAs, it's important if that proposal is to be developed to make sure that CMS is
distinguishing like a face-to-face encounter from an HRA.

In April, there was something published that was an attempt to define a chart review that excluded, that didn't include nurse practitioners administering an HRA, which should have been included. So I just point that out as further exploration of going deeper, so that there are not further inequities that are created because of the way that they are defining, that they know how to capture what they want to capture.

Andy, you know what I'm talking about.

As far as quality is concerned, I really share Jon's concern over quality. I think it's unfortunate that the whole phenomenon of contract consolidations, which have just completely obscured anybody's ability to see what's really going on with quality in the program -- it's also I think an unfortunate device that many multi-region plans have used to game the bonuses and get bonuses that we've discussed before.

And there are inequities for plans that don't have the ability or have chosen not to do that. So I just state that for the record, and I think it leads to the dissatisfaction overall with the data that exists.
On consolidations, the report does not that the measures taken by Congress address it, to a certain extent, by using the weighted average, but that it's still possible to manipulate the system with the right combination of plans.

I didn't see it in here. It may have been in here, and I may have missed it. But I think that there was another phenomenon for new plans, which get a 3 percent increase in payments. I don't think it's called "star," but there have been observations that some plans are setting up new plans getting the 3 percent bump and consolidating lower or no-bonus status contracts into those. So I would suggest if it's not in here to mention that as another thing that needs to be addressed.

The issue around quality -- and there are a lot of recommendations about smaller geographic areas, et cetera, et cetera, which are all good. I think the thing that also needs to be said is if you get to that point of being able to measure at a local level, that the measures should be consistent with the measures in fee-for-service.

We had this conversation yesterday about the HVIP and the overlap of one very key measure, which is avoidable.
readmissions, just making sure that it's capable, they're capable of doing an apples-to-apples comparison.

In particular, I think that the recommendations of MedPAC around peer grouping are critically important to somehow pull into the MA program because even if all this stuff gets straightened out, Jon, and you get to see what's happening at a local level, there's a totally different set of quality metrics that have different SES or no SES adjustments. It's still going to be really hard to do a cross-walk between fee-for-service and MA.

So I think I would encourage the Commission to continue to try to bring the quality measures used in those systems together to the greatest extent possible.

Totally agree on some of the other observations around treatment of EGWP, disenrollment, I-SNP, readmission measures, and excluding those as kind of outliers. I still suggest that for I-SNP, the care of older adults and the SNP HRA measures are also a little bit different when you have a captive audience in I-SNP situation, and that those should be looked at as potentially skewing the results.

I appreciate the observations around CAHPS. We sort of talked about that.
I would just point out -- I think it was on page 43, Table 8. This is just an observation. The headline is there was little change in results for survey-based measures in MA over the last year, and then there is measures collected through the Health Outcomes Survey, measures collected through CAHPS. It is just one year of observation year over year. That plus the tightness of the clustering of these scores, I'm not sure that there's a headline here to be observed.

I just wonder whether you have more longitudinal information that might make a comparison of over-time changes.

MR. ZARABOZO: The next page is the four-year look of those.

MS. WANG: Oh, okay. Okay. I missed that.

Thank you. Good.

As far as the benchmarks are concerned, it's a great conversation to have. I think it really is important to emphasize on this Chart 7, again, that the 100 percent fee-for-service equivalency is a combination of plans in 95 percent benchmark counties bidding at 79 percent of fee-for-service and those in 115 percent counties bidding at 99
percent fee-for-service, and in some cases, over the blend
of those is what creates the 100 percent.

So in deciding how to march forward to bring the
systems closer together, I think that's an element of how
do you adjust -- are there still four tiers of benchmarks.
What's the approach? I just want to make sure that that
piece is in there. Not everybody is bidding on the same
benchmark.

Okay. That constitutes my comments, but I think
it was a really great chapter. So thank you.

DR. CROSSON: Okay. Thank you, Pat.

Other comments to improve the report?
Brian.

DR. DeBuSK: I just wanted to take a moment in
the discussion around -- first of all, thank you on a
really well-written report -- to comment on it's promising
that the difference in the risk scoring between MA and fee-
for-service appears to be shrinking now.

I mean, I think when I first joined the
Commission, we were sitting at about 10.1, I think was the
difference, and now we're down to 7.

I do hope that we can work into the report -- and
even as a Commission -- develop a philosophy on encouraging
the proper coding of patients in the fee-for-service world
because I think on the program integrity and the RADV
audits and things, to make sure that over-coding doesn't
occur in the MA world, obviously.

But I still contend that we will not be able to
treat patients -- we won't be able to make the correct cost
adjustments between the programs, and to the point that Jon
made earlier, we're talking about wanting to compare
quality between MA and fee-for-service. Well, if the
patients are coded fundamentally differently -- in one
system, they're coded just enough, and the other one,
they're, if anything, over-coded -- I don't see how you can
make -- and maybe I just don't know quality well enough.

But I don't see how you can make that many adjustments and
correct for data that just isn't there.

And we talk about coordinating care, and we talk
about providers in fee-for-service becoming more
accountable. If these patients aren't properly coded, I
don't even understand how we're going to develop plans of
care. I mean, to me, it seems like you'd be trying to
build a building with only half a set of plans.
So, again, I think any policies that would encourage parity in the coding, I think would be good for the program and good for the beneficiaries.

DR. CROSSON: Bruce.

DR. PYENSON: I'd like to pick up on Pat's point with respect to Slide 7 and raise the question whether this structure makes sense to have the subsidies for the lowest-cost areas. It's an issue we've grappled with in other topics in the last day and a half and whether from a policy standpoint this is the direction we want to go in.

It strikes me that there are alternatives in many of the lowest-cost areas through the ACOs for managing care, and as we hope that ACOs and Medicare Advantage will increasingly dominate the health care system, I think we can reflect on those alternatives and the roles they play in different areas.

One aspect of that I'd like to consider is the role of ACOs and Medicare Advantage with respect to the socioeconomic determinants of health, and that perhaps is seen strongly in I-SNPs and D-SNPs, where the socioeconomic determinants of health are perhaps very important. But in theory, it would seem that the ACOs with their physical
location in communities should be able to access the 
resources in the communities to the advantage of the 
beneficiaries.

Bringing in those kind of determinants into the 
program of whether it's ACOs or Medicare Advantage, I think 
is important.

We've begun to see some of that with rebates 
being used in ways that can address non-Medicare benefits, 
which I think is very useful. It's less clear to me that 
that's gotten the attention it deserves to bring value to 
the program and to beneficiaries.

DR. CROSSON: Bruce, thank you.

And I'll just talk to Jim. We will ask the staff 
to look at in the next year an analysis of the MA payment 
system.

Okay. I didn't see who was first, but Jonathan 
and then Kathy.

DR. JAFFERY: Thanks.

This is a comment that builds on both what Bruce 
just said and Brian before, mostly Brian.

I agree with you. It's really important to get 
some parity in the two types of systems for us to
understand risk.

What I think we are really getting at, though, what we really want is to make sure that we can compare our assessment of risk in patients, both for payment equity and outcomes and whatnot and not coding, per se.

So I wonder if over time there is a risk assessment model that does more than what we've seen in MA and now we're seeing in fee-for-service, particularly in some of the ACO models that have risk adjustment factors baked in to get at risk assessment, and where that aligns with what Bruce was saying I think is perhaps bringing in social determinants as well or other types of things where we can get data from external sources and aren't just asking providers, both because it's using more administrative time and cost and a bit of a burden for providers, it's time consuming. And then we get some perverse outcomes, I think sometimes, so something to think about.

DR. CROSSON: Thank you.

Kathy.

MS. BUTO: So I was just thinking. I was looking at Slide 14, the fourth bullet down, disconnect between
fee-for-service and MA, and I think some of the comments made so far point to some of those disconnects.

The statement that if fee-for-service strategies are successful, MA benchmarks go down, I don't see that as a problem. Maybe you weren't identifying it as a problem, but it sort of caused me to think about something else, which I think we could spend more time on, which is that MA plans are able to leverage fee-for-service on DRG payments, for instance, to hospitals.

There are areas where MA plans are kind of at the mercy of fee-for-service policies, like coverage, midyear coverage decisions that may have big implications.

I think we should spend a little more time, not in this report, thinking about those places where MA plans are able to leverage fee-for-service and where they are not and why this issue of parity is maybe difficult to fully address. But we should be aware of those areas where there are opportunities that maybe we haven't spent enough time thinking about, because I'm reflecting back to the work two or three years ago now where we looked at premium support, and we found in some areas, fee-for-service was the most efficient. In other areas, MA or even potentially ACO fee-
for-service was more efficient.

And it strikes me that where fee-for-service is able to really leverage national policymaking in setting rates -- and I guess by implication, having to leverage the budget implications of making a policy decision in fee-for-service -- MA plans are much more at the mercy of their local conditions and so don't have that same leverage.

So I just think we need to get our minds a little bit more around those issues and not think that we can achieve full nirvana and equity in the way these two play out together in an area.

MR. ZARABOZO: Just on the point of midyear coverage changes, midyear coverage changes that are significant are paid by the fee-for-service program, not the MA plans.

MS. BUTO: Okay. So they did make that change.

Okay.

MR. ZARABOZO: Yeah. It's been longstanding.

MS. BUTO: It's just all the other ones that are quote/unquote "not significant."

DR. CROSSON: Jon.

DR. PERLIN: Terrific report. It's interesting.
Our conversation has two threads. I mean, one obviously is the comparison of the MA versus fee. The other is sort of taking the broader context of how do we fulfill our fiduciary responsibilities to support the Medicare program.

And to go back to really thinking about the conversation yesterday about everything ranging from social determinants to improved outcomes to coordination of care, and it just strikes me that, you know, maybe one of the things that we should consider, as a committee, not in the context of this specific conversation but more broadly, is that we're suffering from sort of administrative limitations here in terms of comparison of data for the purpose of understanding the utility of the resources expended and simultaneously the quality of the outcomes for the beneficiaries.

Now if you sort of step back from that it takes me back to my VA days, where, you know, there and DoD, a functional data assessment, regardless of whether the patient was managed by direct service provision or through a contractual relationship or otherwise, it provided a basis for understanding what the inherent risk for individuals were, which allowed some attention to social
determinants, but also stepping back to the risks of population.

And, you know, as we go forward, would this be a point where patient-completed functional status assessment would have utility that would transcend some of the limitations that we're talking about in terms of these programmatic comparisons and simultaneously help providers address those social determinants and planners address population health opportunities. Thanks.

DR. CROSSON: So I agree, and I think Jon made similar points earlier that, you know, perhaps as we go into the next round and the next year, and we take a look at MA, this particular point, which is, you know, comparisons of what we're getting for our dollar, if you will, may be the paramount issue.

Jon.

DR. CHRISTIANSON: I think one of the things that your chapter did, obviously, as we hear the comments, is stimulate some sort of higher-level thinking about where we're going and how we get there. And so we see the Medicare program moving more and more towards some kind of population-based payment with a value component to it, and
you're kind of reporting to us on the status of the component of the program that has had, at least the population-based payment part of it, for 33 years now. And Carlos and I were there at the beginning. A lot of these discussions sound pretty familiar to me, and you didn't even bring up encounter data in your presentation.

[Laughter.]

DR. CHRISTIANSON: So, I mean, I think it re-emphasizes to our group what a daunting challenge it's going to be to Medicare, given here's where we are after 33 years, as they move in this direction -- clearly things are moving in this direction -- how really hard it's going to be to get this right, and what a challenge it's going to be for us as a Commission to help Medicare get this right.

DR. CROSSON: Yes, David.

DR. GRABOWSKI: Yeah, I just wanted to build on Jon's comments there. I'm struck by the fact that we've spent roughly a day and a half on all these different sectors, and gone over them with a fine-tooth comb, and looked at margins and all these other metrics, and then it's not just a quality issue for Medicare Advantage. All those other metrics we've thought about -- adequacy of
payment, access to capital -- all of these same issues are present here. And I'm just struck by how different we think about this sector, which accounts for a third of beneficiaries relative to all these different fee-for-service beneficiaries in all the different sectors that they touch.

And so I share the other Commissioners' concerns around quality but I think this could even be a broader discussion about how we think about Medicare Advantage and how we think about a lot of the metrics here, and going back to some of the comparisons we want to make across, obviously, Medicare Advantage and traditional Medicaid but also thinking about splitting traditional Medicare into these different alternative payment models we've been advocating for alongside those who are in traditional fee-for-service relative to Medicare Advantage.

So I think we have a lot of work to do. This was a great chapter but I think it's a start towards beginning to think about some of these comparisons more generally.

DR. CROSSON: Good point. And just to be clear, particularly for the new Commissioners, the reason we don't do a Medicare Advantage update analysis and recommendation
is that the Medicare Advantage payment system is set in
law, and as was mentioned, it spins off the fee-for-service
payment benchmarks. So it's not part of our -- it would
make no sense for us to do that sort of analysis, in the
context of the update work that we do in December and
January. But we have, you know, almost on an annual basis,
taken on one part of MA or the other traditionally, to try
to analyze, from a policy perspective, how the system
should work and whether it should be changed, and we're
going to continue to do that.

Yeah, Pat.

MS. WANG: Just on something that Jon said, we
really will not be able to understand what goes on in MA
without full encounter data. That's what's missing. And
so I think that we should take every opportunity to
continue the conversation. You guys last time presented a
lot of information on, you know, the state of encounter
data submissions, and I think that there are issues on both
types. But a strong signal really has to be sent to
everybody, including, you know, CMS, which has tried and
struggled. But I think, you know, many plans are having
issues. I think CMS is having issues.
And so, you know, just coming up with like we're going to do this, we have to do this, would perhaps, I think, you know, we should continue to say that. I don't think that it's all on one side or the other. I think it's just a lack of -- I think we're a little stuck in the progression towards full encounter data submission, and even if it just focuses on, you know, development of risk scores and encouraging CMS to keep that blend going, to keep folks focused on at least those components of encounter data that needs to be submitted and then I know that the more challenging ones are, you know, physician offices, home health, things like that. That can be phase two.

The other thing is -- and I don't have a proposal for this -- I think it is important for the Commission to be thinking about what to do with benchmarks. Obviously the program has grown and companies have adjusted to the benchmarks that exist, which is really interesting, which I think demonstrates that there is -- there's no magic to setting the benchmarks where they are. There's no science. There's no, you know, sort of needed policy rationale. There were some in the beginning but clearly the managed
care industry can continue to adjust, flex, adapt to change
in the benchmarks. And they're kind of old and the program
has grown a lot, so I think it's good time to have an open
mind about what should the future look like? MA is here to
stay, which I think is a great thing. I think it's a great
thing.

But these things shouldn't be, you know, like
locked in stone forever, probably. Maybe they should but
they should be validated that they should be locked in
forever.

DR. CROSSON: Well, at least that question can be
analyzed.

MS. WANG: Yeah.

DR. CROSSON: Okay. Seeing no further discussion
I'd just like to make one comment before we have the public
comment period. I'd like to thank the staff for the
excellent work that has led to these discussions. It's
always that way, but I think this year, particularly, it's
been terrific.

Beyond that, I really would like to thank the
Commission. You know, over the years I've warned
Commission members about the December meeting, because
sometimes it can be quite repetitive and difficult to
maintain concentration at times. This has been a very
different experience for me. I mean, I think the energy
here, the quality of thought, the dedication that I saw
yesterday as well as today to make sure we get it right,
you know, kept up, for me, the intellectual energy
necessary, because I was feeding off of what is just an
excellent group of people, and I thank you for that.

So we are open now for public discussion. If we
have any members, any of our guests who would like to make
a comment, please step to the microphone.

[No response.]

DR. CROSSON: Seeing nobody heading that way we
are adjourned until the meeting in 2019. How about that?

[Whereupon, at 11:55 a.m. the meeting was
adjourned.]