

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 7, 2017
9:17 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

AGENDA	PAGE
Assessing payment adequacy and updating payments: Physician and other health professional services; and An alternative to the Merit-based Incentive Payment System (MIPS)	
- Kate Bloniarz, David Glass, Ariel Winter.....	4
Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services	
- Jeff Stensland, Stephanie Cameron, Zach Gaumer, - Dan Zabinski.....	71
Assessing payment adequacy and updating payments: Ambulatory surgical center services	
- Zach Gaumer, Dan Zabinski.....	124
Public Comment.....	150
Post-acute care: Increasing the equity of Medicare's Payments within each setting; and Assessing payment adequacy and updating payments: skilled nursing facility services	
- Carol Carter.....	151
Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services	
- Dana Kelley.....	182
Assessing payment adequacy and updating payments: Long-term care hospital services	
- Stephanie Cameron.....	214
Assessing payment adequacy and updating payments: Home health care services	
- Evan Christman.....	236
Public Comment.....	294

P R O C E E D I N G S

[9:17 a.m.]

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22

DR. CROSSON: Okay. Let's see if we can reconvene as our audience gets settled.

I'd like to welcome our guests. For those of you who have not been to a MedPAC meeting before, we have two pieces of work that we do. One is to develop policy for consideration by Congress, in some cases CMS. And every year in December and then again in January, in addition to issues of policy -- and we will discuss one this morning, at least -- we also take on the responsibility the Congress has given us to make recommendations to Congress with respect to financial updates for the year 2019 for the various portions of the health care industry that the Medicare program supports.

And so we're going to have a series of presentations this morning, this afternoon, and tomorrow morning as we work our way through each of those Medicare payment areas, and we are going to begin this morning with payment to physicians and other providers, and I think we have got Kate, Ariel, and David. And Kate looks ready to begin.

1 MS. BLONJARZ: Good morning. Our agenda today
2 has two parts. First, Ariel and I will cover the payment
3 adequacy assessment for physician and other health
4 professional services and present the Chairman's draft
5 recommendation.

6 Then I'll recap our alternative to the Merit-
7 based Incentive Payment System and present the Chairman's
8 draft recommendation on MIPS. And thanks to both Ledia
9 Tabor and Kevin Hayes for their help in putting this
10 together.

11 The Commission has an established payment
12 adequacy framework that all of us will use, today and
13 tomorrow. But not every sector uses the same measures.
14 For clinician services, we look at whether beneficiaries
15 report that they can access needed care, focus groups and
16 site visits, and other surveys. We review the supply of
17 providers and the volume of services, and we also look at
18 quality information.

19 We are unable to use margins or other cost-
20 dependent measures because physician offices do not submit
21 cost data to CMS. But we do look at differences in
22 compensation and the ratio of Medicare's payments to

1 private insurance payments.

2 Here's a background slide on the sector, and
3 recall that there's more detail in your mailing materials.

4 Total spending was about \$70 billion in 2016, or
5 15 percent of fee-for-service benefit spending. There are
6 about 952,000 clinicians billing Medicare, and the Medicare
7 Access and CHIP Reauthorization Act of 2015, or MACRA,
8 established permanent statutory updates for clinician
9 services. The statutory update is 0.5 percent on January
10 1, 2019. And as I've outlined prior, MACRA also
11 established an incentive payment for participants in
12 Advanced Alternative Payment Models and the Merit-based
13 Incentive Payment System for other clinicians.

14 Our first data source is the yearly telephone
15 survey that we sponsor of 4,000 Medicare beneficiaries and
16 4,000 privately insured individuals, asking them about
17 their ability to access the care that they need. It's
18 timely, fielded in the spring and summer of 2017.

19 Generally, beneficiaries' access to ambulatory
20 care services appears adequate. It is as good as or better
21 than privately insured individuals. Some of you may recall
22 that last year's survey showed a modest decline in reported

1 access, but this year it bounced back up to trend, meaning
2 that last year's findings were probably normal year-to-year
3 variation in survey results.

4 Some groups report more trouble with access.
5 Minority beneficiaries in particular report waiting longer
6 than they wanted to in order to obtain needed care than
7 white beneficiaries.

8 Among other indicators, we don't see much change
9 over time in the share of providers who are participating
10 in Medicare and assigning claims.

11 The total number of providers billing Medicare
12 per beneficiary in 2016 was similar to 2015. The number of
13 primary care physicians per bene was unchanged, the number
14 of specialists per bene declined modestly, and the number
15 of APRNs and PAs billing Medicare directly increased.

16 And we also consider measures of financial
17 performance. Medicare's payments relative to privately
18 insured PPO payments averaged about 75 percent in 2016, but
19 that is our preliminary estimate because we are still
20 working with the data, and it may change. This is a
21 decline from last year of 78 percent. We believe that this
22 is due to a rise in private sector prices (not reflected in

1 Medicare payments) due to consolidation of physician
2 practices and hospital purchasing of physician groups, both
3 of which increase providers' negotiating leverage over
4 private insurers.

5 For the past couple years, we have generally been
6 reporting population-based measures that assess ambulatory
7 care quality, and we report on two measures this year, and
8 outcomes are mixed. Low-value care remains quite common in
9 Medicare, with between a quarter and a third of Medicare
10 beneficiaries receiving a low-value service in 2014. But
11 national avoidable hospitalization rates continued to
12 decline for most conditions.

13 Medicare's current quality programs largely use a
14 lot of self-reported process measures that we don't think
15 are particularly meaningful. In your mailing materials
16 this year, we also discuss the results from the first three
17 years of the value-based payment modifier. Because that
18 program was budget neutral and all penalties were
19 distributed to those eligible for bonuses, a small number
20 of clinicians received very high payment adjustments, as
21 high as 77 percent in 2017. This underscores the
22 importance of setting limits on both maximum bonuses and

1 penalties in any value-based purchasing program in
2 Medicare.

3 Stay tuned for more MIPS talk, but first Ariel
4 will continue our payment adequacy assessment for 2019.

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

11 Across all fee schedule services, average annual
12 volume growth per fee-for-service beneficiary was 0.5
13 percent from 2011 to 2015. But in 2016, there was an
14 uptick in volume growth of 1.6 percent. This growth
15 occurred while services were shifting from physician
16 offices to hospital outpatient departments, which had the
17 effect of dampening volume growth. So in the absence of
18 this shift, volume growth would have been higher.

19 In 2016, growth by type of service ranged from
20 1.1 percent for evaluation and management services to 2.8
21 percent for major procedures.

22 This chart is similar to one that you've seen in

1 prior years. It shows that from 2000 to 2016, fee schedule
2 spending per beneficiary, which is the red line at the top,
3 increased faster than both input prices, the white line in
4 the middle, and payment updates, the bottom yellow line.
5 Volume growth accounts for most of the difference between
6 the payment updates and spending growth.

7 So to summarize our analysis, payments appear to
8 be adequate. Access indicators are stable, as measured by
9 surveys, focus groups, provider participation rates, and
10 the number of clinicians billing Medicare. The ratio of
11 Medicare's payment rates to private PPO rates declined, but
12 this was probably due to higher prices paid by private
13 payers. Quality was indeterminate. And there was an
14 increase in the volume of services.

15 Finally, it's worth noting that underpricing of
16 E&M services in the fee schedule contributes to an income
17 disparity between primary care clinicians and certain other
18 specialties.

19 This leads us to the Chairman's draft
20 recommendation: The Congress should increase the calendar
21 year 2019 payment rates for physician and other health
22 professional services by the amount specified in current

1 law. Current law calls for an update of 0.5 percent.

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

6 And now I'll hand things back over to Kate.

7 MS. BLONIARZ: Okay. Turning back to MIPS,
8 recall that last month we came back to you with some of the
9 questions you raised in October about the policy option
10 that David and I presented in September. So as discussed
11 we are now moving to the Chairman's draft recommendation.

12 As a reminder, our discussion today and the draft
13 rec you'll see only address one part of MACRA: the Merit-
14 based Incentive Payment System. We are not talking about
15 the other parts: repealing the SGR, statutory updates, nor
16 the A-APM incentive payments.

17 The Commission generally supports the elements of
18 MACRA designed to move towards models of care that deliver
19 improved care at lower cost.

20 MIPS is an individual level payment adjustment
21 based on four areas: quality, cost, care information
22 (which means EHR use), and practice improvement activities.

1 It is substantially similar to prior value-based purchasing
2 programs in Medicare, including the value modifier, the
3 physician quality reporting system, and meaningful use.

4 In MIPS, CMS will assess clinician performance
5 for three out of the four MIPS categories using measures
6 that clinicians themselves choose and report.

7 We've laid out a number of concerns with this
8 approach, starting with reporting burden. CMS estimates
9 the clinician reporting burden at over \$1 billion for the
10 first year of the program. CMS is also supporting six ways
11 of reporting quality measures and two systems for advancing
12 care information and clinical practice improvement
13 activities.

14 Further, it's unlikely that all of this
15 information is useful. The measures are variable in their
16 clinical appropriateness and association with meaningful
17 outcomes. Many are process measures. And ACI and CPIA
18 have not been shown to be associated with high-value care.

19 There is the perennial issue of small sample
20 sizes for individual clinicians, and this is exacerbated by
21 MIPS' design and action taken by CMS.

22 Each clinician will get a composite MIPS score

1 reflecting a different mix of measures. By construction,
2 it's not comparable across clinicians. But, nevertheless,
3 CMS will move substantial funds around each year based on
4 these non-comparable scores.

5 CMS has also acted to exempt about 500,000
6 clinicians through a low-volume threshold for 2018 who
7 would otherwise be subject to MIPS. And there are special
8 rules applying to participants in CMMI models, small
9 practices, non-patient-facing clinicians, rural clinicians,
10 facility-based clinicians, and clinicians who report
11 measures without benchmarks or below the minimum size
12 thresholds. These actions just continue to make the
13 program more and more complex.

14 Because of how the program is designed, plus CMS'
15 action to set the performance threshold at three points out
16 of 100 for the first year, we know that for the first year
17 of the program payment adjustments will be tightly
18 compressed and 90 percent of clinicians will either receive
19 no adjustment or a minuscule adjustment. In years three
20 and later, because CMS will be constrained by statute to
21 set the performance threshold at the mean or median of
22 scores, small differences in MIPS scores will be blown up

1 into potentially massive differences in payment
2 adjustments.

3 Because of these and other factors, we believe
4 that MIPS is inequitable, burdensome, and will not improve
5 care for beneficiaries nor move the Medicare program and
6 clinicians towards high-value care. If MIPS was supposed
7 to reward and penalize clinicians based on the value of
8 care that they provide, it will not do so.

9 We need to act on this now. Clinicians are
10 reporting in 2017 for the 2019 payment year. And while CMS
11 has used its flexibilities to phase in requirements for the
12 first two years, some provider groups have requested these
13 flexibilities continue for an additional three years. But
14 CMS will still be calculating scores and making payments
15 during this time.

16 The longer the payments go out, the more there
17 will be an established constituency of clinicians receiving
18 very high payment adjustments, who will resist any changes
19 to the program. And when penalties really start hitting in
20 a serious way, there will be calls at that point to change
21 the program. So our approach is to eliminate MIPS and
22 create a new value program for Medicare clinician services.

1 In designing the new policy, we have a couple of
2 goals. First, the Commission believes that there should be
3 some kind of value component in Medicare fee-for-service
4 payment.

5 Second, that the incentives in Medicare fee-for-
6 service should be to move towards more organized delivery
7 systems, like those in the most rigorous advanced
8 alternative payment models. It would do so by limiting the
9 potential upside to remain in traditional fee-for-service.
10 It would send the signal that clinicians should look to
11 join voluntary groups in which they assume responsibility
12 for the outcomes of their patients outside their four
13 walls. And it should eliminate all clinician measure
14 reporting to CMS and its associated burden and biases.

15 The design of the program would use a uniform set
16 of population-based measures in the categories of quality,
17 patient experience, and cost or value. The measures would
18 assess care across time and the delivery system, would be
19 aligned with other Medicare value-based purchasing programs
20 and A-APMs, and consist of outcomes important to
21 beneficiaries and the program.

22 Clinicians would need to join voluntary groups of

1 other clinicians in order to have sufficient detectable
2 performance. The performance of the voluntary group as a
3 whole would determine whether they would qualify for a
4 value payment, funded by a withhold applied to all
5 clinicians.

6 As we discussed last month, the draft
7 recommendation would outline a general approach for the
8 VVP, and the language around the recommendation would
9 provide the Commission's discussion on some issues. It
10 would also raise policy decisions for the Congress to
11 consider and discuss the various tradeoffs. These include
12 the size of the withhold and the value payment and how the
13 voluntary group's composite score would be calculated.

14 There are other design elements that CMS could
15 provide insight into. These include the minimum case sizes
16 and resulting minimum voluntary group size, and the
17 exchange function of the composite performance score. CMS
18 has significant experience with these topics through not
19 just their experience with MIPS and the value modifier, but
20 other value-based purchasing programs and the MA Stars.
21 And some of the same issues that you have raised, like, for
22 example, the issue of social risk factors, have been looked

1 at in the context of those programs.

2 There would also be a role for stakeholder input,
3 and the regulatory process would allow for the evolution of
4 the program over time.

5 So turning to the Chairman's draft
6 recommendation, it reads: The Congress should eliminate
7 the current Merit-based Incentive Payment System; and
8 establish a new voluntary value program in fee-for-service
9 Medicare in which clinicians can elect to be measured as
10 part of a voluntary group; and clinicians in voluntary
11 groups can qualify for a value payment based on their
12 group's performance on a set of population-based measures.

13 Here are the implications of the Chairman's draft
14 recommendation.

15 With respect to spending, payment increases in
16 the VVP would be designed to offset payment decreases.
17 This is a change from MIPS, which, as you'll recall, has an
18 additional \$500 million appropriated each year for
19 exceptional performance. Our current intent, over the
20 remaining cycle, is to raise considerations for reinvesting
21 these funds elsewhere in Medicare clinician payment, and
22 options potentially include primary care or A-APMs, both of

1 which we plan to discuss this spring.

2 We expect that the recommendation would be
3 unlikely to affect beneficiaries' access to care. It would
4 reduce provider burden by eliminating all quality measure,
5 ACI, and CPIA reporting. Providers could incur an
6 administrative cost in creating or joining voluntary
7 groups.

8 It would also eliminate extremes in payment
9 adjustments. Some clinicians would see a payment
10 reduction, others would see a payment increase.

11 So I'll conclude here, and we're happy to answer
12 questions on either topic -- clinician payment adequacy or
13 MIPS. And we look forward to hearing your guidance on the
14 two draft recommendations.

15 DR. CROSSON: Thank you, Kate.

16 So we're going to be open for clarifying
17 questions, so we'll run the discussion on this topic this
18 way. We'll have clarifying questions on the whole
19 presentation, and then we'll have a discussion on the
20 recommendations separately, the update recommendation and
21 then the MIPS recommendation. And we're going to do that
22 all within the next 45 minutes or so.

1 Clarifying questions? Alice.

2 DR. COOMBS: Two things. First of all, thank you
3 very much for a well-written chapter. I appreciate all
4 that you've done.

5 Ariel, when you talk about the re-appropriation
6 of the misvalued codes, how much does that result in cost
7 changes from for the conversion factor from year to year?

8 MR. WINTER: So the target for redistributing
9 money from misvalued codes for 2018 was 0.5 percent, but
10 that's the last year under current law in which that target
11 exists. It does not exist currently past 2018, and we're
12 looking at a 2019 calendar year for our update. So that
13 target does not apply to the year we're considering for the
14 update.

15 DR. COOMBS: About 35 cents, roughly?

16 MR. WINTER: 35 cents?

17 DR. COOMBS: Dollars and change, what is it
18 equivalent to?

19 MR. WINTER: In terms of the total pool of
20 dollars or the conversion factor?

21 DR. COOMBS: The conversion factor.

22 MR. WINTER: Oh, I can't do that math really

1 quickly. I'll get back to you maybe later in the
2 discussion about that.

3 Also, the way that works is if the amount of
4 money that is redistributed from misvalued codes is less
5 than 0.5 percent, then they take the difference between
6 that amount and 0.5 percent and take that out of the
7 conversion factor, just to explain for everybody.

8 DR. COOMBS: Okay.

9 Kate, I have a question. When a provider is
10 under the APMs, the APM itself entity does not report those
11 population measures that we're looking at for the fee-for-
12 service?

13 MS. BLONJARZ: So, yeah. Let me explain what
14 happens under current law and then what we're envisioning
15 for VVP. Under current law, clinicians that are in
16 advanced alternative payment models, if they meet a
17 percentage threshold of having revenue going through that
18 model and that threshold goes up by year, then they are
19 exempt from MIPS. But then there are others in those
20 advanced alternative payment models that fall below that
21 threshold who would have to participate in MIPS.

22 DR. COOMBS: Just by comparison, if you find

1 yourself in an advanced APM that meet the threshold --

2 MS. BLONIARZ: Yeah.

3 DR. COOMBS: -- you are not required to -- under
4 our proposal, there would be two different citizens here?

5 MS. BLONIARZ: Under our proposal, we were
6 thinking that if you are in any type of advanced
7 alternative payment model, you'd be entirely out of VVP, no
8 matter what threshold of spending or patients you have
9 going through that APM.

10 DR. COOMBS: So you would have neither population
11 measures or process measures necessary if you're over here
12 in this group?

13 MS. BLONIARZ: Yeah. I think the idea is that if
14 you're -- the way we were thinking about it, if you were in
15 an APM, that that has its own set of quality resource use
16 and patient experience measures that it's using for
17 rewarding performance.

18 MR. GLASS: I think we were talking about making
19 sure that in the A-APMs, they have similar --

20 DR. COOMBS: Right. But that isn't the way it's
21 done right now, correct?

22 MS. BLONIARZ: That's right.

1 DR. COOMBS: Okay.

2 DR. CROSSON: Brian, on this point?

3 DR. DeBUSK: Did I hear you correctly? Did you
4 say there was no threshold? If you're in an APM, there's
5 no threshold to keep you out of VVP?

6 MS. BLONJARZ: That was our intent, and we kind
7 of write it up that way over this summer. The idea behind
8 it was wanting to make the program simpler and that
9 clinicians only had one set of strong incentives they were
10 facing.

11 DR. CROSSON: Okay. Clarifying questions? I saw
12 Rita and then Jack.

13 DR. REDBERG: Thanks. The chapters were great,
14 and you clearly put up even more work and thought into the
15 VVP since our last discussion, which really answered a lot
16 of the issues.

17 My questions were on -- actually, in the reading
18 materials -- and you mentioned how the volume of services
19 has increased, particularly for certain procedures. Are
20 you able to now or in the future break that down by
21 physicians and other health professionals? I'm interested
22 in seeing how that plays out and the same geographically.

1 MR. WINTER: We have not done that yet. So we're
2 suggesting to look at physicians versus -- let's say PAs
3 and NPs.

4 DR. REDBERG: Right. Because we know that
5 there's been a growth in certain specialties --

6 MR. WINTER: Yeah.

7 DR. REDBERG: -- and certain areas and in
8 particular in non-physicians doing more physicians.

9 MR. WINTER: We can look into that.

10 One complication is that, as you know, when
11 services are built incident to a physician service, they
12 could be performed by a PA or NP but billed by the
13 physician, and we don't have any insight into when that
14 occurs. We are somewhat limited in whether we can
15 attribute a service to a physician or another professional,
16 but when the other professional bills the program directly,
17 we can attribute that obviously. So we can look into that
18 for the future.

19 DR. REDBERG: That would be a good start.

20 MR. WINTER: There are particulars. You
21 mentioned procedures. Are there particular kinds of
22 services you would like us to look at if you were to narrow

1 it down?

2 DR. REDBERG: Office-based procedures --

3 MR. WINTER: Okay.

4 DR. REDBERG: -- and germinologic procedures, I
5 was thinking that recently.

6 MR. WINTER: Okay. We'll see what we can do.

7 DR. REDBERG: Also, on page 26 in the mailing
8 materials, you had mentioned -- and we've talked about
9 before -- the requirement for the AUC for imaging --

10 MR. WINTER: Yeah.

11 DR. REDBERG: -- and CMS is in the process of
12 implementing.

13 MR. WINTER: Yes.

14 DR. REDBERG: Do we have any timeline on that?

15 MR. WINTER: I'll get back to you on that. I
16 think they discussed this in the most recent Final Rule
17 that came out in November. I have not looked at that
18 section yet, but I'll get back to you on the latest
19 timeline.

20 DR. CROSSON: Okay. Other clarifying questions?

21 Jack.

22 DR. HOADLEY: Thank you again for this chapter,

1 and I think even though most of our discussion time will be
2 on the MIPS stuff, it's always a great source of other
3 information that you provide in this chapter that doesn't
4 get as much air time.

5 I had a couple of questions, like Rita, on some
6 of those other aspects. In the text on page 17, you have a
7 table of total number of physicians and other health
8 professionals, and I was wondering whether the data allow
9 you to break out primary care versus specialty for the PAs
10 and NPs.

11 MR. WINTER: Are you referring to Table 8 on page
12 17?

13 DR. HOADLEY: Yes.

14 MR. WINTER: Yeah. The first two columns that
15 says primary care --

16 DR. HOADLEY: Right.

17 MR. WINTER: -- that is physicians.

18 DR. HOADLEY: Right.

19 MR. WINTER: Primary care physicians.

20 If you go a couple of columns over, there's a
21 header that says advanced practice, registered nurses, and
22 PAs. So those are the numbers for that group.

1 DR. HOADLEY: Can those numbers be broken out,
2 how many of those are doing primary care versus sort of
3 specialty services, or is that just something that isn't
4 available in the data?

5 MR. WINTER: We could look at the kinds of
6 services that they bill for. Yeah, we can drill down into
7 that.

8 Kate, do you want to add something?

9 MS. BLONJARZ: Yeah.

10 This has come up a couple times because there's
11 no -- the specialty categories --

12 DR. HOADLEY: Designation.

13 MS. BLONJARZ: -- is APRN.

14 When we looked at it a couple years ago, about
15 half of nurse practitioners were providing primary care. A
16 higher share of PAs were providing specialty care, and then
17 CRNAs and clinical nurse specialists are providing all
18 specialty care by designation. But unfortunately, we don't
19 have a great sense from the Medicare data we have.

20 DR. HOADLEY: Something at some point, think
21 about whether there's a way to get those providers to
22 provide some kind of a designation because -- when you

1 think about what's available.

2 Also, I was wondering -- I think I've seen this
3 in the past, but whether you've broken out the data on non-
4 PAR providers or unsigned claims by what specialty they're
5 in?

6 MS. BLONJARZ: We've looked at it in the past.
7 My recollection is nonparticipating providers are fairly
8 concentrated in things like chiropractor services. It is
9 not as much kind of medical services, and then the opt-out
10 clinicians are very --

11 DR. HOADLEY: Right.

12 And then my third question had to do with the
13 PPO, commercial PPO and the commercial to Medicare ratio.
14 I know you mentioned there that there's a lot of geographic
15 variation potentially. I don't know if that's something
16 you're able to provide, whether that ratio of 75 percent or
17 whatever it settles out to be, how much that goes up or
18 down across different geographic areas, if that's something
19 you're able to pull out of those data.

20 MR. WINTER: Unfortunately, our data use
21 agreement with the provider of the data precludes us from
22 looking at calculating geographic --

1 DR. HOADLEY: Okay.

2 MR. WINTER: -- calculating the ratio of the
3 geographic level. So we can't answer it with this dataset,
4 but in our 2011 report, June, we did have a chapter on
5 variation in hospital and physician prices using data from
6 MarketScan from 2008. So I understand this is fairly old.

7 And there was significant variation with the
8 cross-markets and even within markets. So that's the most
9 recent work we've done looking at geographic variation for
10 commercial prices for physician services.

11 DR. HOADLEY: At some point, it might be
12 interesting, because we've obviously seen a lot and we've
13 talked about a lot of the trends in the marketplace of
14 acquisition by hospitals and all that and mergers in the
15 insurance side as well, so whether some of those ratios
16 would have changed a lot, it would be interesting to look
17 at, at some point in the future.

18 DR. CROSSON: Questions?

19 Pat.

20 MS. WANG: I was wondering if you could comment
21 on two issues. One is with the proposed elimination of the
22 meaningful use of EHR in the incentive program, if we move

1 to VVP. Whether you think that the current inclusion of
2 EHR has actually made a difference and what the
3 implications would be to remove it.

4 I understand that somebody who has got EHR
5 installed is not going to de-install it, but there's still
6 a lot of physicians who don't have EHR, and I just wonder
7 if you have a view on, you know, removal of that as an
8 incentive.

9 And the second thing I was going to ask you about
10 was whether you had additional thoughts on how to adjust
11 for socioeconomic status factors, an important
12 consideration and a fair comparison of quality.

13 MS. BLONJARZ: On EHR use, yeah. This is
14 something that Craig brought up in an earlier session, and
15 here, we did think about would you want to make it kind of
16 a condition of participation.

17 I think that there has clearly been a significant
18 amount of take-up for EHRs in both hospitals and physician
19 offices, and I think some of the things that meaningful use
20 is assessing now probably are fairly standard as part of an
21 EHR package. So the one thing we have thought about a
22 little bit is whether you'd want to have an

1 interoperability requirement or requirements around data
2 blocking, which we think is probably some -- kind of the
3 most pressing issues around EHRs right now.

4 But the rate of adoption is fairly high in both
5 the hospital and the physician office setting. So we
6 weren't too concerned that there would be a lot of
7 backsliding there.

8 For social risk factors, yeah, we've talked a
9 little bit about adjusting measures, whether there's a need
10 to adjust measures at the measure level for everything
11 that's in the HCCs. There's also techniques to address
12 other -- even when measures are adjusted for HCCs and dual
13 status and things like that, there may still be a
14 persistent difference across high- and low-need providers.
15 So some of the things that we've looked at in the past are
16 either shrinking or grouping within peer groups. These are
17 all kind of some of the tools that you could use here.

18 DR. CROSSON: Okay. Questions?

19 Bruce.

20 MR. PYENSON: Thank you. I have got a question
21 on the MIPS section and the mailing materials on page 16,
22 at the top of page 16. You're discussing -- you're

1 pointing out that VVP and the data could be of interest to
2 other parties in the health care system. I thought that
3 was a very, very rich area to identify, and you mentioned
4 measuring performance and quality improvement. When you
5 think about the dollars associated with a voluntary group
6 from Medicare and then the -- for the same voluntary group,
7 the dollars associated with commercial, is I think probably
8 for most groups dollars associated with commercial probably
9 be bigger.

10 So I'm wondering how you think about a voluntary
11 group figuring out how to work together for Medicare. Have
12 you thought about how that could spill over into the
13 commercial world, for example?

14 MS. BLONJARZ: So let me try to just explain kind
15 of how we were thinking about -- what we were thinking
16 about in writing this section, and hopefully, that gets
17 close to what you're asking about.

18 The idea would be if there are kind of broad
19 signals from the Medicare program, that clinicians should
20 focus on these types of measures that policymakers believe
21 are important to providers, to beneficiaries in the
22 program. That there are going to be associated kind of

1 process improvements at the clinician level that help
2 achieve those outcomes, and that a lot of the decision on
3 what the specific process improvements need to be and how
4 they're measured would take place at a level below the
5 Medicare program, so a large group practice or MSSP Track 1
6 ACO, but that Medicare would not be involved in saying I
7 want to make sure that you are documenting all medications
8 in the medical record because we assume that as a matter of
9 course.

10 I think in terms of how it aligns with other
11 payers. There's a lot of other payers involved in value-
12 based purchasing programs. We've looked at some of them.
13 Some of them use a mix of outcome measures and clinician-
14 reported measures. A lot of them use patient experience
15 measures. I think it's a mix.

16 We could think a little bit more about how maybe
17 those things would mesh, how they would kind of come
18 together for the voluntary group.

19 MR. PYENSON: Thank you.

20 DR. CROSSON: Okay. Clarifying questions?

21 Warner.

22 MR. THOMAS: You referenced -- and just remind me

1 of this -- the cost of aggregating the quality indicators
2 around MIPS. Can you refresh my memory a little bit about
3 that, the actual amount, and how we determine that amount?

4 MS. BLONJARZ: Of reporting costs?

5 MR. THOMAS: Yeah.

6 MS. BLONJARZ: So that is actually directly from
7 CMS. They do a regulatory impact analysis and say assuming
8 that this many providers report quality measures to MIPS
9 through no-pay claims, this is our assumption about the
10 amount of time it will take. This is our assumption about
11 the type of provider that would be involved, a half an hour
12 of a medical assistant time, two hours of physician time,
13 and then they sum it all up.

14 It is fairly comparable to some of the prior
15 Medicare clinician reporting programs because it's a lot of
16 the same tools, but some of the reporting methods have a
17 fair bit of burden associated with them to report those
18 measures.

19 MR. THOMAS: Have you thought about a scenario
20 plan like what physicians might do with MIPS being
21 eliminated? I mean, obviously, we're trying to create the
22 incentive to get them to evolve into an APM, but do you

1 have any sense or have you thought about kind of what the
2 approach or what the response may be?

3 MR. GLASS: I think one interesting thing is some
4 groups feel that they're going to do really well under MIPS
5 and get some of those really high rewards, and if that's
6 taken away, we say yeah, the new program will have some
7 reward, but it won't be very big. It will probably be less
8 than the 5 percent you get for just being in an A-APM.
9 Then we would think that would have some sway. We think
10 the size of the incentive under the new system would be
11 fairly small and probably not convince anyone to make a big
12 effort to invest a lot of money to be doing something
13 different. So we don't think the size of the incentives
14 under the VVP would push people to make big investments to
15 do different things in their practices, but we do think it
16 might convince them that, hey, we could take the extra step
17 and go into the A-APM without that much more effort. And
18 the rewards would be much better. So I think that's kind
19 of the behavior we're trying to influence.

20 MR. THOMAS: And do you think there's enough --
21 do we have enough insight to think that that is the
22 direction versus just not progressing in any way, not

1 collecting quality measures, and just driving utilization
2 to make up for any differential in payment reductions?

3 MR. GLASS: I think that's always a problem.

4 MS. BLONJARZ: I would say that's a concern now
5 even with MIPS.

6 MR. THOMAS: Even with MIPS, essentially that can
7 happen today because we've seen it. I guess under MIPS, I
8 mean, we do have -- I mean, they do have to collect some
9 quality measures in the report.

10 MR. GLASS: At least one for one patient, right?

11 MS. BLONJARZ: And I do want to say as well, I
12 mean, this is a concern we've heard from some physician
13 communities that, you know, the process of merely
14 collecting data and having to kind of get on board with,
15 you know, I'm going to be taking in information and
16 reporting it to someone else, it's probably going to go
17 through an EHR, that that has the effect of kind of
18 changing the way people think about quality. I don't know
19 how universal that sense is.

20 DR. CROSSON: Kathy.

21 MS. BUTO: I think, Ariel, you were the one who
22 mentioned the issue of the disparity in compensation

1 between primary care and specialty care or procedural care.
2 And in the chapter we talk about it, and we mention the
3 primary care bonus, if you will. I'm just wondering if
4 there's -- if we've made any -- do we have an assessment of
5 whether moving to the alternative, the VVP approach, will
6 have a positive impact on primary care payments overall and
7 begin to address the disparity, or whether that's really
8 not the avenue for addressing?

9 MS. BLONIARZ: I would say to the extent it has
10 an effect, it would be a modest one. I think that's not --
11 I think there's other pathways that would be far more
12 direct.

13 MS. BUTO: And I just wanted to mention that I
14 think as we look at population-based measures, I assume
15 we'll look at those in relation to those that where primary
16 care might have a noticeable effect or potential
17 positive/negative impact on what those population effects
18 are, so that that's at least within the realm of bringing
19 more accountability to that process.

20 DR. CROSSON: David.

21 DR. GRABOWSKI: Kathy really asked my question.
22 We've shared this goal of rebalancing payments away from

1 specialists and towards primary care physicians, and I
2 wondered the same thing: How will the voluntary value
3 program do that or not do that? And then, also, how can we
4 think about this -- you talked a lot in the chapter around
5 the per beneficiary payment to primary care physicians.
6 Are there other mechanisms that you're thinking about here
7 to help us with this rebalancing? Thanks.

8 DR. CROSSON: Yes, and in the presentation, of
9 course, is the \$500 million and potential redistribution of
10 that money, which we've talked about previously.

11 Okay. Seeing no more clarifying questions, let's
12 put up Slide No. 10. The first part of the discussion then
13 is on the Chairman's draft recommendation with respect to
14 update for 2019. So we'll open that for discussion. Paul?

15 DR. GINSBURG: Yes, well, the chapters were
16 excellent, and I was really focused on some of the
17 findings, particularly from 2000 to 2016, there was a 10
18 percent cumulative rate increase for physicians and other
19 clinicians, a 32 percent increase in the Medicare Economic
20 Index, which in a sense means roughly a 20 percent fee cut.
21 You know, this happened year after year in very small
22 amounts. I don't see Congress -- Congress has had many

1 opportunities to contemplate a 20 percent fee cut, and it
2 clearly decided not to do that but to take a fee cut of a
3 percent or two and push it off the most. And, you know, it
4 has led us all to and led MedPAC to invest heavily in
5 monitoring changes in beneficiary access to care, which
6 have, you know, been somewhat encouraging in the sense that
7 there have not been significant problems undertaken. And,
8 you know, the analyses have been extensive to look for it.

9 But some of the things mentioned in this year's
10 report about the movement of physicians from freestanding
11 settings to hospital employment and the implications for
12 Medicare as far as spending substantially more per service
13 get movement tells me there's another potential negative
14 consequence of this fee cut year after year, as to whether
15 the Medicare program could actually be penny wise and pound
16 foolish. By driving physicians into hospital employment,
17 it winds up paying them more than if it had not pursued the
18 payment cut.

19 So I've thought about rather than supporting the
20 Chairman's recommendation, which is what is in current law,
21 whether we contemplate at least for the services that we've
22 studied and believe are relatively undervalued, such as

1 evaluation/management services, as to whether we should
2 recommend a full MEI update for those services. It could
3 either be all evaluation/management services or those
4 evaluation and management services in specialties that have
5 -- where a high percentage of their revenues are from
6 evaluation/management services, which would include primary
7 care, include psychiatry, and some other so-called
8 cognitive specialties, which I think are under the same
9 pressure in surviving an office practice as many primary
10 care physicians are. So I just wanted to put that thought
11 in front of the Commission.

12 MR. GLASS: Paul, would that be -- depend on
13 whether the site of -- on the site of service?

14 DR. GINSBURG: This would only be for
15 freestanding office space service.

16 DR. CROSSON: I'm going to make a comment, but
17 let's hear from Kathy and Jon first.

18 MS. BUTO: A question to Paul. In looking at
19 those data, is it primary care specialties that are moving
20 into those relationships with hospitals to a greater degree
21 than other specialties? I don't have a feeling that that's
22 happening. So I'm wondering --

1 DR. GINSBURG: I think this is a --

2 MS. BUTO: -- what we're trying to stop from --

3 DR. GINSBURG: Yeah, this is a general incentive
4 for all physicians to move into these --

5 MS. BUTO: Yeah, but are primary care physicians
6 doing that to a greater extent?

7 DR. GINSBURG: Definitely primary care -- to a
8 greater extent than specialties? I don't know. Maybe the
9 staff has knowledge.

10 MS. BLONJARZ: We looked at this last year. You
11 know, there's variation over time. Five years ago,
12 cardiologists were all getting bought up. You know, more
13 recently it's more emergency room doctors and, you know,
14 some other groups that formerly were independent
15 contractors. I think primary care is about in the middle
16 in terms of, you know, their affiliation with hospitals.

17 DR. CROSSON: Jon.

18 DR. CHRISTIANSON: Yeah, Paul, you used the
19 phrase "Medicare payment was driving physicians into
20 hospital employment." I think that's a pretty complicated
21 dynamic that's going on there in terms of why more
22 physicians are ending up in hospital employment. And I

1 think some of my work and others' would suggest that trying
2 to -- hospitals trying to leverage more negotiating power
3 in their negotiations with private payers is at least
4 another thing. I mean, hospitals -- it's a transaction,
5 and physicians may want to go to hospital employment.
6 Hospitals have to want them. And so I think that could be
7 one factor, but I'm not convinced that there's this dynamic
8 where somehow Medicare prices are the primary driving
9 feature of all of this.

10 DR. GINSBURG: I probably shouldn't have used
11 those words. I mean, clearly there are many factors. You
12 know, when you mention cardiology from five or ten years
13 ago and oncology more recently, there are very specific
14 factors driving that. And, yes, there are -- I mean,
15 clearly there's an attractiveness for physicians of the
16 potential of higher pay because through Medicare and
17 through leverage with private insurers hospitals collect
18 substantially more revenue from an employed physician than
19 an independent practice can. So I'm not saying that's the
20 key factor, but I'm saying that, you know, to continue to
21 have real cuts in Medicare physician payment rates clearly
22 is a contributor to the motivations of physicians to move

1 into hospital settings.

2 DR. CROSSON: So could you just put up Slide 8
3 for a second? I just want to make a point here,
4 particularly for some of our guests. I know Paul
5 understands this well, but what Paul was talking about was
6 a relative difference in rates per procedure or per visit
7 compared to MEI. What we also have to wrestle with here at
8 the Commission and what the Congress has to wrestle with
9 with respect to the Treasury is the total impact on
10 Medicare spending, which is a function of both the rates --
11 now, I fully agree with what your point is, but the volume
12 of services as well. And as the chart clearly shows, the
13 total amount of dollars has gone up significantly, although
14 it has leveled out in the last few years.

15 I sympathize with what you're saying. I think
16 the notion -- it's not shown here on this depiction, but
17 that volume increase and that dollar increase in payment to
18 physicians over these years has been not equally spread
19 among specialties. In fact, a lot of it has been driven by
20 increase in procedures and tests and other things like
21 that, which have flowed to some parts of the physician
22 community and not others.

1 So I think your point needs further elaboration
2 and thought. It is consonant in many ways with the
3 directions that we have been taking overall, which is to
4 take a hard look at the physician fee schedule and the way
5 it's been put together over the years, the way it has
6 played out over the years, which is not necessarily the
7 same as what was intended. And we will return to this
8 issue starting in January where we're going to take a more
9 comprehensive look at the fee schedule. And I think this
10 proposal that you've brought up is a valid one, and as I
11 said, it deserves due consideration.

12 Okay. Other clarifying questions? Well, no,
13 we're off clarifying. We're on Slide 10 on the first
14 Chairman's recommendation. Seeing no other comments on
15 that, Jack?

16 DR. HOADLEY: Yeah, I wanted to partly pick up on
17 what Paul was saying. I think what's clear is that we've
18 been looking at access, and I think it's important to just
19 emphasize -- it got, you know, pointed out in the
20 presentation -- that our access indicators do continue to
21 be strong, and I think that's an important part of the
22 context for this recommendation, whether we, you know,

1 stick with the Chairman's draft recommendation or whether
2 we were to modify it along the line that Paul talked about.

3 I would also say that, you know, we've implicated
4 sort of the site-of-service thing, and I wonder if it would
5 make sense to include -- I don't think I saw in this
6 chapter any sort of recalling of the site-of-service
7 recommendations we've done before, and it seemed like maybe
8 there was -- in conjunction with the discussion of the
9 volume trend that you just alluded to, it seems like it
10 would make sense to just reemphasize that we have these
11 recommendations from the past, which goes partly to the
12 kind of point that Paul was making.

13 I'm certainly comfortable with deferring the
14 consideration of how to address primary care to the
15 discussion that would start in January. You know, it's
16 obviously the consequence of sort of splitting up these
17 conversations that we're sort of forced to by the schedule
18 that we, you know, could see this kind of thing of
19 differential update as part of the basis, and maybe in that
20 discussion that goes into, I guess, the June chapter, maybe
21 that's something to think about, whether that's part of the
22 alternative, and then that could be fed into the next

1 cycle's recommendations. So I think, you know, it's a good
2 point to try to get at.

3 DR. CROSSON: Okay.

4 MS. BUTO: Can I ask Jack for a clarification of
5 what he just said?

6 DR. CROSSON: Yes, go ahead, Kathy.

7 MS. BUTO: Site of service, you mean site-neutral
8 payments?

9 DR. HOADLEY: Site-neutral payments.

10 MS. BUTO: So approaching it from the hospital
11 end rather than from the physician payment end, if you
12 will, of trying to address the incentive to --

13 DR. HOADLEY: Right.

14 MS. BUTO: For practices to move into the
15 hospital.

16 DR. HOADLEY: And because we've made that
17 recommendation, particularly here, the most relevant one in
18 some ways would be the E&M if we're going to the primary
19 care, we've talked about that. We've recommended on that
20 in the past.

21 DR. CROSSON: Pat, on this point?

22 MS. WANG: Just in general, I find Paul's

1 approach very appealing, and I would suggest as we continue
2 to discuss this in January and think about it, from my
3 perspective I think it could be a budget-neutral update
4 that is differentiated between what Paul describes as the
5 cognitive specialties and other specialties. I don't think
6 that that would be an unusual approach to take if you
7 looked at what happens in the MA world or the Medicare
8 Advantage world. There are certain specialties that are
9 supported more because of the implicit -- some assessment
10 of need, value to the population, et cetera.

11 The second thing is that I think the discussion
12 about movement of physicians to hospitals is very
13 interesting. I do agree with the cautionary note that
14 folks have raised, but there are a lot of reasons that that
15 may be happening, you know, malpractice exposure, the
16 signals about ACOs, you know, kind of join -- the signal
17 there is join a larger organization. So I would not rush
18 to judgment about it being so directly tied to the fee
19 schedule, though that certainly is -- I'm sure it's in
20 there someplace.

21 I think that it has merit just to explore in and
22 of itself and doing it through the update factor in a

1 budget-neutral overall fashion. I would not differentiate
2 between site of service on this one. I would say whether
3 you're hospital-based in a clinic, and you're a cognitive
4 specialty, or you're in a freestanding physician office, if
5 we believe that those cognitive specialties are being
6 underpaid, which we have talked about endlessly, I don't
7 think we should differentiate by site of service. I would
8 just offer that.

9 DR. MATHEWS: If I could just weigh in on the
10 notion of differential updates by type of service, it's not
11 something we would rule out out of hand, and we could
12 definitely consider it in the course of the discussion on
13 rebalancing the fee schedule and different approaches to
14 better supporting primary care. This is an issue we first
15 joined to this cycle back in November, and we'll come back
16 to it in January. But you'll recall we focused on, you
17 know, ways of injecting more dollars into E&M services in
18 ways that benefit those specialties that disproportionately
19 provide those services. So that is one avenue of
20 supporting primary care in addressing the imbalances that
21 we currently have underway and we've got some analytic plan
22 for proceeding.

1 I would be very hesitant to make a decision here
2 and now with respect to a differential update being applied
3 to, you know, as of yet an undefined set of services and
4 specialties for the purpose of the January meeting and, you
5 know, potentially coming up with a different approach to
6 the physician update here. I think we would need to do a
7 lot more analytics in terms of which specialties, which
8 services, how many dollars would move from one side of the
9 ledger to the other. And then we would also need to
10 contemplate differential impacts over time. So, for
11 example, even if we were to identify a set of physicians
12 who warranted a higher update on the basis of the mix of
13 services they provided in year one, you know, are they
14 likely to continue to provide that same mix of services in
15 year two and then still qualify? Or do they drop down into
16 a lower update status?

17 Again, we can contemplate this, and we can
18 continue to do some exploratory analysis. But I don't
19 think it's feasible within the time frame that we're
20 looking at for a final recommendation here.

21 DR. CROSSON: Yeah, in general, you know, what
22 we've tried to do -- and sometimes we've not been perfect

1 at it -- is to not make major policy shifts in a very short
2 period of time without due consideration by the staff and
3 due discussion here at the Commission. Think about how
4 long we spent on the PAC-PPS, for example. You know, we've
5 been dealing with the MIPS question since well in the
6 previous year and its inclusion in the June report. So
7 we've spent a lot of time on that.

8 While I think, as I said, what Paul has brought
9 up has merit, I think to ask the staff to analyze all the
10 considerations that would need to come into place so that
11 we could have a different recommendation three or four
12 weeks from now I think would be too much to ask.

13 Having said that, I have to say from the time
14 I've been on the Commission, I have -- you know, I've had
15 this concern about the fact that, you know, across a number
16 of areas but particularly physician and hospital, we have
17 one update recommendation for everybody, when, in fact, we
18 know and we try through other mechanisms to find ways of
19 adjusting that because we kind of recognize at the same
20 time not every provider, not every physician, not every
21 hospital is exactly the same. And so I think this issue is
22 going to come up over and over again, and I think it's a

1 valid question. It's much more complicated for us to think
2 about it with respect to updates in this way, and,
3 nevertheless, I think it's a valid consideration.

4 Paul, Kathy, and then Rita.

5 DR. GINSBURG: I think, Jim -- and your points
6 are really excellent -- that this is potentially -- because
7 we're not talking about an overall update for everything,
8 that it is better handled through the fee schedule and the
9 various payment approaches rather than through an update.
10 But I think that we may want to, in our wording, say that
11 we are increasingly uncomfortable, given the distortions
12 that we understand in payments about continuing to apply
13 negative updates, in real terms, to the parts of the
14 payment system that are already relatively underpaid.

15 DR. CROSSON: Very good. Kathy and then Rita,
16 and then we have to move on.

17 MS. BUTO: I would like to see us do a better job
18 of rationalizing why primary care is underpaid. We pointed
19 to the disparities in salaries and so on, and there is more
20 degradation going on with the participation of primary care
21 physicians. But as we do this work, I think that is part
22 of the case that needs to be made robustly. And I would

1 actually say, I don't think payment is the only issue here.
2 I think there are other issues involving primary care, like
3 record-keeping, reporting measures, et cetera, some of
4 which we've touched on, that we shouldn't ignore, that
5 payment is not the only deal when it comes to why primary
6 care physicians get discouraged in Medicare.

7 So I'd like to see us really take it on in a
8 robust way, and we may want to attached it, or discuss some
9 of the issues of site-neutral payment in that context, but
10 I wouldn't make that the central part of our discussion.

11 DR. CROSSON: Okay. Rita. Rita, Warner, and
12 then we really do have to move on.

13 DR. REDBERG: Thanks. I wanted to acknowledge,
14 also, the excellent discussion on the work on low-value
15 care services. I found it astounding that 72 per 100
16 beneficiaries have instances of low-value care, and 37
17 percent of beneficiaries receive at least one low-value
18 service at a cost of \$6.5 billion, which, as you say, is
19 probably underestimating because, first of all, that was
20 only the low value we could easily measure and there's a
21 lot more low value, and it only measured the actual service
22 and not all of the things that happened.

1 But we are talking about services that cause more
2 harm than good. So we're spending billions and
3 beneficiaries are suffering, so it's an area that
4 certainly, I think, is a good one for us to continue to try
5 to remedy.

6 I will note, in the one point -- in the large
7 buckets, PCI with balloon angioplasty for stable coronary
8 disease was \$1.3 billion, and just since our last meeting,
9 you know, stenting for stable coronary disease -- for years
10 there have been randomized trials showing no benefits
11 compared to medical therapy, yet it is a very common
12 Medicare procedure. No benefit in terms of reducing heart
13 attack or preventing death, but some cardiologist have held
14 onto the idea that there was a benefit in terms of symptoms
15 or quality of life. But a recent, and I will say the
16 first-ever blinded trial, where there was sort of a real
17 PCI and then a sham PCI, a fake PCI, there was absolutely
18 no difference in any of the endpoints, like angina, quality
19 of life, time on a treadmill.

20 And so, essentially, we're talking billions now
21 for a procedure that has not demonstrated, in any high-
22 quality studies, any benefit compared to medical therapy.

1 So I think there's a lot of low-value services and when
2 we're talking about those, you know, spending per
3 beneficiary, I think that's where we -- that's low-hanging
4 fruit.

5 DR. CROSSON: Warner.

6 MR. THOMAS: I'll be brief. Two comments. One,
7 I think the comment on physicians sharing hospitals has a
8 lot to do with the complexity of the payment systems and
9 the implementation of ACOs and the complexity around, you
10 know, quality reporting. I think that's driving a lot of
11 that consolidation.

12 I would say, as it relates to the elimination of
13 MIPS, if we go in that direction I would encourage us to
14 think about the withhold being larger, just because I think
15 it's going to -- it's going to take a larger incentive to
16 move physicians, many physicians into the alternative
17 payment mechanisms, and I worry that if it's a small
18 withhold then we will see people avoid going in that
19 direction and really just make it up through utilization
20 changes.

21 So I would encourage us to really put those
22 dollars into the APMs and incent people to be in them, and

1 to make it budget neutral by having the withhold on the
2 other side, for those that choose not to go to in that
3 direction.

4 DR. CROSSON: Okay. Good discussion. Let's put
5 up Slide 17, Chairman's draft recommendation on MIPS.
6 We're under time pressure, of course. I think we'll be
7 able to make up time during the day, because the afternoon
8 ones tend to go a little more quickly, but I would like to
9 try to get through the morning's agenda if we possibly can,
10 for the benefit of our guests.

11 Since we've been talking about this for over a
12 year or more, I would ask folks to be fairly succinct with
13 their comments. So comments on Chairman's draft
14 recommendation, starting with David.

15 DR. NERENZ: Thanks. It's really a question. I
16 apologize to the guests in the room. I'm going to ask
17 about page 12 of the materials that we got, Table 2. This
18 addresses the question that a number of people raised about
19 how big do these groups have to be, and there are some
20 estimates there about sample sizes.

21 I just did a quick one of these online power
22 calculations. I'm looking at the line having to do with

1 readmissions. It says 200 cases. And then this is
2 attributed to either CMS or AHRQ. It didn't look like you
3 checked it independently.

4 In order to detect -- if you've got, say, two
5 groups, you're going to compare readmission rates, with 200
6 cases on each side you have adequate statistical power to
7 deduct a 13 percent difference in rate. Now, in kind of an
8 all-cause readmission rate in Medicare, 13 percent is kind
9 of just where things run, in general. So as I extend the
10 logic, if I've got 200 cases in each of two groups, I can
11 detect a difference between 13 and 0, or I can detect a
12 difference between 13 and 26, but I sure as heck can't
13 detect a difference, say, between 13 and 16.

14 Now nowhere in here is there any discussion of
15 how big difference in any of these measures is actually
16 meaningful or important or actionable. But just to take 3
17 percent as arbitrary -- let's say I care about this measure
18 and I really want to know whether one group is better than
19 another, say 13 versus 16 percent, I need 7,000. Now --
20 and it's not 7,000 attributed beneficiaries. It's 7,000
21 discharges.

22 Now my point is, if we just play this logic out,

1 unless I've missed something important here, we need really
2 big group in order to be able to detect differences of that
3 size -- I just pulled that as an arbitrary example. And
4 then we finally got the last point that in any system like
5 this, groups are going to be sort of relatively good at
6 some things but perhaps not at others. We're going to come
7 up with a total score probably.

8 My point is, in order to detect meaningful
9 differences when all this gets rolled together, I think the
10 groups will have to be huge. So I'm just raising that as a
11 question. Maybe I'm missing the logic. Maybe there's
12 something going on where I've missed -- picked up
13 something. Looking to others with statistical expertise.
14 But that's what I'm picking up in the way I look at it.

15 DR. CROSSON: I think it's a fair point, and, you
16 know, it's a little difficult to assess the whole thing
17 because we're not going to try to determine which measures.
18 We're potentially going to leave that up to Congress, but
19 more likely to CMS. And so the actual choice of measures
20 influences what you're saying.

21 You know, and -- so I think for us to try to do
22 that, try to take -- you know, say only these measures,

1 and, you know, to specify our estimate of group size or
2 estimate of significant difference would take our analysis
3 beyond where we have to go.

4 But your point is valid, and I'd only -- I would
5 only point out that it's not only valid for the idea we
6 have on the table, it's more valid for the situation with
7 respect to MIPS as it stands, which is that when we're
8 reporting any kind of measures at the level of one
9 individual physician, there are very few types of measures
10 -- there are some, satisfaction measures, maybe surgical
11 mortality for certain physicians -- but for the vast
12 majority of measures, at the individual physician level,
13 there is not statistical significance.

14 DR. NERENZ: And I don't dispute that. I'm just
15 saying that if, on this alternative side, I think there's
16 some questions about group size that I'm certain--

17 DR. CROSSON: Perfectly valid. Yeah.

18 Okay. Other points on this recommendation,
19 coming around here? Brian.

20 DR. DeBUSK: I do support the recommendation as
21 written. I do think it's also important that we get ahead
22 of this early, because as the reading materials have

1 discussed and as we've talked about in the past, I think
2 once CMS loses control of setting that MIPS threshold, I
3 think you're actually going to see a lot of constituencies
4 coming to us wanting MIPS reform. I just don't think
5 people fully realize what this means.

6 The three areas that I hope we develop out over
7 time would be the risk adjustment on the measures, the peer
8 grouping for sociodemographic adjustment, and then also
9 working on these episodes of care. I think that will have
10 some appeal to the specialists.

11 So my comment on this whole -- on the whole VVP,
12 which again I'm very much in favor of and very much in
13 favor of repealing MIPS, I think, over time, specificity
14 only makes our recommendation stronger. And I would
15 contrast that, say, of MIPS to the PAC-PPS. You know, MIPS
16 was arguably just an idea as it was done in law. I mean,
17 it had some prescriptive aspects to it but it was somewhat
18 vague. I think the PAC-PPS, part of what makes it strong
19 is the specificity, of seeing the coefficients.

20 So I would just encourage us to develop out the
21 VVP over time, knowing that when CMS loses control of that
22 threshold, I think people are going to have a lot of

1 questions and want the specificity that maybe only we can
2 provide.

3 DR. CROSSON: Fair enough. Alice.

4 DR. COOMBS: Thank you very much. I'm actually
5 very concerned about eradication of MIPS for a number of
6 reasons. Paul, you spoke about the migration of practices,
7 the acquisition and mergers. I think that contrary to
8 beliefs around the table, if the withhold was higher than
9 that might make people transition into APMs faster. I
10 think that underneath that is the fact that they probably
11 would go to the nearest hospital and say, "I want to jump
12 on your wagon. Let me join quickly" because that withhold
13 is so large that the viability of the practice is
14 threatened immediately.

15 So as I sit here and talk, there's one internist
16 that I had a chance to kind of dialog with, who is under an
17 advanced APM, and she described her day as coming to the
18 office there's a dashboard that says "Have you had your
19 well visits? Percentage are down. Perhaps you can call
20 these patients in for your well visits. Medicare
21 reimburses for this." And she's under an advanced APM.

22 And then there's another algorithm on her

1 dashboard that says, "Your colonoscopy screening is X, Y,
2 and Z." A bunch of process measures, the very thing that,
3 in the fee for service we're saying process measures are
4 not -- do not determine those big outcomes that we're
5 trying to study on the fee for service side, and we're
6 saying that if eradicate MIPS we're going to have this
7 value program. The very thing that we're saying doesn't
8 matter in the fee for service world, look what happens in
9 the advanced APM world. That very essence.

10 So I, for one, have a problem with the two-tier
11 systems, one being that if I meet the threshold and I can
12 qualify to go to the University of APM school -- advanced
13 APM school -- then I don't have to do the same reporting
14 mechanisms of this other group that resides over here.

15 I think understanding the pieces of the puzzle
16 that will force the dynamics within the practices, one is
17 the fact that the family practice docs didn't come and say,
18 "Yay, we're getting rid of MIPS. I like that." And you
19 haven't had any large physician groups come in and say,
20 "It's a great idea." I have found that in talking to
21 physicians they may initially have a very positive reaction
22 to getting rid of MIPS, but when you tell them that this is

1 what we're going to, in terms of this voluntary value
2 program, then they say, "Wow, I'm going to be judged on
3 something I have absolutely no control over, and how is it
4 done? Is it done in my region? It is done in the MSA?
5 How will I have this comparison drawn?"

6 So my problems have to do with, MIPS is not a
7 perfect program. There are many problems with MIPS, but I
8 can say that some process measures that we've had to
9 report, whether it's ultrasound, with putting line
10 placements in, pneumothoraces, whether it's keeping people
11 on antibiotics, they don't need to be on antibiotics and
12 they get C. diff. There are a lot of process measures
13 that, you know, you do the check-off and it cues you into
14 something else.

15 And I've found that even in my colleagues, their
16 whole attitude has changed because they now have to report,
17 and it is a true thing. This is grassroots where I am in
18 medicine. And I think that patients are better for it.

19 Are all process measures good? I wouldn't argue
20 that. But I will tell you that the climate has changed in
21 terms of what physicians are coming to the table and saying
22 what can I do in the quality realm.

1 So, you know, I won't belabor the point but I
2 think this piece of having a two-class system for
3 physicians based on whether or not they could hurdle enough
4 to get into the University of APMs -- advanced APM school,
5 versus whether or not they are in the fee for service.

6 And the other thing is that many areas,
7 geographically, may not have access to advanced APMs being
8 available to them, and that's the harsh reality. And I
9 know that many physicians who are caring for minority
10 patients, or patients that are vulnerable, are really faced
11 with the fact that they have higher-risk patients and it's
12 not well adjusted.

13 So these are some of the issues that I have with
14 just getting rid of MIPS right now. There might be a phase
15 in the future where there's a reconsideration or refinement
16 of the program or something, but right now at this very
17 moment I think I have a major problem with eradicating
18 MIPS.

19 DR. CROSSON: Thank you, Alice. I understand
20 your points. I'd just like to make one clarification here,
21 in terms of, you know, the position of the Commission.
22 This policy change that we are proposing in no way should

1 be read as that we don't believe in the value of process
2 measures. We certainly do. I think what we're saying here
3 is that process measures, at the national level, as a
4 mechanism to move money from the Medicare program to
5 different physicians, at the individual physician level, is
6 a system that will not be effective.

7 Now, I would -- you know, as an infectious
8 disease physician I'd be the first one to point out that
9 measuring things like hospital mortality from infections
10 and the rate of acquisition of Clostridium difficile are
11 very important. But I think that the place that they
12 belong is at the local system level, not at a level where
13 CMS tries to measure this for the entire country at an
14 individual doctor level.

15 That's the point we're making, but in no way are
16 we saying that we undervalue process measures when applied
17 to patient care.

18 Okay. Bruce.

19 MR. PYENSON: Thank you. I strongly support the
20 Chairman's draft recommendation as written, and I'd like to
21 point out a virtue of this approach, which hasn't been
22 highlighted, is that it's something that the rest of the

1 health care system, Medicare Advantage plans and commercial
2 plans, could use on a practical basis.

3 So part of the difficulty that we at MedPAC have
4 had, and, frankly, providers have had and private payers
5 have had, is everyone is using different metrics and
6 different approaches. And here we have an opportunity, at
7 least in principle, to set forward the type of data
8 collection and the type of measurements that could be
9 universally applied.

10 So I know that's not in the recommendation and it
11 probably doesn't belong in the recommendation, but I think
12 it's a really important virtue of this kind of approach. I
13 think that's especially important when we recognize that
14 most of the health care spending in the United States does
15 not flow through Medicare, and we're always struggling with
16 how to deal with our piece of it when it's not the
17 majority. But I think here is a way where the Medicare
18 program can actually make things easier for the rest of the
19 health care system through reform. And part of that, the
20 principle there is that although Medicare is not the
21 majority of spending, it is the biggest single payer, and
22 as the largest single payer, the density of that and the

1 density of the influence is a very powerful thing.

2 So for those reasons I strongly support the
3 Chairman's recommendation.

4 DR. CROSSON: Thank you. So we've got David and
5 then Pat, and Paul. David, Pat, Paul, Kathy, and Rita.

6 DR. GRABOWSKI: Great, thanks. I just also
7 wanted to add that I strongly support the Chairman's draft
8 recommendation. We have a lot of experience with pay for
9 performance in this country. We have a lot of experience
10 with doing it badly. I would put MIPS in the bad pay for
11 performance Hall of Fame, like this is not going to end
12 well. And Kate did a great job of sort of talking us
13 through all the different problems here. It's burdensome,
14 it's complex, it's inequitable, it's arbitrary. And I
15 think most importantly it doesn't target and encourage
16 high-value services.

17 So we have time and time again moved forward with
18 pay-for-performance systems that have actually, I think,
19 pushed us back as a health care system. This is an
20 opportunity to repeal the MIPS and think about a program
21 that would actually push us forward. Thanks.

22 DR. CROSSON: Thank you. Pat.

1 MS. WANG: I also support the Chairman's
2 recommendation. I think that even though the VVP raises a
3 lot of really important questions, such as what Alice has
4 raised and others have raised, it is directionally the
5 better way to go. There's a lot of important detail that
6 is noted in the chapter and I think acknowledged in the
7 recommendation. A lot of important details, you know,
8 attribution, risk adjustment, socioeconomic status. All of
9 these things need to be addressed, and I would encourage us
10 to, you know, really make that clear when this is written
11 up. But I do support it because I think it's directionally
12 better and has potential to be a better system.

13 On the issue of quality metrics, I don't want to
14 lose the point that has been raised. This, I think, should
15 be highlighted as a separate important topic for us to
16 continue to address. First of all, standardization across
17 all of the different programs. MA has a program. ACOs
18 have a program. You know, VVP is going to have a program.
19 We really need to move in the direction of saying these are
20 the measures that we think are important and everybody's
21 going to be measured by them, so that, you know, I do think
22 it's fair, docs have like -- there's a lot of signal noise

1 coming in from everywhere. It's overwhelming. States have
2 their own measures. Medicaid programs, commercial payers
3 have their own measures. But as Medicare goes, it tends to
4 be the rest of the country follows, so I think it's really
5 important that we focus on that. You know, low-volume
6 services, are we -- low-value services, are we capturing
7 all of that in the development of these quality metrics?
8 Which process measures are important to keep? Which
9 outcomes measures? How are they assessed, et cetera? We
10 should really keep that high on the radar screen, and
11 included in there, critically important, in my view, is
12 socioeconomic status adjustment. That is the state of the
13 art around that, and I think MedPAC has had lots of really
14 good recommendations in this area. But if we are going to
15 increasingly move in the direction of comparing
16 institutions, clinicians, et cetera, on quality, this has
17 to be refined much more because it's just in its infancy
18 right now. Thanks.

19 DR. CROSSON: I completely agree. I hear from
20 physicians all the time, at least in the commercial
21 environment, you know, about having to report different
22 things to different plans, and then as you say. So if

1 Medicare could be successful over time in leading to
2 synchronization of some sort, that would be very helpful
3 and reduce both costs and reporting burden for doctors.

4 Paul?

5 DR. GINSBURG: I support the Chairman's
6 recommendation. I've long felt that in the context of
7 MACRA, MIPS was a fig leaf that Congress wanted to do some
8 -- you know, that MACRA is about advanced alternative
9 payment mechanisms. There was a feeling that letting the
10 physicians off the hook we needed to do something else for
11 the rest of it. But I think it's turning out to be a very
12 expensive fig leaf, and I believe that we should eliminate
13 MIPS. I think the VVP is a very good idea for a
14 replacement for it. I like the fact that it gets away from
15 measuring individual physician performance at a national
16 level and brings in physician organizations, groups of
17 physicians, to do that. I think it can have some very
18 positive impacts, making IPAs more viable. But I think we
19 need to be careful in our language to say that even if the
20 world does not agree with us about VVP, we still believe in
21 ending MIPS. And hopefully VVP will be a good replacement
22 and perhaps can be improved. But I don't want this, you

1 know, whether we can eliminate MIPS or not, to depend on
2 the acceptance of VVP.

3 DR. CROSSON: Okay. Kathy.

4 MS. BUTO: I agree with -- I support with Paul
5 and Pat in particular, I support the Chairman's
6 recommendation, but I do think the weak link is population-
7 based measures and not having enough specificity. We say
8 on the one hand it's urgent to do something, eliminate MIPS
9 or repeal MIPS. But I don't think we have a good grasp of
10 the complexity of what's going to be needed to get those
11 population-based measures up and running. So we may want
12 to think about some sort of intermediate space -- I don't
13 know what that is -- but where we eliminate MIPS, we go
14 with the withhold, and we come up with a place where we
15 give the agency and others time to develop thoughtful
16 population-based measures.

17 I'm worried about glomming on to what's out there
18 already and then discovering that, you know, we all know
19 that whatever you pay for will be done. So we need to be
20 careful about that.

21 DR. CROSSON: Yeah, I mean, I think the notion in
22 the text to have at least a brief discussion about staging

1 makes a lot of sense.

2 Rita, and then I think it looks like we're done.

3 DR. REDBERG: I also strongly support the
4 Chairman's draft recommendation and agree that the time to
5 act to get rid of MIPS is now because, you know, for all of
6 the reasons my colleagues have already eloquently stated
7 about the reporting burden and the arbitrary and capricious
8 nature and not valuing value in MIPS, as people -- and the
9 only things -- when I've talked to a lot of colleagues and
10 listened to people, the only thing people say is, well,
11 they've already started getting ready for MIPS. You know,
12 it's not a good reason to continue a terrible system, but
13 the longer it goes on, the more we'll hear that because
14 that's human nature, and inertia and things will go. And I
15 think we really owe it to the program and our beneficiaries
16 to work on getting rid of MIPS, not, you know, spending \$1
17 billion and a lot of time on something that we've all
18 agreed is not going to improve quality or value, but
19 instead, you know, to work on all of the things we've been
20 talking about and more Advanced APMs, which clearly, I
21 think, can achieve our goals.

22 And, last, I'll just say the article by

1 McWilliams and colleagues that, according to Austin Frakt
2 and Ashish Jha, should be the last nail in the coffin for
3 the current generation of P-for-P, you know, show that the
4 value-based identifier which is like MIPS had absolutely no
5 beneficial effect on quality or spending on care. So I
6 support the recommendation.

7 DR. CROSSON: Okay. Thank you. So we'll be back
8 in January to discuss further and vote on these two
9 recommendations. Thank you very much for the discussion.
10 Thank you, Kate, Ariel, and David.

11 We'll move on now to a discussion of hospital
12 inpatient and outpatient payment update.

13 [Pause.]

14 DR. CROSSON: Okay. Let's move on to the next
15 presentation. Let's see. We've got Stephanie, Zach, and
16 Jeff, and I guess Dan Zabinski is in the bull pen.

17 We're trying to turn up the microphone levels.
18 We're having trouble hearing you, and I think people are
19 having trouble hearing me. I think the whole volume thing
20 is a little bit down below what it should be, so we're
21 working on that right now. I guess this applies to
22 everybody, including the presenters. Try to speak up a bit

1 until we get that adjusted.

2 Who's going to begin? Zach?

3 MR. GAUMER: Yes.

4 DR. CROSSON: Okay.

5 MR. GAUMER: Okay. Good morning. This session
6 will address issues regarding Medicare payments to
7 hospitals. Thank you to Dan Zabinski, Craig Lisk, and
8 Ledia Tabor for your contributions to this work.

9 In this session, we will cover both hospital
10 inpatient and outpatient payments, and we will discuss
11 whether payments are currently adequate. As a part of
12 this, we'll provide you with the Chairman's draft
13 recommendation for updating hospital payment rates for
14 2019.

15 To evaluate the adequacy of Medicare payments, we
16 use a common framework across all sectors. When data are
17 available, we examine provider capacity, service volume,
18 access to capital, quality of care, as well as providers'
19 costs and payments for Medicare services. We will discuss
20 costs and margins for 2016, including Medicare and all-
21 payer margins, efficient provider margins, and Medicare
22 marginal profits. We will also provide projected Medicare

1 margins for 2018.

2 As you can see on the bottom row of this slide
3 above, in 2016 Medicare fee-for-service hospital spending
4 amounted to approximately \$183 billion. From 2015 to 2016,
5 hospital spending per beneficiary increased 2.3 percent.
6 The components of this growth include a 3 percent increase
7 in inpatient spending, a 3 percent increase in outpatient
8 spending, and an anticipated decline in uncompensated care
9 payments of roughly \$1.2 billion, and that is due to the
10 decline in uninsured patients.

11 Access to hospital care is good, and although the
12 hospital industry appears to be changing, we do not see any
13 issues that would affect beneficiaries' access to care.
14 Inpatient discharges decreased from 2015 to 2016 by 2.8
15 percent per beneficiary. This follows a broader 10-year
16 trend in declining inpatient use. However, 2016 was unique
17 in that while medical cases continued to decline as they
18 have in previous years, surgical cases increased both in
19 terms of the number of cases and the share of all inpatient
20 cases.

21 The volume of outpatient visits increased 1.1
22 percent per beneficiary. This is slower than in prior

1 years, but continues the long-term trend in growth. The
2 increase in 2016 is in-part due to increases in chemo
3 therapy administration, clinic visits, and emergency
4 department visits. So, therefore, what we are seeing is
5 inpatient use becoming more surgical and outpatient use
6 growing.

7 The hospital industry maintains excess inpatient
8 capacity. The aggregate hospital occupancy rate was 62
9 percent in 2016, which is roughly unchanged from 2015.
10 This means that many inpatient beds go unfilled. Rural
11 hospitals tend to have lower occupancy, and in 2016 we
12 observed a small decline in occupancy rates there.

13 We also observed a decline in the national level
14 in inpatient beds per capita from 2010 to 2015, and this
15 suggests that hospitals are shedding some of their extra
16 inpatient capacity.

17 Hospital closures in 2016 outnumbered openings,
18 but the numbers of both were relatively low. We saw 21
19 hospitals close in rural areas, which were generally small,
20 rural, and close to other hospitals, and 11 hospitals open,
21 which were generally small and urban.

22 Access to capital is good for most hospitals. In

1 2016, hospital-related construction spending amounted to
2 \$24 billion. This is roughly the same as the prior year.

3 From 2015 to 2016, nonprofit hospital bond
4 issuances increased from \$25 billion to \$37 billion in
5 2016. This 2016 amount includes roughly \$22 billion in new
6 debt financing and \$15 billion in the refinancing of old
7 debt. Both of these increased proportionately from the
8 prior year. Bond growth likely reflects low interest rates
9 and the current strong financial position of hospitals.
10 Finally, from 2015 to 2017, hospital employment increase by
11 4 percent.

12 The quality of hospital care has been improving,
13 and we see this through the lens of readmission and
14 mortality rates.

15 All-condition 30-day readmission rates declined
16 from 17.1 percent in 2010 to 14.4 percent in 2016. Now,
17 we'll be talking more extensively about readmissions at our
18 January meeting when we begin discussing our mandated
19 report on the subject.

20 We also observed a decline in mortality rates.
21 All-condition risk-adjusted 30-day mortality rates declined
22 from 8.4 percent in 2010 to 6.7 percent in 2016.

1 The key point here is that we are simultaneously
2 seeing reductions in both readmissions and risk-adjusted
3 mortality rates.

4 Stephanie will now walk you through the rest of
5 our work.

6 MS. CAMERON: Good morning. Now shifting to
7 changes in costs and case mix. From 2012 through 2015,
8 hospital per case cost increases had been relatively low,
9 averaging about 2.6 percent per year over the four-year
10 period. However, in 2016, hospital cost growth increased
11 more rapidly, as shown in the right column of this table.
12 In addition, the 3.4 percent increase in inpatient case mix
13 represents the most significant increase in Medicare
14 inpatient case mix over the past 10 years. The change in
15 case mix index and cost growth per discharge reflect the
16 increase in inpatient surgery discharges that Zach
17 previously discussed. If we adjust cost growth for the
18 increase in case mix, inpatient costs grew by 0.8 percent.
19 This growth is about half of the 2016 input price
20 inflation.

21 Moving to margins, we assess the adequacy of
22 Medicare payments for hospitals as a whole including

1 Medicare payments for all patient care services and
2 uncompensated care. We compare these payments to the
3 allowable cost of providing services to Medicare fee-for-
4 service beneficiaries. Using the most recently available
5 data, we find that the overall Medicare margin continues to
6 trend downward, falling from negative 7.6 percent in 2015
7 to negative 9.6 percent in 2016. This decrease in the
8 overall Medicare margin starting in 2014 is not unexpected
9 given several payment adjustments required by statute
10 including: reductions to the annual payment update;
11 adjustments for documentation and coding improvement;
12 decreases in incentive payments for the adoption of
13 electronic health records; and decreases in uncompensated
14 care payments that correspond with increases in the insured
15 population.

16 While the average overall Medicare margin was
17 negative 9.6 percent in 2016, rural IPPS hospitals had a
18 negative 7.4 percent overall Medicare margin, which was 2.4
19 percentage points higher than the negative 9.8 percent
20 margin for urban hospitals. Major teaching hospitals had
21 an overall Medicare margin of negative 8.6 percent, which
22 is higher than the margin for the average IPPS hospital in

1 large part because of the extra payments they receive
2 through IME. As in prior years, for-profit hospitals had
3 the highest overall Medicare margins, well above the
4 overall Medicare margin for nonprofit hospitals.

5 Next we look at marginal profits, an indicator of
6 whether providers have an incentive to admit an additional
7 Medicare patient. If payments exceed costs which exclude
8 expenses for building and fixed equipment, then a provider
9 has a financial incentive to take the patient. But if
10 payments do not cover these marginal costs, then the
11 provider may not have a financial incentive to take the
12 patient. In 2016, we find that the marginal profit for
13 Medicare services in hospitals was positive 8 percent,
14 meaning that hospitals continue to have an incentive to
15 take Medicare patients.

16 While margins continue to be low, all-payer
17 margins remain at relatively high levels. The aggregate
18 average all-payer margin equaled 6.4 percent in 2016 and
19 the operating margin, which includes revenues and costs
20 from all hospital operations, but excludes income from
21 investments and endowments, equaled 5.8 percent. Other
22 total hospital financial indicators also continued to stay

1 strong in 2016, as shown by the EBITDA, the top line on the
2 slide, which is a cash flow measure.

3 Next we turn to our relatively efficient
4 providers where we identify a set of hospitals that perform
5 relatively well on both quality of care and cost measures.

6 Looking at these hospitals' performance in 2016,
7 we find 7 percent lower mortality and 6 percent lower
8 readmissions, all while keeping costs 9 percent lower than
9 the national median. Lower costs allow about half of these
10 hospitals to generate positive Medicare margins in 2016,
11 with a median margin across all relatively efficient
12 providers around negative 1 percent.

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

20 We project margins for 2018 based on margins in
21 2016 and policy changes that take place during 2017 and
22 2018.

1 We estimate that the overall Medicare margin will
2 decline from negative 9.6 percent in 2016 to about negative
3 11 percent in 2018.

4 Although payment rate updates and case mix growth
5 will increase payments, cost growth is expected to be
6 larger than payment updates. The update is equal to
7 expected input price inflation, less an adjustment for
8 productivity and additional downward adjustments mandated
9 by the ACA. The net is a 1.65 percent increase in 2017 and
10 1.35 percent increase in 2018. We expect the margin to
11 decline due to expected cost growth around 2.5 percent per
12 year.

13 In summary of our payment adequacy findings, we
14 find that access to care is good, access to capital remains
15 strong, and quality is improving.

16 Medicare margins are low for the average
17 provider, but payments cover the marginal costs of treating
18 Medicare patients. Relatively efficient providers had a
19 median margin around negative 1 percent.

20 There are expected statutory and regulatory
21 payment policy changes in 2017 and 2018 that reduce
22 payments to hospitals. If current law holds, we would

1 expect negative Medicare margins in 2018. That said, we
2 expect hospitals to continue to have a financial incentive
3 to see Medicare patients because we project that Medicare
4 revenues will continue to exceed marginal costs in 2018.

5 Here we show the estimated update for inpatient
6 and outpatient rates for 2019, which would be 1.25 percent
7 if the current estimated market basket for 2018 remains at
8 2.8 percent.

9 With that, the Chairman's draft recommendation
10 reads: The Congress should increase the 2019 payment rate
11 for acute-care hospitals by 1.25 percent.

12 As this recommendation would provide the current
13 law update, we expect no impact on program spending or on
14 beneficiaries or providers.

15 The 1.25 percent update is appropriate given that
16 beneficiaries maintained good access to care, providers
17 continued to have strong access to capital, outpatient
18 volume growth remained strong, all while quality
19 improvement continued, despite negative Medicare margins
20 for most providers. This 1.25 percent update balances the
21 need to have payments high enough to maintain access to
22 care and the need to maintain fiscal pressure on hospitals

1 to control their costs.

2 And with that I turn it back to Jay.

3 DR. CROSSON: Thank you, Stephanie.

4 We'll now do clarifying questions.

5 DR. CHRISTIANSON: Let's start with Alice and
6 move down here, and we'll just come right around.

7 DR. COOMBS: Thank you so much, Stephanie. I
8 want to go to the marginal profit or the Medicare margin,
9 and how good are we at estimating -- I know there's a
10 calculation in the paper. It talks about the fixed cost
11 and the variable cost. Specifically in disproportionate
12 share hospitals, we're doing this blanket Medicare margins
13 across the board for all types of hospitals, and I'm
14 wondering if there's some type of variation within
15 disproportionate share hospitals. A lot has to do with the
16 infrastructure, but there has to be some overall
17 consistency within the disproportionate share hospital.
18 There are some things that might be different, and then
19 there are some things that you are doing that kind of level
20 the playing field between the hospitals. But I'm
21 wondering, have you thought about the disproportionate
22 share hospitals a little differently than the for-profit

1 hospitals in terms of calculation of the Medicare marginal
2 cost -- I'm sorry, the Medicare marginal profit?

3 MS. CAMERON: No. So we have one consistent
4 formula that we use to determine each aggregate marginal
5 profit. However, we do apply very specific -- every
6 hospital's cost report, we use the same formula. But it is
7 on a cost report-by-cost report basis, and we step down the
8 cost-to-charge ratio to take out some of those fixed costs
9 that we mentioned in the paper. So on a per hospital
10 basis, we're not just simply applying one kind of new cost-
11 to-charge ratio. We are recalculating every single cost-
12 to-charge ratio based on removing the fixed costs.

13 DR. COOMBS: And so that cost does not include
14 necessarily labor units, like if one nurse has one patient
15 that goes home, she doesn't go home; she stays for the
16 other patient, too, if it's a ratio -- you know, like a
17 2:1 ratio in some intensive care units. Right? You don't
18 include labor costs in there?

19 DR. STENSLAND: Yeah, we do include labor costs,
20 and we look at this as how much could your costs move over
21 a one-year period if you saw a reduction in your patients.
22 And so we think of that as if you saw a reduction in your

1 patients, generally you will see a reduction in labor costs
2 along with the other costs. And we did this on a cost
3 accounting basis in here, but a couple years ago, we did an
4 econometric approach where we basically looked at, well,
5 what happened to these places when their patient loads went
6 up or their patient loads went down. How much did their
7 costs change? And it was pretty consistent with these
8 marginal cost computations.

9 DR. COOMBS: A question I'm having about this is
10 that a Medicare additional patient, you know, that one
11 extra patient, just happened to be a Medicare patient.
12 It's very different than that one extra patient being a
13 commercial patient. So I'm wondering how the
14 differentiation happened. You know, we talk about the
15 additional marginal cost of that patient. It's not the
16 same as having a non-Medicare patient. So how is that
17 incorporated in the calculation?

18 MS. CAMERON: We are looking then specifically at
19 the Medicare charges and applying this cost-to-charge ratio
20 to Medicare charges to get a Medicare estimate of cost.

21 DR. MATHEWS: Alice, I could try and take a stab
22 at answering your question. What we are saying is while

1 the overall Medicare margin for a given hospital may be
2 negative, given the fact that in the aggregate the
3 hospitals have a 62 percent occupancy rate, they've got a
4 lot of empty beds that could be filled. And given the
5 nature of, you know, the marginal profit calculated on the
6 basis of the variable cost relative to Medicare payments,
7 the hospitals do have an incentive to bring in an
8 additional Medicare patient to fill an empty bed because
9 they will have, you know, an 8 percent marginal profit on
10 that patient in the aggregate.

11 But you are correct that given, you know, the
12 fact that private pay rates are higher on average, the
13 marginal profit for that private pay patient will be even
14 higher than it is for the 8 percent Medicare patient. I'm
15 not sure if that's what you're asking.

16 DR. COOMBS: Actually, that helps a lot, Jim, but
17 the other piece of this is that if they have a 62 percent
18 occupancy, they just don't have nurses roaming around to
19 pick up the next Medicare patient that gets admitted. So
20 that was part of that. But that's very helpful. Thank you.

21 DR. CHRISTIANSON: Go ahead.

22 MS. WANG: This is actually on the same topic

1 that Alice raised, and I apologize because it might have
2 been in the paper and you might have just said it, but just
3 clarify for me, once more, in calculating marginal profit,
4 you're excluding fixed costs on the cost side. Are you
5 also excluding Medicare payment for capital on the Medicare
6 revenue side?

7 MS. CAMERON: We are not.

8 MS. WANG: I mean, is that a little apple and
9 orange kind of -- because that would sort of suggest if
10 you're not excluding Medicare payment for the fixed cost
11 that you're removing them across side, like, is there an
12 assumption somebody else is paying for all the fixed costs?

13 DR. STENSLAND: Because when you have one more
14 Medicare patient you will get more capital payments. So
15 for every patient there's a certain amount of capital
16 attached to that patient. So, for instance, you'll have a
17 discharge and Medicare will pay you \$10,000 in operating
18 payments for that one discharge and another \$500 in capital
19 payments for that discharge, so you're going to get \$10,500
20 for that one additional discharge.

21 Then the question is, how much additional costs
22 are you going to have by having that additional payment --

1 patient in there, and those additional costs would be all
2 your labor costs and your supply costs and all of that kind
3 of thing.

4 MS. WANG: I guess -- I mean, you've been doing
5 this for a long time. It's just at first blush the gut
6 reaction is if you're taking it out of the cost side and
7 you're not taking it out of the payment side, are you
8 overstating the revenue a little bit, because you're giving
9 -- I mean, fixed cost is fixed cost, and, you're right,
10 you're getting extra capital. But it also assumes that the
11 fixed cost is being covered by something or somebody else
12 or some other component of the Medicare rate so that the
13 variable cost piece, which is sort of what I think your --
14 this marginal analysis is attempting to get it. I just --

15 DR. STENSLAND: Right. So we're not saying that
16 you can survive as a hospital only with the marginal
17 profits. Somebody has to cover the fixed costs at some
18 point.

19 DR. GRABOWSKI: Yeah, I think the key here is
20 just distinguishing, Pat, between the marginal and average,
21 and I think they've already presented and shown the sort of
22 average margins. But when you're thinking, you know, kind

1 of incrementally, fixed costs, the capital, you wouldn't
2 consider that. It's just the additional revenue you're
3 taking in and thinking about that, without -- you know, you
4 don't have to factor in for that incremental cost. You're
5 not thinking about the capital. The capital is already
6 fixed. You're paid for.

7 And so it's just thinking at the margin versus
8 thinking at the average here, I think that's where maybe --

9 MS. WANG: Okay.

10 DR. GRABOWSKI: -- confusion lies.

11 MS. WANG: Okay. That's helpful. Thank you.

12 On Slide 12, the all-payer average margin, do you
13 -- can you tell us what the average payer mix is in that
14 average, particularly what percentage of Medicare that
15 average represents?

16 MS. CAMERON: I have that number but not with me.
17 I can get back to you in January.

18 MS. WANG: Okay. And then final question is,
19 simply, on Slide 8, the increase in case mix complexity is
20 attributed to an increase in surgical and a decrease in
21 medical admissions. Did you, in the course of this, have
22 you detected anything in CMI that has changed as a result

1 of ICD-10?

2 MR. GAUMER: Okay. So the answer is no, we
3 haven't tied anything specifically to ICD-10, but what we
4 do see is -- and we don't think that that's the key player
5 in the growth in CMI this year, from '15 to '16. There are
6 a couple of trends taking place. You've got this surgical
7 and medical -- surgical going up as a share, medical going
8 down as a share -- and because medical and surgical cases
9 have those different average case mixes, and surgical's
10 case mix, on average, is about 3, medical, let's say, is
11 about 1.2, because more surgical cases are flowing in, that
12 makes the average CMI go up and the change turn out to be a
13 historical high.

14 So what's underlying the surgical story here is
15 we're seeing a growth in three particular kinds of cases.
16 We're seeing hips and knees, about 30,000 more of those in
17 2016, and this looks to be new case, new admissions.
18 They're not getting taken from another DRG, if that makes
19 sense. We're also seeing a growth in some specific GI-
20 related DRGs, surgical DRGs, and that does seem to be kind
21 of a transfer from the medical to the surgical. And it
22 seem -- you know, what could drive that could be practice

1 patterns, more procedures getting done. I'm certainly not
2 a clinician so I can't go much deeper than that. But there
3 seems to be a transfer happening.

4 And then there's this third category which is
5 sepsis cases, and we're looking into sepsis cases more,
6 based upon what we've found, and I think we mentioned this
7 in the paper. But we're seeing a growth in sepsis cases
8 across the board, for surgical and for medical. And what
9 really seems to be driving the growth in sepsis cases is
10 the fact that, we think, the definition of sepsis changed
11 in 2015-16, somewhere in there, but perfect timing for the
12 growth that we've seen. The Society for Critical Care
13 Medicine -- Alice, I was hoping you'd jump in here -- made
14 a fairly significant change, judging based upon the
15 comments that they got in JAMA, to how sepsis is defined.
16 And in my laymen's terms it look like they've --

17 DR. COOMBS: Broadened it.

18 MR. GAUMER: -- broadened the definition to allow
19 more -- I mean, in effect, to allow more sepsis diagnosis.
20 And it looks like, just from looking at the DRGs and the
21 codes within these cases, that more procedures are being
22 done to these sepsis cases as well, which means more sepsis

1 being diagnosed and being put into the inpatient setting,
2 and possibly, because of those procedures that are being
3 done, more people getting put into the surgical DRGs.

4 So all of this is driving that 3.4 percent.
5 Usually it's like 1.6.

6 MS. WANG: What's the SIW for a sepsis cases? Do
7 you know offhand?

8 MR. GAUMER: The weight for a sepsis case? It's
9 -- so there's a couple of different sepsis diagnoses, but -
10 - or DRGs, but for the surgical infectious disease category
11 of DRG, it's about 5.0. So we're seeing some growth in the
12 higher level -- higher-weighted DRGs, and that -- that's
13 always a concern for all of us.

14 DR. CROSSON: Brian, on this point.

15 DR. DeBUSK: Zach, you did mention the surgeon in
16 hips and knees, and I noticed the reading materials sort of
17 alluded to maybe some of that was driven by these episodic
18 payment models. Could you speak to how much of that we
19 could account for through just sheer demographics? I mean,
20 for example, a new Medicare beneficiary may expect to be
21 more mobile than, say, their predecessors.

22 Can we tease apart how much of that really could

1 come from episodic models, and could this be the first
2 evidence of serial bundling that we're concerned with, with
3 this particular payment type?

4 MR. GAUMER: So similar to sepsis, this is
5 another area that we need to drill down into a little bit
6 more, and we haven't had the time to do that yet. You
7 know, I think what we put in the chapter about the CJR demo
8 is our best suggestion for what's going on, but we need to
9 -- we haven't drilled into who these people are that are
10 getting these -- you know, in the increase in surgeries.
11 They could very well be younger. They could very well be
12 in the parts of the country that have this CJR. So we need
13 to do more on that and suggestions would be welcome.

14 DR. DeBUSK: I would be particularly interested
15 if you could tease apart those other factors, because I do
16 think they're significant. I mean, I think -- again,
17 today's beneficiary expects more in terms of mobility and
18 things than their predecessor. But I would be really
19 interested in seeing if we could quantify the inductive
20 properties of having these, say, a BPCI or a CJR, where
21 there are incentives for beating your benchmark, because I
22 do wonder if that induces procedures.

1 DR. COOMBS: I just had a question. Brian
2 brought up a very interesting point in that if you were to
3 do an age distribution for those new joints in the CJR,
4 plus or minus whether or not they're in CJR, if you see if
5 they're waiting to time into Medicare before they have
6 their joint done.

7 DR. CROSSON: Okay. We're moving down this way
8 with questions. Jack.

9 DR. HOADLEY: So I wanted to turn to the
10 uncompensated care numbers. You presented, on I guess it
11 was Slide 3, that they're down 16 percent, and that that
12 makes sense given that we've seen an increase in insured
13 patients, ACA-related, and perhaps other things, and then,
14 in turn, that brings the payment through Medicare for
15 uncompensated care down.

16 I want to think about how that plays out with the
17 margins, and I think you cited that it is a factor in
18 pushing the Medicare margin downward, and presumably
19 because the same hospital is now getting a Medicaid payment
20 or a commercial payment it's pulling their all-payer
21 margins up. What I'm not clear from that is levels of
22 magnitude, if you have any sense of how much of the,

1 whatever it is, 2 percent decrease in margins from '15 to
2 '16 might be attributable to this uncompensated care
3 phenomenon, or whether that's even doable.

4 DR. STENSLAND: What did we say it was -- a
5 billion dollars or something like that? So, you know,
6 maybe three-quarters of a percentage point decrease in the
7 Medicare margin. Probably they got more benefit than that
8 on the Medicaid expansion side, because, you know, you're
9 going from somebody paying you nothing to somebody paying
10 you Medicaid rates. And so that's probably why we saw
11 record high operating margins in 2015, as that was kind of
12 the expansion period, and this doesn't affect our marginal
13 profits at all --

14 DR. HOADLEY: Right.

15 DR. STENSLAND: -- because this is not -- it
16 doesn't -- this doesn't move up and down with cases.

17 DR. HOADLEY: Okay. Thank you.

18 DR. CROSSON: Questions? Warner.

19 MR. THOMAS: How do we account for, in the
20 occupancy percentage, observation patients?

21 MR. GAUMER: So the observation patients are
22 built into that. We look at it without the observation,

1 but OBs is in that 62 percent.

2 MR. THOMAS: So basically you include them on it.
3 And how do you run, like length of stay, that sort of
4 thing, on OBs?

5 MR. GAUMER: How do we run?

6 MR. THOMAS: How do you look at the length of
7 stay? Do you have the length of stay for obs as well in
8 there?

9 MR. GAUMER: Yeah. So what we do is, when we
10 identify an observation case, we generally will look at
11 only those cases that have been there for more than eight
12 hours, and that's a payable case. Well, in general, that's
13 a payable case for Medicare.

14 MR. THOMAS: And how do you -- do we have the
15 trend on marginal cost? Has that been trending -- are the
16 -- I guess the marginal margin, if you will, on Medicare?
17 Is that -- do we have the trend on that?

18 MS. CAMERON: We do, and it's been trending
19 slightly down --

20 MR. THOMAS: Okay.

21 MS. CAMERON: -- over time.

22 MR. THOMAS: And on the efficient hospitals now,

1 you know, basically, it looks like it's the first time it's
2 been negative. Has it been negative before?

3 DR. STENSLAND: No.

4 MR. THOMAS: Okay. So do we have an idea of what
5 the floor is there, what it -- I mean, how far negative can
6 we go for all hospitals and/or efficient hospitals, from a
7 negative perspective, before we think we have a payment
8 adequacy issue?

9 DR. STENSLAND: I think that's purely a judgment
10 call for all of you.

11 DR. CROSSON: Bruce.

12 MR. PYENSON: Thank you. The question on page 8,
13 going back to the shift the reduction in medical cases and
14 the increased surgical cases, but it's a little different
15 than the CMI issue we've been discussing.

16 The quick rule of thumb that I've gotten from
17 hospital administrators is they make money on surgical
18 cases and lose money on medical cases, or the surgical
19 cases are way more profitable. And the kinds of shifts in
20 percentages we've seen from 2015 to 2016 are pretty
21 dramatic, and dramatic towards the more profitable cases
22 and away from the less-profitable cases.

1 So looking at that shift, I'm surprised that the
2 Medicare margin has decreased, and I'm trying to reconcile
3 that -- those issues. So I wonder if you could help me
4 with that.

5 DR. STENSLAND: I don't know what the hospital
6 administrators are talking. They may be talking about the
7 private side as opposed to the Medicare side. This -- just
8 the numbers themselves would imply that there's not this
9 huge differential in profitability or we just would have
10 seen a higher -- you know, we would have seen more -- less
11 of a reduction in the Medicare margin.

12 So I think there might be a private commercial
13 relative price versus Medicare relative price going on.

14 MR. PYENSON: I guess I could be, but my
15 impression is that the scales would be similar on the
16 commercial side to the Medicare DRGs, at least on the
17 hospital side.

18 DR. GINSBURG: I don't think so, Bruce. I think,
19 you know, by a cost-based DRG system, Medicare -- I mean,
20 there was a problem of the surgical cases were more
21 profitable. That was reduced by a revamping of the
22 weights. I'm sure it's not perfect yet but I think, you

1 know, with commercial, where some of it is charge-based or
2 per diems, there's scope for a lot more than imbalance
3 there.

4 MR. GAUMER: Just one other thing, actually. I
5 just wanted to say, to Bruce's point, that, you know, the
6 scale that we're dealing with here is, in 2016, surgical
7 cases made up about 29 percent of all the cases for
8 Medicare, and there was essentially a 1.8 percent or 2
9 percent jump in that share. So surgical represents about a
10 third of cases, a little less than that.

11 DR. CROSSON: Amy.

12 MS. BRICKER: To build off the point that Warner
13 was just making around what do we think the floor is, is
14 there a way for us to model, not just this year or next,
15 but in the out years, the additional subsidy that we're
16 going to have to assume hospitals are getting from the
17 commercial market in order to rationalize continuing
18 support of the Medicare population? You know, there's
19 reference in the material to there being a point by which
20 the commercial market will not be able to continue to
21 sustain, year over year, sort of increases in reimbursement
22 in order to subsidize what the hospitals are needing on the

1 Medicare side, if I follow the material.

2 So is there a way for us to forecast, based on
3 what we know in current law, the changes in Medicare
4 reimbursement and then, therefore, the burden that we would
5 expect the commercial market to bear, and then would we be
6 able to assess what we believe the floor to be? Does that
7 make sense?

8 DR. STENSLAND: -- somewhat differently in that I
9 think the problem -- I would almost frame it as if you look
10 at the rates of commercial price growth over the long haul,
11 the last 20 years, they have generally been quite high,
12 like over the rate of other prices. And when you have that
13 more revenue in the hospital, then, especially the
14 nonprofit hospitals tend to spend that revenue, so you tend
15 to have higher price growth. So the higher the commercial
16 price growth, the higher the cost growth, and the lower the
17 Medicare margin.

18 So in terms of -- I think the problem for
19 Medicare might almost be the opposite of like saying, you
20 know, the higher the commercial prices grow, the faster
21 they grow, the more problematic it is for Medicare, because
22 then you have a bigger spread between Medicare and

1 commercial. If the commercial price froze out, then the
2 differential would be smaller and we would probably have to
3 -- then the hospitals would have to see some reduction in
4 their cost growth, or the freezing of their cost growth.

5 So I think there's a few different philosophical
6 things going on there. The one main thing, I think, is the
7 hospital costs will change, depending on hospital revenue,
8 so they're not immutable. That's one. And the other thing
9 is that it's really this differential between Medicare and
10 commercial that is the big danger for Medicare.

11 MS. BRICKER: So then on the efficient hospital
12 that was -1, or whatever it was quoted, and you said this
13 was the first year that they saw a negative margin profile
14 with respect to Medicare, what was it previously, like
15 historically?

16 DR. STENSLAND: Historically it's been pretty
17 close to 0. This is not something that, you know, dropped
18 off the cliff. This was like, maybe it was like 1 or 2,
19 and then it was 0, and now it's -1. So you're seeing maybe
20 a movement of 1 percent per year on the median efficient
21 provider.

22 MS. BRICKER: And do we have a goal of what that

1 -- continue to just erode over time?

2 DR. STENSLAND: I think that's completely a
3 judgment call, whether you think we should be paying the
4 efficient provider their full costs, or somebody else might
5 say we should pay enough to keep access going, and that's
6 why we can put in this marginal profit, because that tells
7 you that the hospital still has an incentive to see these
8 patients because their profits will go up if they see more
9 Medicare patients, and also why we put these total margins
10 in there, so you can see the overall financial health of
11 the hospital, and we've already put access to capital in
12 there, and quality, and all of that.

13 But, in general, this is really a judgment call.

14 DR. CROSSON: David.

15 DR. GRABOWSKI: Thanks. This is a good follow-
16 up, actually, to Amy's question.

17 Jeff, you mentioned that the issue can be the
18 difference between kind of the commercial margins and the
19 Medicare margins, and I'm curious. There must be parts of
20 the country where we see bigger gaps right now between
21 commercial prices and Medicare. Are we seeing any negative
22 outcomes in those markets in terms of access? I guess, how

1 large would that gap have to get? It's pretty big right
2 now, and we're not seeing those kind of access issues.

3 DR. STENSLAND: I think it would have to get
4 really very large in my mind. When we look at the
5 differential between these profit margins, there is a big
6 difference across the country. If you look in Alabama, you
7 have one dominant insurer, so prices are generally low.
8 Hospitals have low revenue. Then they have low wages, and
9 because they have low wages, they have low costs. And
10 because their costs are low, their Medicare margins are a
11 little bit better down in Alabama. Basically, they just
12 can't afford to lose that much on Medicare because they're
13 not making that much on the private side.

14 You could go to some other places where you have
15 like one dominant hospital, and they're making huge amounts
16 on their private side. And they might have a negative
17 marginal profit on their Medicare side, but even those, we
18 see them continuing to take Medicare cases, I think, in
19 part because a lot of these big places with dominant
20 positions are nonprofit hospitals, and one of the things
21 IRS looks at to see if you can keep your nonprofit status
22 is how you're serving Medicare patients.

1 In general, when we've seen the couple cases
2 where people have tried to go without Medicare patients, it
3 hasn't been successful.

4 DR. CROSSON: On this point?

5 DR. GRABOWSKI: I just want to make one other
6 comment, which I think is something Jeff is stressing here,
7 which is really important. This is all jointly determined
8 that costs are not fixed here. They're not exogenous, and
9 I think that's a really important point that's worth
10 stressing here.

11 DR. CROSSON: So, in other words, the floor
12 moves.

13 DR. GINSBURG: If I can add something to this
14 point?

15 DR. NERENZ: Weaving through our discussion, a
16 couple things, both on the low wages and the marginal
17 thing.

18 Even though there is a financial incentive, there
19 may not be appropriate patients to admit. We sort of act
20 as if a hospital can just go out and pull people off the
21 street and fill beds. It doesn't work that way.

22 Also, I'd ask any of us, do we want to go to a

1 hospital that has low nursing wages, like distinctly low
2 nursing wages? Is this a good idea? Because nurses can
3 work a lot of different places, and maybe as we go through
4 the rest of today and tomorrow, we'll find places that are
5 making a whole lot of money that are attracting the best
6 nurses from these low-wage hospitals. So let's keep that
7 in mind before we say that low wage, low cost is a good
8 thing.

9 DR. CROSSON: But it's mitigated by our measures
10 of quality, to be fair.

11 DR. NERENZ: Sometimes.

12 DR. CROSSON: Well, in terms of construction of
13 an efficient hospital, which is our benchmark.

14 DR. NERENZ: This is not a complete portfolio of
15 quality measure. I have no disagreement with what you're
16 doing, but those measures don't necessarily pick up the
17 signals of trouble.

18 DR. CROSSON: Fair enough.

19 DR. GINSBURG: If I could just jump --

20 DR. CROSSON: I'm sorry. Jon is in the queue.
21 Are you on this point? All right. Go ahead.

22 DR. CHRISTIANSON: So I do think when we're

1 talking about low nursing wages, Alabama, it's kind of a
2 market-determined thing, so hospitals buying nurses at
3 similar prices. It is not like one hospital is going out
4 and finding somehow nurses that will work for low costs.

5 DR. NERENZ: Assuming it's only hospitals where
6 nurses work.

7 DR. CHRISTIANSON: Well, I think there's a
8 general variation in the geographic market for nurses that
9 contributes to what the nurse wage is.

10 My question for you is on Slide 14. Could you
11 expand a little bit more on how you project cost growth?
12 Is it totally things that are not under control of the
13 hospital, like the people are Medicare beneficiaries
14 getting sicker, or does it reflect also decisions that
15 hospitals can make with respect to investments and fixed
16 costs, or how does that break out?

17 DR. STENSLAND: We generally just look at the
18 historical trends of costs, and then we get some data
19 through 2017. The government has some surveys of hospitals
20 where they ask them what's your cost change and your price
21 change, and we also look through the third quarter of 2017
22 at what's happened to the for-profit hospitals, and they in

1 their 10-Q's at the quarterly filing, and they often report
2 on their revenue changes per discharge and their cost
3 changes per discharge.

4 We look at that, and we pretty much just take
5 that trend and then just project it out through 2018. So
6 our cost projections aren't super fancy.

7 Within there, we expect a little bit of
8 efficiency gains because we've seen that in the last couple
9 years. Like maybe your costs per discharge grow a little
10 bit slower than your input costs, meaning you have a little
11 bit fewer inputs per case mix-adjusted discharge. But that
12 is pretty much what's happening there.

13 DR. CHRISTIANSON: So it's kind of the ruler
14 method more than anything else.

15 DR. STENSLAND: Yeah.

16 DR. CHRISTIANSON: Because we were told the past
17 few years, the cost for growing may be more rapidly because
18 hospitals needed to invest in electronic health records and
19 so forth. So, I mean, there has been some discussion over
20 the years about specific things that drive cost growths
21 from year to year, but that's not what you're doing here.
22 You're not thinking about those things. You're just

1 basically looking at trends and forecasting and just
2 extrapolating.

3 DR. STENSLAND: Yeah. It's pretty much a ruler
4 with a couple of extra adjustments.

5 The revenue side is much more precise because
6 then we can look at the payment formulas.

7 DR. CHRISTIANSON: Right.

8 DR. DeBUSK: I just felt compelled to make one
9 comments about this notion of celebrating Medicare policy
10 that does result in lower hospital wages.

11 We have a pretty harsh correction in the hospital
12 wage index that then gets applied to 62 percent of that fee
13 schedule.

14 So one thing I would caution is we're sending a
15 very conflicting signal here, which is, gosh, we want to
16 drive these large negative Medicare margins because
17 presumably -- and I do agree with you. I think,
18 presumably, that does force hospitals to move the baseline.

19 To David's point, these are exogenous factors
20 here, but then we send a conflicting signal by making a
21 very harsh adjustment to 62 percent of their entire fee
22 schedule and 60 percent of their outpatient fee schedule.

1 It spills over into nursing home payments and even beyond
2 the hospitals' walls. So I do think that's something that
3 we should reconcile or hopefully we can reconcile because
4 we're sending a very conflicting policy or message.

5 DR. STENSLAND: I would just say there is a
6 standing recommendation out there from the Commission to
7 change the way the wage index works, so it's not just based
8 on hospital employees. We're trying to get away from this
9 downward spiral of if you reduce your wages, you're going
10 to get less of an update, and I think that's the --

11 DR. DeBUSK: It's the death spirals.

12 DR. STENSLAND: And I think that's also one of
13 the reasons that now we have a number that we're saying,
14 1.25 percent. So, in theory, if Congress took this
15 recommendation, if you guys made the recommendation of 1.25
16 percent and Congress took it and then if wage growth was
17 really low next year, they would still get that 1.25
18 percent. If it was really high, well, they would still get
19 that 1.25 percent, and we're trying to kind of get away
20 from some of the problem that you talked about.

21 DR. DeBUSK: Well, the recommendations on
22 Hospital Wage Index Reform celebrated their tenth

1 anniversary this summer, so it might not hurt to dust that
2 off and put that in the 2018 work plan. I'm just
3 suggesting.

4 DR. CROSSON: Okay. Just a point, we're starting
5 to leak into Round 2 here. So we're still on questions.
6 Questions?

7 Pat. I'm sorry. Pat, Paul, and Jack.

8 MS. WANG: Does the overall Medicare margin
9 include Medicare Advantage?

10 MS. CAMERON: No. It is only a Medicare fee-for-
11 service.

12 MS. WANG: Okay. So then what's happening in
13 that 30 percent of the Medicare Advantage world is
14 reflected in the all-payer margin?

15 MS. CAMERON: That's correct.

16 MS. WANG: Okay. Thank you.

17 The other question I had, just factually, is has
18 there been any change -- or what's going on with direct and
19 indirect GME payments at least on the fee-for-service side?
20 They're still largely inpatient-driven, I think, the
21 statistics. So volume is down, but case mix is up. Have
22 you seen any major changes, one way or the other, in GME?

1 MR. GAUMER: I think that when we looked at the
2 IME payments, they're pretty steady from year to year, and
3 even as we project them out in '18, it's ironclad. I mean,
4 they're pretty consistent, but GME, I'm not sure I can
5 speak to.

6 DR. CROSSON: Paul.

7 DR. GINSBURG: Pass.

8 DR. CROSSON: Jack.

9 DR. HOADLEY: Just something I should have asked
10 when I had the mic before.

11 In terms of the uncompensated care, what are you
12 assuming for the 2018 projected margin? Are you assuming a
13 continued downward trend in uncompensated care or leveling
14 out?

15 MR. GAUMER: It levels out, actually, for 2018.
16 I think it jumps back up to 8- or 9 billion. I think
17 that's what happens.

18 DR. HOADLEY: Okay. that seems to make sense,
19 yeah. It's on the tax reform bill, though.

20 DR. CROSSON: Okay. Warner.

21 MR. THOMAS: Just real quick. On Slide 12, is
22 that all hospitals?

1 MS. CAMERON: It is.

2 MR. THOMAS: And do you run a similar all-payer
3 margin by type of hospital? I guess is that the --

4 MS. CAMERON: By type of hospital, do you mean a
5 teaching, urban, rural?

6 MR. THOMAS: Yeah, yeah.

7 MS. CAMERON: Yes. We have that information.

8 DR. CROSSON: Would you like to see that, Warner,
9 next month?

10 MR. THOMAS: I think it would be helpful to have
11 it just to understand a little bit more behind this graph
12 because I'm sure there's some takeaways behind this. With
13 more of the details, it would be helpful.

14 MS. CAMERON: We can get that to you.

15 DR. CROSSON: Okay. Let's put Slide 17 up so
16 that we're on the recommendation. I want to hear comments
17 about the recommendation. Who would like to make a comment
18 on the recommendation?

19 Jack. Jack and Pat.

20 DR. HOADLEY: Warner, I think, also.

21 DR. CROSSON: Jack and Pat and Warner.

22 DR. HOADLEY: I mean, I think this seems to me

1 like a pretty good recommendation, given some of the things
2 we talked about, about the overall margins. The questions
3 I was asking about the uncompensated care, it seems like
4 that's one place where sort of Medicare is -- when it makes
5 uncompensated care payments, it's not really paying for the
6 Medicare.

7 Now, on the one hand, if you took that out,
8 obviously it would bring the margin down even further, but
9 the hospitals are overall financially healthy or your
10 measures are good. So I think sticking to the current law
11 recommendation makes sense to me.

12 DR. CROSSON: Pat.

13 MS. WANG: I am not sure that I have a different
14 recommendation than what is shown here, but I do want to
15 know -- that I have concerns over the data and the great
16 analysis that you have shown here with the decline in
17 Medicare margins, and it's very helpful to know that the
18 DSH cut is accounting for three-quarters of a point of that
19 decline. Nevertheless, the slope is worrisome. The fact
20 that the efficient hospital cohort is negative, even though
21 it wasn't a cliff -- it's negative, so, again, the slope,
22 the trend is a little bit of a concern to me, more than a

1 little bit of a concern.

2 When the margins are getting that tight, I guess
3 that I get more focused and more concerned about moving
4 away from the average hospital and that average payer
5 margin to kind of look at little bit more carefully at
6 what's going on with the hospitals that are more on one
7 side of the bell-shaped curve in terms of Medicare volume
8 as a percentage of total payer mix and perhaps even other
9 public payers. That's why I asked, and maybe in the
10 follow-up with Warner in January, we could learn a little
11 bit more about characteristics of that average payer margin
12 and what the Medicare share is.

13 And similarly, kind of what the slope is or what
14 the curve looks like as you move from high Medicare to
15 lower Medicare and what happens to the overall margins, I
16 think we can probably guess that.

17 So I have a little bit more concern about the
18 need to pay a little bit more attention to the institutions
19 that are having -- experiencing differential all-payer
20 experience, for example, because of their payer mix and the
21 need to kind of maybe think about payment policy for
22 hospitals being a little bit more fine-tuned, to make sure

1 that those that are really serving a higher proportion of
2 Medicare, low-income Medicare, duals, whatever it might be,
3 are not hurt by these recommendations.

4 DR. MATHEWS: Pat, while we haven't made any
5 decisions yet, this very idea is on our list of major
6 efforts to consider for the next analytic cycle, so this is
7 something we could potentially bring back to you.

8 DR. CROSSON: Warner and then Alice.

9 MR. THOMAS: So a couple of comments. One, I
10 share Pat's concerns just as far as we're heading to a
11 place where we don't have payment adequacy.

12 I think some things that would be helpful to have
13 in the chapter include trend and more information and
14 what's happening in the hospital cost, because you
15 basically do a good job of looking at total cost. But I
16 think there's components of the cost that hospitals have to
17 deal with that would be very helpful to provide more
18 transparency around, specifically drug costs and device
19 costs, which are escalating, continue to escalate
20 significantly higher than we're seeing any of these payment
21 changes occur.

22 I think the second phenomena that we have here is

1 that we're just seeing an increasing amount of Medicare
2 revenue in hospitals as we see the aging of the population,
3 and we know there's been cost shifting. But the ability to
4 do that going forward is just mitigated. It's just not
5 going to be sustainable. So I think it's going to force us
6 to take a very different look at this going forward.

7 I would encourage us to look at what that trend
8 has been over the past few years and make sure we include
9 that in the chapter because it is a big driving factor of
10 the payment adequacy and the sustainability of kind of
11 where we are. So I think those are critical.

12 I think the other thing is if you look at our
13 summary slide that we have with all the payment updates and
14 the Medicare profitability compared to other components of
15 the Medicare program, it's just there's a very wide
16 differential between this payment and other payments such
17 as home health, dialysis, et cetera, et cetera. So I think
18 we need to take that into consideration as we look at these
19 bigger decisions.

20 I don't have a specific change to the
21 recommendation, but I think we need to understand that
22 there is -- the market basket is 2.8, but there's a

1 significant modification for productivity in the PPACA
2 adjustment that really mitigate this issue. I don't think
3 the trend is sustainable, and I think what you're going to
4 see, it's going to drive more consolidation.

5 Going back to, I think, a point that Paul was
6 making earlier, you may have a reverse impact here that is
7 not positive.

8 The other thing is I'm not sure that looking at
9 the issue of whether hospitals accept Medicare is really a
10 reasonable factor because Medicare is such a large
11 component of our population that hospitals have to accept
12 Medicare, unless they're a specialty, kind of surgical
13 physician-owned hospital.

14 Hospitals will always have to accept Medicare
15 because it's such a large component of what they do, and I
16 think if you look at a hospital's role in the community, it
17 would not live through the negative impact that it would
18 get from its reputation if it decided not to take Medicare.

19 But I don't think we should be pushing on that.
20 I think we should be mindful of it, and we should stay
21 ahead of that and make sure we're paying adequately.

22 What percentage do we have of hospitals that are

1 efficient hospitals? Isn't it like 8 to 9 percent,
2 something like that, roughly?

3 DR. STENSLAND: Fifteen, something like that.

4 MR. THOMAS: Fifteen? So 15 percent, we're
5 looking at -- that's kind of what we're looking at, and
6 they're now negative. And they're the best of the best of
7 the best.

8 So I think we just have to keep that in front of
9 our mind when we're making these decisions and know that
10 we've seen a pretty steep slope, and it's probably not
11 sustainable going forward.

12 DR. CROSSON: Warner, I think these are all good
13 points that you've made, and I would point out that as we
14 get into a discussion subsequently about our general policy
15 on hospital payment, the issue of -- I don't want to call
16 it a Medicare burden, but the difference among hospitals in
17 terms of how much is Medicare versus other payers, it will
18 be one of those kind of distinctions that I think we need
19 to look it.

20 Yeah. Okay. So --

21 MR. THOMAS: It is such a huge driver. I mean,
22 it's just the reality. If you have a much -- and I think

1 the expansion of Medicaid has exacerbated that really in
2 many markets as we've seen folks transition from the
3 commercial payer to Medicaid in many markets. So I think
4 that's another phenomena here that is driving this payer
5 mix change and impacting the overall economics of
6 hospitals.

7 DR. CROSSON: Okay. I see the general reticence
8 has resolved, and we'll start moving up this way with David
9 next.

10 DR. NERENZ: Thanks. I'll try to be brief.

11 I will support the recommendation. I just want
12 to play a little bit off both Pat and Warner's comments.
13 It would be interesting to see this particular increase
14 cast in the context of other payment changes in the
15 Medicare program to hospitals that are creating some really
16 big winners and losers. A couple examples. There's a 340B
17 proposal now that's going to move double digit millions of
18 dollars, up/down to different hospitals. There's an IME
19 legislative proposal that's going to move even bigger
20 double digit millions of dollars from some hospitals to
21 other hospitals. There are no winners in the readmissions
22 penalty program, but there are millions at play there. The

1 DSH cuts we've talked about. Again, that produces winners
2 and losers. It's good for hospitals in Texas. It's not
3 good for hospitals in California.

4 And you look at all this together, and I think
5 it's -- you know, we talk about the averages. But I think
6 what we're going to find is if there are hospitals who are
7 on the bad end of all these other things, you know, this is
8 going to be a drop in the bucket. But I'd be interested in
9 knowing how big a drop and how big a bucket.

10 And, on the other hand, there are hospitals
11 getting windfalls here and here and here for which this is
12 just icing on the cake, so to speak.

13 So I'd love to see this set in context if we
14 could do that.

15 DR. MATHEWS: David, just one comment on that.
16 When we do project Medicare payments and costs going
17 forward in each of the sectors, we do indeed reflect major
18 current law or policy shifts that we anticipate, you know,
19 2018 and 2019. And we do our best sector by sector to, you
20 know, try to project anticipated cost growth on a sector-
21 by-sector basis. So there's no question there.

22 Where I would differ a little bit is we tend not

1 to reflect proposed legislative changes, proposed
2 regulatory changes, given the fact that those things may or
3 may not transpire. When they do, obviously we take them
4 into account, but we kind of avoid accommodating something
5 that's not quite baked yet.

6 DR. NERENZ: Granted, and I understand because
7 until it's finally in place, and even then it can evolve.
8 So no problem with that. The only quick response is that
9 sometimes the effects are much more granular than just the
10 sectors as we define them. You know, we make reasonable
11 groupings -- urban, rural, teaching -- that all makes
12 sense. But there are major up/downs going on even within
13 those categories, and it just sets a context in which this
14 has its effect.

15 DR. CROSSON: Okay. Bruce, David.

16 MR. PYENSON: I support the Chairman's
17 recommendation and would like to echo the views of others
18 to look at the stratification within the hospital sector.
19 However, I don't see anything in this report that's
20 especially alarming, either in trends or in the current
21 situation. The hospital sector does not appear to be
22 hurting. There seems to be a quite adequate supply of

1 capital investment and expansions and other things going on
2 that the aggregates, of course, can distort what are
3 happening to particular circumstances. The trend I'm
4 concerned with, of course, is the one that we begin every
5 session with, which is the spending on health care in the
6 U.S. and Medicare's overall spending.

7 DR. CROSSON: Thank you. David?

8 DR. GRABOWSKI: Thanks. I support the Chairman's
9 draft recommendation. I was really struck in this chapter
10 and just this interplay between the commercial prices and
11 what Medicare pays, and I think it's really hard to look at
12 Medicare margins in a vacuum. For this sector, we're going
13 to talk about skilled nursing facilities after lunch.
14 There the cross-subsidization goes the other direction from
15 Medicare to Medicaid. Here it's obviously going from
16 commercial to Medicare. But I think looking at both the
17 Medicare margins but also those overall margins and then
18 thinking about these other payers and their adequacy going
19 forward is a really important issue and something we'll
20 want to continue to consider as we project forward.

21 DR. CROSSON: Thank you. Jon.

22 DR. CHRISTIANSON: Yes, I was going to say

1 something very similar to what David just said. You know,
2 Pat is worried, I think rightly so, about that declining
3 margin graph. I worry a lot about the graph that Jeff has
4 produced that shows the increasing difference between what
5 hospitals tell us their costs are and what they get paid in
6 the private sector. And it's astounding. It's 50 percent
7 above what they say their costs are they're now getting
8 paid on average by private payers. And so what that means
9 going forward for, you know, the Medicare program and how
10 we look at margins for Medicare, I think we need to
11 continue to discuss, and we'll have, you know,
12 disagreement. I think we've heard disagreement today how
13 much of that actually gets reflected in higher costs in the
14 future and how does that relate to Medicare margins. So
15 probably David and I and Jeff will take on that, but other
16 people will say, well, it's necessary because it's a cross-
17 subsidization issue. And all that's going to be important
18 in terms of how we look at this margin, because it's margin
19 relative to the hospital self-reported costs, and that is,
20 again, as David was saying, not fixed on the basis of a lot
21 of management decisions.

22 So I don't see that differential declining, and

1 to the degree that that continues to grow, I think that's
2 going to have huge implications for how we view hospital
3 prices that Medicare should pay.

4 DR. CROSSON: Okay. Alice.

5 DR. COOMBS: Thank you very much. So I looked at
6 the graph, and what I immediately thought about was the
7 disproportionate share hospital, and if that's the
8 culmination of all the hospitals, what must the DSH
9 hospitals look like?

10 I think, correct me if I'm wrong, didn't we look
11 at -- in your chart you have nonprofit, profit, academic,
12 non-academic. Didn't we put disproportionate share
13 hospitals in there awhile back?

14 DR. STENSLAND: We may have. Generally, the DSH
15 hospitals do a little better on Medicare because they get
16 the DSH money.

17 DR. COOMBS: Right.

18 DR. STENSLAND: And they do a little worse on the
19 total margin because they don't have the private payers.

20 DR. COOMBS: So I would like to know, especially
21 in reference to the uncompensated care in 2016, what has
22 happened, because I think that is going to present a

1 different scenario. The drivers specifically for the
2 margins in the disproportionate share hospitals are the
3 costs of the drugs, the drugs are fixed. A few weeks ago,
4 I went to drop tPA on a patient, \$11,000, it doesn't matter
5 if you're a DSH share hospital or not. That was the charge
6 master on that drug. And I think, you know, obviously, the
7 other fixed costs that we talk about, but I'd be interested
8 in the DSH share hospital.

9 And then I think we talked about there might be
10 an overlap between the academic and the disproportionate
11 share hospitals, but you can't assume that they're the same
12 thing.

13 DR. CROSSON: Thank you. Further comments?

14 [No response.]

15 DR. CROSSON: Okay. Seeing none, we've had a
16 good discussion. We're coming back in January. I think
17 we'll have a little bit more discussion on this topic. I
18 think some good issues have been raised, and I'd like to
19 hear a little bit more discussion when we meet in January.

20 So let's move on to the final presentation of the
21 morning. Thank you very much, Stephanie, Zach, Jeff.

22 [Pause.]

1 DR. CROSSON: Okay. We're going to take on
2 payment adequacy and recommended update for ambulatory
3 surgical centers. We've got Dan and Zach. Zach, you have
4 no rest here, I guess.

5 MR. GAUMER: Yeah. No rest.

6 DR. CROSSON: You're up again.

7 DR. ZABINSKI: No rest. Okay. In our assessment
8 of payment adequacy for ambulatory surgical centers, we
9 used the following measures: access to care as measured by
10 capacity and supply of providers and the volume of services
11 access to capital, and aggregate Medicare payments. We
12 also have quality data but we have some concerns about
13 those data, and Zach will discuss the quality data later in
14 this presentation. And finally, we're not able to use
15 margins or other cost-dependent measures because ASCs don't
16 submit cost data to CMS.

17 Important facts about ASCs in 2016 include that
18 Medicare payments to ASCs were nearly \$4.3 billion, the
19 number of fee for service beneficiaries served in ASCs was
20 3.4 million, and the number of Medicare-certified ASCs was
21 5,532. Also, the ASC payment rates will receive an update
22 of 1.2 percent in 2018, and, finally, most ASCs have some

1 degree of physician ownership.

2 We think it's important to compare ASC with
3 hospital outpatient departments because OPDs are the
4 setting that's most similar to ASCs, and the ASC payment
5 system is based on the outpatient prospective payment
6 system. There are some benefits to having surgical
7 services provided in ASCs rather than OPDs because ASCs
8 offer efficiencies over OPDs such as shorter waiting times
9 for patients and greater control over the work environment
10 for physicians. In addition, ASCs have lower Medicare
11 payment rates than OPDs, which can result in lower payments
12 for Medicare and lower cost-sharing for patients. However,
13 encouraging greater use of ASCs should be considered
14 alongside the issue that most ASCs have some degree of
15 physician ownership, which raises concerns about induced
16 demand.

17 Finally, relative to OPD patients, ASC patients
18 are less likely to be dual eligible, minority, under age
19 65, or age 85 or older. There appear to be a number of
20 underlying causes, including the fact that ASCs tend to be
21 in higher-income locations.

22 So in our assessment of payment adequacy, we use

1 the measures that we discussed on Slide 2. Also, we are
2 unable to use margins or other cost-dependent measures
3 because ASCs don't submit cost data to CMS.

4 On this table, the values for measures of payment
5 adequacy in the second column indicate a stable situation
6 in 2016. First, the number of fee for service
7 beneficiaries served and the volume of services per fee for
8 service beneficiary decreased slightly, while the number of
9 Medicare-certified ASCs and the Medicare payment per fee
10 for service beneficiary both increased. The rates of
11 increase in 2016 were similar to the rates of increase over
12 the 2011 through 2015 period.

13 Factors that may have contributed to the slowdown
14 in volume in 2016 include increasingly higher Medicare
15 payment rates when a service is provided in an OPD than in
16 an ASC, and this may have caused a shift of services from
17 ASCs to OPDs, especially for GI and pain management
18 services. Also, more physicians are becoming hospital
19 employees, so they may be more inclined to provide surgical
20 services in hospitals instead of ASCs.

21 ASCs are shifting their resources from lower
22 intensity services, such as injections for pain management,

1 to higher intensity services, such as implanting spinal
2 neurostimulators.

3 To evaluate ASCs' access to capital, we examined
4 the growth in the number of ASCs, because capital is needed
5 for new facilities. A positive growth of 1.4 percent in
6 the number of ASCs in 2016 indicates that access to capital
7 has been adequate. In addition, there has been a fair
8 amount of acquisitions and partnerships with ASCs by
9 hospital groups and other health care companies. Also, it
10 is important to understand that Medicare is a small part of
11 ASCs' total revenue, perhaps 20 percent. Therefore,
12 Medicare payments may have a small effect on decisions to
13 create new ASCs.

14 Now I turn to Zach who will discuss ASC quality
15 and our draft recommendations.

16 MR. GAUMER: In 2012, ASCs began submitting their
17 quality data and in 2014, CMS began reducing payments by 2
18 percent for ASCs that failed to submit those data. Based
19 on the first three years of quality data we observe slight
20 improvement in the performance of ASCs in some measures.
21 As you can see on the table above, the first three rows
22 display adverse event measures, the level of these adverse

1 events is extremely low, and frequency of these events
2 declined from 2013 to 2015.

3 However, other measures show opportunities for
4 potential improvement for ASCs. The last two rows display
5 relatively low levels of the share of ASC staff receiving
6 flu shots, and the share of patients with a history of
7 polyps receiving post-colonoscopy surveillance. These two
8 rates are substantially lower than 100 percent and thus
9 suggest ASCs have room to improve.

10 In addition to the performance-related
11 improvements we have identified, we also believe the ASCQR
12 program itself could be improved upon. First, CMS should
13 reduce the deficiencies in ASC data reporting. Roughly 5
14 percent of ASCs received reduced payments in 2017, because
15 of their failure to sufficiently report data to CMS. In
16 terms of individual measures, 20 percent of ASCs did not
17 report data for the flu vaccination measure and 98 percent
18 of ASCs did not report data for the voluntary cataract
19 surgery measure.

20 CMS should also strengthen the list of measures
21 used for the ASCQR. To their credit, CMS made changes to
22 the measures in 2018, that were consistent with the

1 Commission's comments last year. What they did was they
2 removed three process measures that were topped out, they
3 added two measures of subsequent hospitalizations for
4 specific procedures. The Commission prefers that CMS use
5 claims-based outcomes measures within the ASCQR, and while
6 they have started to do that, we believe that they could
7 consider other measures of subsequent hospitalizations that
8 apply to all types of ASCs, or surgical site infection
9 measures.

10 Finally, CMS should consider the Commission's
11 2012 recommendation to implement a value-based purchasing
12 program.

13 To summarize our ASC findings, indicators of
14 payment adequacy suggest access is good. In 2016, the
15 number of fee for service beneficiaries served at ASCs and
16 the volume of ASC services per beneficiary declined very
17 slightly, suggesting a stable status. Medicare payments to
18 ASCs per beneficiary increased. In addition, the number of
19 ASCs increased. The increase in ASCs also suggests access
20 to capital is good, and the various ASC acquisitions we
21 observed over the last two years also suggests ASCs remain
22 an attractive investment.

1 Initial quality data shows slight improvement in
2 some measures, and we reporting deficiencies do persist and
3 the measures used in the program should be strengthened.

4 We remain concerned that ASCs do not submit cost
5 data, even though the Commission has recommended doing so.
6 The cost data could be used to develop an input price index
7 and better assess payment adequacy.

8 For the Commission's consideration, the Chairman
9 has the following draft recommendation. The Congress
10 should eliminate the calendar year 2019 update to the
11 payment rates for ambulatory surgical centers. Given our
12 findings of payment adequacy and our stated goals,
13 eliminating the update is warranted. This is consistent
14 with our general position of recommending updates only when
15 needed. The implication of this recommendation for the
16 Medicare program is that it would produce small savings.
17 The anticipated statutory update for ASC payments is 1.3
18 percent in 2019, and anything less than that would produce
19 savings.

20 We anticipate this recommendation having no
21 impact on beneficiaries' access to ASC services or
22 providers' willingness or ability to furnish those

1 services.

2 Now changing gears a little bit, dating back to
3 2009, the Commission has combined its ASC update
4 recommendation with language directing the Congress to
5 require ASCs to report cost data. The Congress has not
6 acted on this recommendation and in recent years some
7 Commissioners have expressed frustration. Therefore, what
8 we have done for the 2018 ASC update is to break the ASC
9 update language and the cost-reporting language into two
10 separate recommendations and address the cost-reporting
11 recommendation to the Secretary of HHS, rather than
12 Congress.

13 The rationale for changing our approach on this
14 issue is that Medicare spends over \$4 billion on ASC
15 services. Other small providers submit cost reports, such
16 as hospices, home health agencies, and dialysis facilities.
17 Also, larger organizations are entering the ASCs industry.
18 And finally, maybe most importantly, the Secretary of HHS
19 has the statutory authority to require ASCs to submit these
20 data.

21 So in a separate draft recommendation, the
22 Chairman offers that the Secretary should require

1 ambulatory surgical centers to report cost data.
2 Collecting these data, as Medicare does for other
3 providers, would improve the accuracy of the ASC payment
4 system. The Secretary could limit the burden on ASCs by
5 requiring a cost report that is limited in scope.
6 Implementing this recommendation would not change
7 Medicare's program spending. We also anticipate no effect
8 on beneficiaries. However, ASCs would incur some added
9 administrative costs.

10 Okay. That concludes our presentation. We
11 appreciate your time. And, we would now like to open the
12 session up now. Thank you.

13 DR. CROSSON: Thank you, Dan and Zach. So we're
14 going to do -- here's what we'll do. We'll do a round of
15 clarifying questions and then I think since these two
16 recommendations are substantively related, we'll carry on a
17 discussion on both simultaneously.

18 Clarifying questions. Brian.

19 DR. DeBUSK: On page 4 of the reading materials
20 you talk about the difference -- you know, the ASC
21 reimbursement being linked largely to the OPPIs. You talk
22 about the ASC relative weight difference of 10.1 percent

1 and the conversion factor difference of 45.58 versus 78.64.

2 If I just took the ratio of those and then
3 applied the 10 percent weight difference, is it fair to say
4 that is, you know, with the exception of some of the other
5 things mentioned in the reading, is that the difference
6 between the two fee schedules, in terms of pricing?

7 DR. ZABINSKI: Yeah, it is.

8 DR. DeBUSK: Okay. I'm guessing that's about 60
9 cents on the dollar of the OPPS?

10 DR. ZABINSKI: A little less than that.

11 DR. DeBUSK: A little less than 60 cents.

12 DR. ZABINSKI: Yeah.

13 DR. DeBUSK: Okay. So there's -- we're clearly
14 getting a lower price for the same service.

15 DR. ZABINSKI: Correct.

16 DR. DeBUSK: And under the principles that we
17 should -- Medicare should pay similar rates for similar
18 care, I mean, isn't one of the effects of the ASC, or the
19 effects of ASCs, almost to act like a drag or a weight that
20 would, in theory, pull prices downward, outpatient
21 procedure prices downward?

22 DR. ZABINSKI: Well, if you have a, you know,

1 open, free market, yeah. You know, this is Medicare
2 setting the rates, so, that's a--

3 DR. DeBUSK: But I mean even for Medicare, I mean
4 we could use this as a basis for cost-neutral payments.

5 DR. ZABINSKI: Oh sure.

6 DR. DeBUSK: This is a justification.

7 DR. ZABINSKI: Yeah. We've looked into that a
8 little bit, in I think it was the June 2013 report. We
9 talked about setting neutral payments, both between
10 physician offices and hospitals, and ASCs and hospitals.
11 And then last year, in the chapter for -- in the March 2017
12 report, the chapter for ASCs, we had a small text box on
13 this matter.

14 DR. DeBUSK: Well, just in the name of, again,
15 protecting beneficiaries and taxpayers, aren't we a little
16 bit better off seeing this sector flourish, and maybe then
17 using that growth as a means to pull these rates down
18 overall?

19 DR. MATTHEWS: So if I could weigh in a little
20 bit here, I think, you know, the value judgment of whether
21 or not we want much more ASC volume is something, you know,
22 in your job description. But in making these

1 determinations, one -- Dan is correct. We did -- when we
2 dealt with site-neutral payments between physician offices
3 and outpatient departments we had also identified, I want
4 to say, 10 potential candidate services between ASC and
5 OPDs that could be subject to a site-neutral payment
6 policy. We brought the OPD physician office piece to a
7 recommendation. We did not do so with respect to ASC and
8 OPDs.

9 There are a couple of factors unique to ASCs that
10 we would want to consider in making a companion
11 recommendation, and the other thing we would want to
12 consider before doing so would be, yeah, on the one hand
13 we're paying 60 cents on the dollar for the same service,
14 but is there a potential for increased reliance on ASCs to
15 produce induced demand, given some of the ownership
16 considerations that apply to ASCs?

17 DR. DeBUSK: Thank you.

18 DR. CROSSON: Okay. Jon next.

19 DR. CHRISTIANSON: You know, the induced demand
20 thing is interesting. Dan, you kind of implied that we
21 should be more concerned about ASCs that are owned by
22 physicians, because of incentives for induced demand. I

1 see -- I don't see -- that's not very convincing to me. I
2 think hospitals have incentives to try to fill their ASC
3 suites. I think if they employ the physicians they have
4 productivity components of their salary. I mean, I think
5 it's not a very compelling argument to say that we should
6 be concerned about ambulatory, physician-owned ASCs
7 relative to hospitals because of an induced demand
8 argument.

9 DR. CROSSON: Paul.

10 DR. GINSBURG: Yeah. Actually, before I comment,
11 I agree with Jon. I think we can go overboard about the
12 induced demand risks of ASCs. And I think just the -- I
13 don't think they are very large compared to the induced
14 demand risks of the payments that the surgeon gets for the
15 surgery.

16 I just wanted to ask if you have or are aware of
17 any data on what MA plans tend to pay ASCs, and how that
18 compares to the Medicare rates.

19 DR. ZABINSKI: No, I have no information on that.

20 DR. CROSSON: So, Paul, the implication of that
21 is just --

22 DR. GINSBURG: The implication is that when we

1 are -- actually, I had done a study of what MA plans pay
2 physicians and happened to include durable medical
3 equipment and laboratory services in there, and found that
4 the MA plans pay substantially less than Medicare for those
5 latter categories, and that's just an indicator that
6 Medicare is paying too much. And I think it came up in one
7 of the other memos that we're going to get to this
8 afternoon, about something where the MA plans pay less, and
9 to me, that's a very reliable indicator when Medicare is
10 paying too much.

11 DR. CROSSON: Pat.

12 MS. WANG: You know, to the discussion that Jon
13 and Brian were having, I do think it's interesting and
14 important to keep in mind the difference in the patient
15 profile it seems that exists in ASCs right now, less likely
16 the dual, non-white, disabled, under 65, and therefore
17 eligible for Medicare or really elderly. Now, you know,
18 you could say that maybe that's a function of the payment
19 rates, but for my money, as a taxpayer, I wouldn't even
20 have this conversation until we have more transparency
21 around reporting of costs and quality for this sector.

22 I think it's a big hole. I don't quite

1 understand. The last time we talked about this, I think
2 there was a follow-up letter that was, you know, angry, and
3 pointed out flaws in our -- named Commissioners by name,
4 you know, like this was totally wrong and unfounded. But
5 it seems to -- there seems to still be some major reporting
6 gaps that make it difficult to assess whether this is a
7 sector that one should think we should promote, or not
8 promote.

9 And so I think we -- as a threshold matter, we
10 need more reporting.

11 DR. CROSSON: Okay. Jack.

12 DR. HOADLEY: Yeah, I just wanted to ask, on the
13 collection of class data, I know you had the comment that
14 CMS did put this out and asked for comments and got
15 negative comments from the industry, and obviously, given
16 the choice of not reporting or reporting, that's -- you
17 know, there's going to be a preference for not reporting.

18 But I just -- I'm trying to figure out why this
19 should be -- the industry should be responding differently.
20 I mean, all these other sectors do cost reports. Is there
21 anything that's different in this sector that makes it
22 harder, less reason, from their -- from an industry

1 perspective?

2 DR. ZABINSKI: Well, they're small, you know.

3 DR. HOADLEY: Okay.

4 DR. ZABINSKI: So, you know, we can argue -- I'm
5 -- you know, so they can argue that, you know, they don't
6 have the resources. But other small providers provide cost
7 data as well. You know, that said, I think it is important
8 to understand that they are small and you want to have a
9 rather streamlined situation so it's not overly burdensome
10 on them. But in the end, I don't really see any strong
11 obstacles to them doing something on a small scale.

12 DR. HOADLEY: And we've said in our proposal that
13 something more streamlined and perhaps what a hospital
14 fills out would be appropriate, right?

15 DR. ZABINSKI: Yeah.

16 DR. CROSSON: On that point?

17 DR. GRABOWSKI: Yeah, I was just going to add to
18 that. On page 30 you note that Pennsylvania requires to
19 collect these data, and just as a question, what do those
20 data show? What do the margins look like in Pennsylvania?

21 DR. ZABINSKI: They're like 25 percent. Yeah,
22 they're high.

1 DR. CROSSON: I guess that's a very helpful
2 answer.

3 [Laughter.]

4 DR. CROSSON: Rita?

5 DR. REDBERG: On the topic of induced demand, I'm
6 not -- I don't think that the induced demand in hospitals
7 is similar to that for ASCs because there's a lot more
8 physician discretion in the ASCs. There's physician
9 ownership in the ASCs. There's the waiving for some reason
10 of the Stark laws, the anti-referrals. And there's data
11 that there's induced demand for ASCs. So I don't think we
12 should just dismiss that.

13 And if you look at the list of most frequently
14 provided ASC services, it's very consistent with the
15 demographics. This is, you know, services that are known
16 to overused and of questionable value. You know, all those
17 injections of spines and paravertebral joints are not
18 things that are, you know, high-quality, evidence-based,
19 and we know that colonoscopies and endoscopies are
20 frequently overused and overdone in the Medicare
21 population. So I do think there's concern for induced
22 demand.

1 DR. CHRISTIANSON: So let me clarify what I was
2 saying. It wasn't that there was not induced demand. It's
3 that there probably is induced demand in hospital ASCs as
4 well.

5 DR. REDBERG: There's more.

6 DR. DeBUSK: And if I could just chime in, if
7 there is induced demand from a fee schedule that pays, say,
8 57 cents on the dollar, can you imagine the induction on a
9 fee schedule that pays 100 cents on the dollar? I think
10 there'd be an issue there.

11 DR. REDBERG: There's also what we talked last
12 time about the durable medical equipment and the role of
13 ASCs in that, too.

14 DR. CROSSON: Okay. Questions? Kathy.

15 MS. BUTO: Okay. I have three questions. One of
16 them is we don't seem to be addressing these 2018 update
17 per se. We mentioned in the beginning that it's 1.2
18 percent, but in our recommendation, I guess I'm wondering
19 why we wouldn't also recommend 2018 be zeroed out, not just
20 2019. Am I missing something?

21 MR. GAUMER: I think it's because the 2018
22 payment update is on the books already.

1 MS. BUTO: Okay. So it's --

2 MR. GAUMER: CMS has finalized that already.

3 MS. BUTO: All right. I got it.

4 MR. GAUMER: So that's why we go to '19.

5 MS. BUTO: So even though it's calendar year,
6 it's already been done as part of the November rulemaking
7 or whatever it is.

8 MR. GAUMER: That's correct.

9 MS. BUTO: I would just suggest that it would
10 have been -- knowing what we know about the reluctance to
11 collect cost report data of any kind, even the most simple
12 kind, that would have been something to have maybe
13 suggested.

14 The second question I have --

15 DR. MATHEWS: Kathy, can you be a little more
16 clear on that point?

17 MS. BUTO: Well, I would have liked to have
18 considered maybe recommending -- and I guess we would have
19 had to do this a year ago -- zeroing --

20 DR. CROSSON: We did have this discussion -- I
21 might be wrong.

22 MS. BUTO: We did have this discussion?

1 DR. CROSSON: We did have this discussion a year
2 ago and --

3 MS. BUTO: And we decided --

4 DR. CROSSON: And the notion was, you know, to
5 get the update, you had to do --

6 MS. BUTO: Cost reports. That's what I thought.

7 DR. CROSSON: Cost reporting. I don't know that
8 --

9 MS. BUTO: Maybe we could just modify our
10 language to point out that that's what we recommended last
11 year, and that we feel just as strongly.

12 DR. CROSSON: Did we have that in the
13 recommendation or not? I can't remember.

14 DR. MATHEWS: The cost reporting requirement?

15 DR. CROSSON: Yeah.

16 DR. MATHEWS: Yes, but as Zach said earlier --

17 MS. BUTO: But coupled with the zero update for
18 ASCs.

19 DR. MATHEWS: Correct.

20 MS. BUTO: I thought we had done that.

21 DR. MATHEWS: Correct.

22 MS. BUTO: Okay.

1 DR. CROSSON: Yeah, I --

2 MS. BUTO: It's just that they went ahead anyway
3 and updated per current law.

4 MR. GAUMER: And I think in the mailing materials
5 or in the chapter, we do have some text that indicates how
6 many years in a row we have said go get some cost data.

7 MS. BUTO: No, no. I know the cost data part. I
8 just think we ought to stick with, you know, a la our
9 approach on SNFs and other things, that we ought to look at
10 trying to leverage some of the update more directly.

11 DR. CROSSON: I'm sorry. Let me be clear. So we
12 haven't -- we're still in the questions here.

13 MS. BUTO: Yeah. I was just asking why we didn't
14 address it. He's saying --

15 DR. CROSSON: Yeah, for Round 2, but I'm going to
16 ask you in Round 2, are you suggesting that we add that to
17 Recommendation 2?

18 MS. BUTO: Well, I think it's already
19 Recommendation 1 that 2019 be frozen, right? Zeroed out?

20 DR. CROSSON: Right, so there's no update --

21 MS. BUTO: So there's no need to add it to
22 Recommendation 2.

1 DR. CROSSON: Thank you.

2 MS. BUTO: The Chairman recommended a zero update
3 in 1.

4 [Laughter.]

5 MS. BUTO: Okay. So I have two other more minor
6 questions. One is: Is there still a rule that says
7 something like if a procedure is performed more than 50
8 percent of the time in a physician's office, it cannot be -
9 - it's not eligible for payment as an ASC service? Is that
10 still a rule?

11 DR. ZABINSKI: It's a case of if it's done more
12 than 50 percent of the time in the physician office, they
13 make a comparison between what the payment rate would be at
14 sort of the standard ASC rate-setting amount or the non-
15 facility physician fee schedule.

16 MS. BUTO: And it's the lower --

17 DR. ZABINSKI: It's the lower of the two.

18 MS. BUTO: Lower of those two, okay.

19 DR. ZABINSKI: Yeah.

20 MS. BUTO: So they still do that calculation?

21 DR. ZABINSKI: They still do that.

22 MS. BUTO: Yeah. But there isn't anything

1 similar between the OPD and -- so if something's done more
2 than 50 percent of the time in an ASC, is there some
3 adjustment? No?

4 DR. ZABINSKI: No, there's not.

5 MS. BUTO: Okay. So when we get back to this,
6 just something for us to take a look at.

7 And then the last was: Do all states now certify
8 ASCs? Because there were some states that used to not
9 recognize or license ambulatory surgery centers, and I
10 don't recall if there was any real degradation in services
11 offered to beneficiaries?

12 DR. ZABINSKI: They're available in all states,
13 so I guess it is if they all certify them.

14 MS. BUTO: Okay. Thank you.

15 DR. CROSSON: Okay. Questions? Seeing none,
16 we'll proceed now -- we have two recommendations on
17 different pages. We're going to do them simultaneously.
18 In the material that you have in front of you, they're on
19 page 10 and 12. So those are on the table for discussion.
20 Discussants? Seeing none --

21 PARTICIPANT: No.

22 DR. CROSSON: What? What?

1 [Laughter.]

2 DR. CROSSON: Alice, okay.

3 DR. COOMBS: So, first of all, I really like the
4 chapter. It's excellent. I've actually seen this chapter
5 for five years straight.

6 [Laughter.]

7 DR. COOMBS: And I'd like to say "ditto" to the
8 recommendations that have occurred over and over again.

9 DR. CROSSON: Thank you, Alice. Yes, Bruce?

10 MR. PYENSON: I support the recommendations. I
11 would like to consider an addition to Recommendation 2, if
12 we could go there, which is that we have an opportunity
13 with ASCs, because there is not an existing cost report, to
14 not mimic the current style of cost reports that Medicare
15 has been using for decades, but to sort of move it into the
16 21st century at least, and to move that into some form of
17 genuine cost accounting basis rather than basis of charges.
18 And I think there's a variety of ways to do that from a
19 technical standpoint, including using OPPS groupers or
20 other types of groupers. But in 2018, to not have -- to
21 have businesses say that cost accounting is a burden is not
22 a credible statement, especially since they're not burdened

1 currently by something that's really obsolete.

2 So what I'd ask for is requiring -- to report
3 cost data, but to move that on to a modern cost accounting
4 basis.

5 DR. CROSSON: I'm going to suggest, Brian, I
6 don't disagree with you -- Bruce, I don't disagree with you
7 at all. It always happens. I'm sorry. But I think that's
8 a little, A, too vague and a little bit too complicated to
9 put into the boldfaced recommendation. Would you be
10 satisfied if we, with your help, put that language into the
11 text supporting the recommendation?

12 MR. PYENSON: Sure, but once you see that, you
13 might realize it could get into the bold spot. The
14 answer's yes.

15 DR. CROSSON: Good.

16 [Laughter.]

17 DR. CROSSON: All right. Jack?

18 DR. HOADLEY: I just want to say I support the
19 pair of recommendations, and if there's any way we can
20 print Recommendation 2 in sort of extra boldface, think of
21 any way to sort of state it particularly, you know,
22 language around it that is as aggressive as we can or as

1 strong as we can, it seems like this is just a no-brainer.
2 Obviously, it hasn't helped to say it all the years we've
3 said it.

4 DR. CROSSON: I agree. Just to remind and point
5 out that this is different in the sense that this is going
6 to CMS based on our assumption of authority there. So
7 whether the result will be any different, I'm not clear,
8 but this is -- I don't know whether I would say it's
9 stronger, but it's directed somewhat differently than the
10 past one.

11 DR. HOADLEY: At least if there's a willingness,
12 it's less of an obstacle to get there.

13 DR. CROSSON: Okay. Seeing no other comments,
14 this will be on the January agenda for expedited voting,
15 unless there are objections. Seeing none, that's what
16 we'll do.

17 This concludes the morning session. Thank you,
18 Zach and Dan.

19 We now have time for a public comment period. If
20 there are any members, any guests who would like to make a
21 comment, please come to the microphone now so we can see
22 who you are.

1 [No response.]

2 DR. CROSSON: Seeing none, we are then adjourned
3 until 1:30 this afternoon. Thanks very much.

4 [Whereupon, at 12:30 p.m., the meeting was
5 recessed for lunch, to reconvene at 1:30 p.m. this same
6 day.]

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

1 weights to establish payments in each setting. We went
2 through this approach in some detail, and there was broad
3 support for the idea. So I'm going to go through this
4 material quickly, but the detail is in the paper.

5 Over many years, the Commission has raised its
6 concerns about how Medicare pays for post-acute care.
7 First, beneficiaries with similar conditions may be treated
8 in different settings, each with its own payment system
9 that can result in very different payments for the same
10 service.

11 Second, there is a lack of evidence-based
12 guidelines to base decisions about which beneficiaries
13 would benefit from post-acute care and which setting and
14 how much care would achieve the best outcomes. It is not
15 surprising, therefore, that per capita Medicare spending
16 varies more for post-acute care than for any other service.

17 Third, the current payment system designs
18 encourage providers to furnish therapy services unrelated
19 to patient care needs and to avoid medically complex
20 patients because the relative profitability of different
21 conditions varies widely.

22 Based partly on their mix of patients and therapy

1 practices, providers' financial performance varies. For
2 example, there is more than a 10-percentage-point
3 difference in Medicare margins for nonprofit and for-profit
4 SNFs and more than a 20-point difference for IRFs.

5 As mandated by Congress in 2016, the Commission
6 recommended the design features of a unified payment system
7 and estimated its impacts. We found that a unified payment
8 system would increase the equity of Medicare's payments by
9 redistributing payments across conditions. This
10 redistribution would narrow the relative profitability
11 across conditions, and as a result, providers would have
12 less incentive to avoid medically complex patients.

13 Before implementing a unified PAC PPS, it would
14 be possible to increase the equity in payments within each
15 setting by using a blend of the current setting-specific
16 relative weights and the relative weights from the unified
17 PAC PPS to establish payments. This would begin to
18 redistribute payments across conditions. Total payments to
19 the setting would remain at the recommended level.

20 This chart illustrates the redistribution of
21 payments within and across settings. The Commission
22 recommended that the implementation of the unified PAC PPS

1 begin in 2021, shown at the bottom, and that will
2 redistribute payments across settings. That's the yellow
3 arrow, and that's not what we're talking about today.

4 Today, we're talking about the approach to
5 redistribute payments within each setting, and that's
6 represented by the vertical green bars shown in the upper
7 section of the chart.

8 Payments to each setting would remain at the
9 recommended levels, but by blending the current relative
10 weights and the relative weights from the PAC PPS, the
11 resulting payments would shift across conditions. Payments
12 would be more closely aligned with the cost of care across
13 conditions, so that the equity of payments within each
14 setting would increase.

15 The proposal to blend the relative weights is all
16 about redistributing payments within each setting, and it
17 would not affect the level of payments.

18 Using a blend of the PAC PPS and each setting's
19 relative weights, payments would shift across conditions.
20 Payments would increase for medically complex care and
21 decrease for stays that receive therapy that is not related
22 to a patient's condition.

1 Within a setting, payments to providers would be
2 redistributed based on the mix of conditions they treat and
3 their current therapy practices. As a result of these
4 shifts, payments would increase for nonprofit providers and
5 hospital-based providers and decrease for for-profit
6 facilities and freestanding providers.

7 These changes reflect the mixes of patients they
8 treat and their therapy practices, not their ownership or
9 provider type per se. The redistribution of payments would
10 narrow the financial performance of providers, all else
11 being equal, raising payments to low-margin providers and
12 lowering payments for high-margin providers. And I want to
13 remind everyone that at current levels, aggregate payments
14 to a setting would remain well above the cost of care.

15 In conclusion, it is possible to increase the
16 equity of payments within each setting before implementing
17 a unified PAC PPS. The redistribution would begin to
18 correct the known biases of the current PPS's; increase the
19 equity of payments across conditions so providers would
20 have less reason to prefer to treat certain types of
21 patients and avoid others, like medically complex patients;
22 and encourage providers to begin to make the kinds of

1 changes they will want to make to be successful under a
2 unified payment system.

3 It would also support update recommendations that
4 would more closely align payments to the cost of care
5 without undesirable financial impacts. Some of you will
6 recall that in past years, the Commission has at times been
7 constrained in its update recommendations because of the
8 wide disparities and financial performance across
9 providers.

10 This leads us to the Chairman's draft
11 recommendation, which reads that, "Congress should direct
12 the Secretary to begin to base Medicare payments to post-
13 acute care providers on a blend of the setting-specific
14 relative weights and the unified PAC perspective payment
15 system relative weights in fiscal year 2019."

16 In terms of implications, program spending will
17 not change relative to current law. For beneficiaries,
18 access would be more equitable and would increase for
19 medically complex beneficiaries. Providers would have less
20 incentive to selectively admit beneficiaries, and
21 disparities in Medicare margins across providers would be
22 reduced. The impact on individual providers would vary

1 based on their mix of cases and their current practice
2 patterns.

3 And now we're going to switch gears and consider
4 the SNF update, and before I get started, I wanted to thank
5 Sydney McClendon for her help with this chapter.

6 So I'll start with a sketch of the industry in
7 2016. There were about 15,000 providers and about 1.6
8 million fee-for-service beneficiaries, or just over 4
9 percent used these services. Program spending was about
10 \$29 billion. Fee-for-service Medicare makes up about 11
11 percent of days at the average facility, but 20 percent of
12 revenues.

13 I will be using our adequacy framework, and I'm
14 going to go through this material quickly. The trends and
15 takeaway points have not changed from last year. Medicare
16 payments are high compared with the cost of care, and the
17 payment system still needs to change.

18 Access to SNF services is adequate. In 2016,
19 supply was steady at about 15,000 providers, and 89 percent
20 of beneficiaries lived in counties with at least three SNFs
21 and less than 1 percent lived in a county without a SNF.
22 Occupancy rates were down slightly but remained high at 85

1 percent.

2 Between 2015 and '16, covered admissions
3 decreased, consistent with the decline in inpatient
4 hospital stays, which is required for Medicare coverage.
5 Stays were shorter, so total days declined. These changes
6 are consistent with expanded MA enrollment and in
7 alternative payment models and are not a signal about the
8 adequacy of Medicare's fee-for-service payments.

9 For years, we've reported on the growing
10 intensity of therapy provision and how this trend reflects
11 the biases of the payment system and not changes in patient
12 characteristics.

13 Since 2002, the share of days classified into the
14 intensive therapy case-mix groups increased from 27 percent
15 to 83 percent in 2016. This growth reflects the design
16 feature of the payment system, which uses the amount of
17 therapy to assign patients to case-mix groups.

18 Further, our work has found that as more therapy
19 is furnished, providers' costs increase, but payments
20 increase even more, so furnishing more therapy is more
21 profitable than furnishing less. The Commission first
22 recommended revising the PPS in 2008.

1 Turning to quality measures, performance was
2 mixed, with small changes from 2015. We track three groups
3 of risk-adjusted measures: discharge to the community,
4 potentially avoidable readmissions -- and here, we look at
5 readmissions during the stay and for 30 days after -- and
6 changes in function.

7 Between 2015 and 2016, the average facility rates
8 of discharge back to the community improved, while the
9 readmission rates were slightly worse, and the function
10 measures were the same. The material in the chapter shows
11 the variation in rates, which suggests room for
12 improvement.

13 Turning to access to capital, industry analysts
14 report that capital is generally available and expected to
15 remain so in 2018. Buyer demand remains strong, fueled by
16 the aging demographics and the setting's lower cost
17 compared to other institutional post-acute care.

18 Some lender wariness reflects the lower service
19 use by MA and alternative payment models, such as ACOs and
20 bundled payments, and the Department of Justice's
21 investigations into therapy practices. That said, Medicare
22 continues to be a provider of choice by those providers.

1 In 2016, the average margin for freestanding
2 facilities was 11.4 percent, and that's the 17th year in a
3 row that the average was above 10 percent. These margins
4 show why Medicare is a preferred provider.

5 Across facilities, margins vary substantially.
6 One quarter of SNFs had margins of .7 percent or lower, and
7 one quarter had margins of at least 20.2 percent. There
8 continue to be a large difference in Medicare margins
9 between for-profit and not-for-profit facilities, in part
10 due to their differences in patient mix and therapy
11 practices, but also because on average nonprofit facilities
12 are smaller. They have higher costs per day and in recent
13 years have had higher cost growth compared with for-profit
14 providers. The marginal profit was 19.6 percent,
15 indicating that facilities with free beds would have an
16 incentive to admit Medicare patients.

17 To understand differences in performance, we
18 identify a set of efficient providers and compare them to
19 other SNFs. Efficient providers are those that perform
20 well on both cost and quality metrics for three years in a
21 row, and the definition is in the paper.

22 The metrics we use here are standardized cost per

1 day, rates of readmission during the SNF stay, and
2 discharge to community.

3 In 2016, there were 970 or about 8 percent the
4 11,000 that we included in our analysis that were
5 relatively efficient. Two-thirds were identified as
6 efficient last year.

7 Compared to other SNFs, efficient providers had
8 higher community discharge rates and lower readmission
9 rates. Because they typically were larger and had higher
10 daily census, they achieved greater economies of scale.
11 Their standardized costs were 8 percent lower than other
12 SNFs.

13 On the revenue side, revenues per day were 10
14 percent higher, in part reflecting their higher share of
15 the most intensive therapy case-mix days.

16 The combination of their lower costs and their
17 higher revenues per day results in an average Medicare
18 margin of over 18 percent.

19 We also looked SNFs that have high margins and
20 SNFs that have low margins and drew similar conclusions
21 about financial performance being driven by both cost and
22 revenue strategies.

1 In assessing the level of payments, we also
2 looked at payment rates that some managed care and MA plans
3 pay for SNF care. In three publicly traded companies that
4 operate SNFs, fee-for-service payment rates averaged 21
5 percent higher than the MA/managed care payment rates.

6 A survey conducted by the National Investment
7 Center for Senior Housing and Care found similar
8 differences, with MA rates about 15 percent lower than fee-
9 for-service rates. Our analysis of the characteristics of
10 SNF users enrolled in MA and fee-for-service concluded that
11 the users are not that different and would not explain
12 these differences. The publicly traded firms also report
13 seeking managed care business, suggesting that the MA rates
14 are attractive.

15 To project the average 2018 margin, we assumed
16 that costs will grow at the market basket between 2016 and
17 2018, and we also factored in CMS's estimates of the cost
18 to comply with the revised nursing home regulations.

19 To project revenues, we updated payments by the
20 estimated market baskets, net of productivity, and for
21 2018, the share of the 2 percent withhold for value-based
22 purchasing that be retained by the program as savings.

1 The estimated average Medicare margin for
2 freestanding SNFs in 2018 is 9 percent.

3 In considering how payments should change for
4 2019, the broad circumstances of the SNF industry have not
5 changed. Medicare SNF margins have been among the highest
6 of any sector for 15 years. The PPS continues to favor the
7 provision of therapy and needs to be revised. With wide
8 variation in Medicare margins, these reflects differences
9 in patient selection, service provision, and cost control.

10 The continued trends lead to the Chairman's draft
11 recommendation, and it reads, "The Congress should
12 eliminate the market basket for fiscal years 2019 and 2010,
13 direct the Secretary to implement a redesigned prospective
14 payment system in fiscal year 2019, and direct the
15 Secretary to report to the Congress on the impacts of the
16 revised PPS and make any additional adjustments to payments
17 needed to more closely align payments with the costs in
18 fiscal year 2021."

19 Like the proposed recommendation to blend the PAC
20 PPS and setting-specific relative weights, the
21 implementation of a revised SNF PPS would redistribute
22 payments across conditions and narrow the profitability

1 differences across providers. Based on their mix of
2 patients and current practices, payments would shift across
3 providers. The redistribution across providers would
4 enable the Commission to recommend, and for policymakers to
5 implement, a level of payments that is more closely aligned
6 with the cost of care.

7 In terms of implications, the recommendation
8 would decrease spending relative to current law.

9 For beneficiaries, we do not expect adverse
10 impacts on beneficiaries, and we expect access to increase
11 for medically complex patients.

12 Given the level of Medicare margins, we expect
13 providers to continue to be willing and able to care for
14 beneficiaries. The impact on individual providers would
15 vary based on their mix of cases and their current practice
16 patterns.

17 On average, the recommendation would shift
18 payments from freestanding SNFs and for-profit SNFs to
19 hospital-based and non-profit providers. As a result, the
20 recommendation would reduce disparities in Medicare margins
21 across providers.

22 And finally, as recommended by PPACA, we report

1 on Medicaid trends in nursing home spending and utilization
2 and financial performance, and I've included that
3 information in the chapter.

4 And with that, I look forward to your discussion.
5 Should I put up the first recommendation?

6 DR. CROSSON: Let's --

7 DR. CARTER: Let's see where we are?

8 DR. CROSSON: Let me -- yeah.

9 So I'm going to at great risk to myself -- I'm
10 going to try to sort of explain it here so we can have an
11 efficient discussion, but I may not be successful.

12 I'd like to take all of this together. We'll see
13 how that's going to work because they are interlocked to a
14 certain degree.

15 So the first discussion, the first presentation,
16 was pretty much what we heard last month, and that applies
17 to all the post-acute care providers that we have
18 considered within this category.

19 As you may remember, we've already agreed to
20 forward a recommendation for a unified PAC PPS, which would
21 begin in 2021. What Carol has brought up here -- and
22 again, it was discussed last month -- was the notion of

1 within -- that said, within each specific post-acute care
2 provider, between now and then, to on a blended basis
3 redistribute payments based on the actual care that was
4 being delivered across all those PAC providers.

5 The second presentation is on just skilled
6 nursing facilities, and just for 2019 -- or 2019 and 2020,
7 and that asked us to recommend no update based on the
8 adequacy of margins but to also come back again -- correct
9 me, Carol, if I'm wrong here -- with the notion that the
10 PPS within skills nursing facilities should also be
11 revised. And this is based on prior work because it's
12 inaccurate and it could be better.

13 So did I get it?

14 DR. CARTER: That's it. Mm-hmm.

15 DR. CROSSON: So I think I'm going to suggest we
16 try to take that altogether. So we'll do clarifying
17 questions, and then we will come back and have a
18 discussion, and then we'll see where we are on the two
19 recommendations, okay?

20 So clarifying questions. I saw Pat's hand, Jack,
21 Alice.

22 Did I confuse you?

1 DR. COOMBS: Yeah, just for a better
2 understanding. So one is like a Phase 1 part in terms of
3 dealing with the interim between now and 2021? Is that the
4 first part that we're going to deal with?

5 DR. CROSSON: The first presentation is interim.

6 DR. COOMBS: Right.

7 DR. CROSSON: Assuming that the unified PAC PPS
8 is implemented, correct. Okay. So I didn't see that. So
9 Pat and then Jack.

10 MS. WANG: This is just to clarify again the
11 recommendation. The recommendation to eliminate the market
12 basket update for SNF as well as the recommendations for
13 all of the other PAC sector is not contingent on
14 implementation of our recommendation for an early phase-on.

15 DR. CROSSON: That's correct, because we're
16 making recommendations for 2019 or in this case 2019 and
17 2020.

18 MS. WANG: Okay.

19 DR. CROSSON: That assumes perhaps 2021.

20 MS. WANG: So our recommendations on the update
21 factor are what they are regardless of what happens.

22 DR. CROSSON: That's correct.

1 MS. WANG: Okay.

2 DR. CROSSON: Jack?

3 DR. HOADLEY: And I had a somewhat similar
4 question about the interaction between the recommendations
5 in the two things. In terms of the redesigned PPS that
6 we've been talking about for a long time, is there any
7 sense in which that becomes moot if we move on to the
8 blended rates and the overall PAC PPS? Or are we
9 suggesting that they should be doing -- implementing this
10 while also starting to blend towards the new PAC PPS?

11 DR. CARTER: That is the latter. So we thought
12 that CMS should proceed with its plans, and it does have
13 plans to redesign the SNF PPS for fiscal '19. And so then
14 we would be blending those relative weights with the PAC
15 PPS relative weights.

16 DR. HOADLEY: That's what I thought.

17 DR. CARTER: Yes, that would be the timing we had
18 in mind.

19 DR. HOADLEY: And my other question is on Slide
20 14 on the readmission rates. You saw this small tick
21 upwards in the readmission rates. Is your sense that
22 that's something to be particularly concerned about or this

1 may really be more of a statistical aberration? What's the
2 feel of it?

3 DR. CARTER: Yeah, I looked into that a little
4 bit. So I think it's really more in the aberration
5 category because days declined and admissions declined, you
6 had readmissions, but they were spread over a smaller base,
7 if you will, and so you did see a small uptick.

8 DR. HOADLEY: So perhaps wait to be concerned,
9 and if we see a couple years in a row of this --

10 DR. CARTER: Right, right.

11 DR. HOADLEY: Okay. Thank you.

12 DR. CROSSON: David.

13 DR. GRABOWSKI: Thanks. Great chapter, Carol. I
14 wanted to ask you about Slide 18, which was the comparison
15 of managed care and fee-for-service payment rates.

16 First, to pick up on the thread that Paul started
17 earlier, I really like these data and would love to see
18 this for all the different sectors that we talk about. I
19 find this fascinating. I know, as Paul said, there's a
20 developed hospital and physician literature around these
21 comparisons, but in some of the other areas, I don't think
22 we know a lot about MA and fee-for-service differences. So

1 I like this a lot.

2 My question was really around that first bullet
3 and the data you included in the report. You have these
4 differences, and you go on to suggest that the patients are
5 relatively similar, yet it's not an apples-to-apples
6 comparison because you're not saying for a given RUGs group
7 this is the payment rate for MA and this is for fee-for-
8 service, correct? It's sort of this is an aggregate what
9 MA's paying and fee-for-service, and then kind of
10 underneath that, the patients look relatively similar, but
11 it's not sort of -- for this particularly -- for 500
12 minutes of therapy, this is what MA would pay, this is what
13 fee-for-service -- and I think that would be really
14 interesting if there's any way to kind of back that out,
15 unless I've misunderstood it.

16 DR. CARTER: So the first -- when we compare
17 patient characteristics, we pull this information off of
18 the MDS, and so it's across, and you can sort those
19 patients by whether they're enrolled in MA or fee-for-
20 service. And I guess I could tie those to the RUG groups,
21 but what you said is right. These are in aggregate. And,
22 of course, the changes in patient characteristics are

1 across all of MA or all of fee-for-service, whereas the
2 rates are just for the specific companies -- well, in the
3 three cases, they're what they reported in their 10-Ks.
4 But for the survey, that's a sample of 2,000 providers or
5 something like that.

6 So it's a bit of a mix, you know, comparison, but
7 I thought it was useful just as a benchmark of, like, well,
8 some of these firms find these 15 percent lower, 20 percent
9 lower rates still attractive. So it's telling you
10 something about the Medicare rates. So it's more as a
11 benchmark, I think. You know what I mean.

12 DR. GRABOWSKI: It's absolutely interesting, and
13 I'd love to see more of it. We're totally in agreement
14 there. I was just trying to improve the comparison, if you
15 will. I think it's fascinating. Thanks.

16 DR. CROSSON: Jon.

17 DR. CHRISTIANSON: So I was reading through the
18 chapter, and I was struck on page 14 where you talked about
19 this sort of share of days that were classified as
20 intensive therapy and how it's increased over time. And
21 you went on and said you couldn't seem to find
22 justification for that in terms of ADLs and other things.

1 And then we went back to the discussion of
2 efficient SNFs. Back on page 39, you have a table,
3 Financial Performance of Relatively Efficient SNFs, and
4 compared those to other SNFs. And it seems like the
5 relatively efficient SNFs with the high margins are the
6 ones that also had the relatively high share, ultra-high
7 therapy days. So are we basically saying, implying that a
8 SNF that's efficient is the one that's able to get most of
9 its patients into high-therapy categories for reimbursement
10 purposes, and that's why they have high margins relative to
11 other SNFs?

12 DR. CARTER: Well, I guess what I would say is to
13 get into the efficient group -- so classifying -- I guess I
14 would say two things. One is classifying patients is to me
15 kind of a revenue strategy, and the efficient provider
16 analysis is looking at costs and quality metrics. So it's
17 true that high margin and relatively efficient have low
18 costs and good quality, and they also have -- I mean, part
19 of their margin is a reflection of the high therapy days.
20 But I don't see being -- the definition of "efficient"
21 doesn't have to do with their therapy strategy.

22 DR. CHRISTIANSON: Well, to get to be efficient,

1 they have to have good margins and good quality, right?

2 DR. CARTER: They have to have low cost.

3 DR. CHRISTIANSON: Okay. Which can mean good
4 margins. In this case it's --

5 DR. CARTER: It can, but it wouldn't haven't to
6 be. Right.

7 DR. CHRISTIANSON: But, in general, it's true
8 that what we're calling efficient SNFs are also ones that
9 are more successful at having more patients in the high
10 therapy categories.

11 DR. CARTER: Those are all true, but I'm not sure
12 they're causal, but yes.

13 DR. CHRISTIANSON: Yeah, yeah. Well, it worries
14 me that they might be.

15 DR. CARTER: Right.

16 DR. CROSSON: Okay. Yes, Bruce?

17 MR. PYENSON: Carol, the question on the table
18 that showed the per diems for managed care versus fee-for-
19 service, do you have information as well on the relative
20 lengths of stay for managed care and fee-for-service?

21 DR. CARTER: That I don't know. I'll look. I'll
22 look. That's an easy thing to look for. I didn't notice

1 it, but I wasn't particularly looking for it. Okay.

2 DR. GRABOWSKI: My sense from the literature,
3 Bruce, is that managed care have shorter lengths of stay,
4 but that's kind of been the result.

5 DR. CARTER: Yeah, right, and the [off
6 microphone] -- some of the capital analysts talk about that
7 as a trend that, you know, some of their volume declines
8 are the shorter lengths of stay by ACOs and managed care,
9 but I haven't looked -- I can look just to see if we have
10 some data points.

11 MR. PYENSON: Another question on the percentage
12 discharged to community, does that include admissions to
13 the nursing home who had gone to a hospital from the
14 nursing home? That is, is it discharge to the community or
15 is it return to the community?

16 DR. CARTER: The discharge to -- so I'm not sure
17 I understood your question. The discharge community does
18 not include patients who were discharged to the nursing
19 home if they were living there. So it is just discharged
20 to the community. We've talked about -- given the risk
21 adjustment, I think we adjust a little bit for the
22 comorbidities of the patients, but it doesn't -- narrowly,

1 it does not include the patients who are discharged to a
2 nursing home.

3 MR. PYENSON: Just so I understand, so if a
4 patient is living in a nursing home, they get admitted to
5 the hospital, stay three days, get sent to a SNF, is that
6 patient in the denominator?

7 DR. CARTER: So if they went to the SNF, they're
8 in the readmission measure, but they would not be included
9 -- if then they go back to living in the nursing home,
10 they're not included in the discharge to community measure.

11 MR. PYENSON: Okay. Thank you.

12 DR. CROSSON: Brian.

13 DR. DeBUSK: I had a question on Chart 4 of the
14 first presentation that spoke to using a blend of the PPS
15 versus these venue-specific payments. I think I have a
16 general idea of how that blending would be done, but could
17 you walk me through the mechanics? You know, for example,
18 one of these is the home health agencies that are on, say,
19 60-day OASIS payment periods. How would you blend, for
20 example, something that may be recertifies for a second
21 OASIS period 50 percent of the time, how do you blend that
22 with the PAC PPS, which is a lump sum payment? Could you

1 just kind of walk me through the mechanics of how that
2 blending would be done?

3 DR. CARTER: Yes. So the PAC PPS and the home
4 health in this case are both episode-based because the PAC
5 PPS is a discharge-based payment system. So if you got
6 recertified, you would have two payments, just like you
7 would under the home health PPS. So that actually would
8 stay the same.

9 In terms of the mechanics -- and this is not
10 something -- this is something that CMS does when
11 introducing a new payment system. It often during a
12 transition has to run parallel systems, and that's what we
13 would be implying here, is under the PAC PPS the stay --
14 the payment for the stay would be calculated, and the home
15 health in this example would -- the PPS for that would
16 calculate the payment, and it would be a blending of the
17 two.

18 DR. DeBUSK: So, for example, in the SNF venue,
19 would you have to take the PAC PPS payment and then use the
20 average length of stay for that particular SNF RUC and then
21 calculate a per diem to blend those two? I mean --

22 DR. CARTER: Yeah, the SNF one's a little bit of

1 a wrinkle just because that's a per day payment system, and
2 so you would have to either -- in one way or the other --
3 because CMS has to have a per day payment system, that's in
4 statute. And so you would have to calculate what the PAC
5 PPS rate would be and then put it on a per day basis.

6 DR. DeBUSK: So just operationally you would
7 calculate the PAC PPS, then translate it into the
8 equivalent payment method of the target venue.

9 DR. CARTER: Right, right. And except for SNF,
10 which is a per day. The other ones are a stay or episode-
11 based. And so there isn't -- there's no translation in
12 terms of the unit of service.

13 DR. DeBUSK: Okay. Maybe offline I'll have some
14 questions on the home health.

15 DR. CARTER: Okay.

16 DR. DeBUSK: Because from what I understand, the
17 home health, some run one OASIS payment, some recertify.

18 DR. CARTER: Yes, but even when they recertify,
19 they're getting another 60-day payment.

20 DR. DeBUSK: Okay, so --

21 DR. CARTER: So it's just triggering another
22 stay.

1 DR. DeBUSK: So the PAC PPS episodes would align
2 with OASIS periods?

3 DR. CARTER: Yeah, and I guess -- and I don't
4 mean to quibble, but the PAC PPS isn't an episode-based
5 payment. It's a discharge-based payment system, so maybe
6 that's what you're confused about?

7 DR. DeBUSK: Well, that's what I'm getting hung
8 up on, is OASIS is a 60-day episode, from what I
9 understand.

10 DR. CARTER: Right.

11 DR. DeBUSK: I'll take it offline. I'll figure
12 it out.

13 DR. CARTER: Okay. Good.

14 DR. DeBUSK: Thanks.

15 DR. CROSSON: All right. More questions? Seeing
16 none, Carol, could you put up the recommendation from the
17 first presentation? That's Slide 7. So we'll take each of
18 these recommendations in turn. So we're now open to
19 comments on this draft recommendation. Kathy.

20 MS. BUTO: I support the recommendation, and I
21 would also note that if Congress were to in the interim
22 need to look for savings from these PAC provider payment

1 streams, they could take the savings, and you could still
2 do the blended approach if CMS and Congress decide that
3 makes sense. In other words, you could take down the total
4 amount in each of those buckets and still do a blended
5 payment. So I like it because it doesn't interfere with
6 that.

7 DR. CROSSON: Yes, Alice?

8 DR. COOMBS: I support the recommendation.
9 Excellent job, Carol. And I'm wondering if there can be
10 more lessons learned just in this interim period of the
11 blended, because I think that if you see that behavior
12 changes in one industry of your group, then it may actually
13 dictate what the future's going to look like once we get to
14 our unified PAC PC.

15 DR. CROSSON: Jack.

16 DR. HOADLEY: I support this recommendation. I
17 like what Alice just said in terms of, you know,
18 emphasizing that we could learn from some of the impacts.

19 The only other thing I was going to add on this
20 was last year in sort of the PAC preamble chapter, we
21 talked about the cumulative impact of our past unused
22 recommendations, if that's the right term, and it seemed

1 like that would fit in quite well and continuing to make
2 the points about, you know, this blending is dealing with
3 the distributional stuff, but we still have this issue of
4 sort of a cumulative question of rates being too high, and
5 it seemed like those were very effective numbers that we
6 built, and it just seems like it would be useful to build
7 those into that chapter and pretty straightforward to do
8 so.

9 DR. CROSSON: I agree. David.

10 DR. NERENZ: Thanks again, Carol. Good work as
11 always. I do support the recommendation and just emphasize
12 that I understand it does not move money among the PAC
13 areas, but I like what it does about getting rid of some
14 perverse incentives and some inequities within them, and
15 for that reason I support it.

16 DR. CROSSON: Okay. I have heard no lack of
17 support. I'm looking for sort of a bobblehead consensus.
18 I'm seeing that and, therefore, without objection, we'll
19 move this particular part to expedited voting at our
20 January meeting.

21 So, Carol, let's move along to the
22 recommendations with respect to payment in 2019, and we've

1 got Slide 21. So these recommendations or this
2 recommendation with its parts are open for discussion.
3 Amy.

4 MS. BRICKER: I support the recommendation and to
5 double-click on the cost reporting, I think that that's
6 important. So I support the recommendation in total.

7 DR. CROSSON: Again, I see a lot of support for
8 this. It's consistent with recommendations previously,
9 and, therefore, without objection, we'll move that forward
10 to expedited voting in January as well. Seeing no further
11 comments, Carol, thank you very much for this work and all
12 your work. Yes, Kathy?

13 MS. BUTO: Carol, just before you leave, do you
14 think it's really feasible -- I'm just curious -- feasible
15 time-wise for CMS to implement the PAC PPS beginning in
16 2019? What's your sense of that?

17 DR. CARTER: Just using the relative weights?

18 MS. BUTO: Yeah.

19 DR. CARTER: I think so, but we haven't talked
20 with them about that.

21 DR. MATHEWS: We've talked with them a little bit
22 about it, so, as you know, we give CMS a heads up in

1 advance of each meeting, and CMS did point out that while
2 we have a set of unified PAC PPS relative weights sitting
3 on a shelf in which we have great confidence, the agency in
4 order to comply with, you know, their obligations under the
5 Administrative Procedure Act, that kind of thing, would
6 probably have to at least replicate this process on their
7 own, go through a notice and comment in that kind of thing.
8 So while --

9 MS. BUTO: That was my point, because I think it
10 generally takes about a year to do notice and comment
11 rulemaking.

12 DR. MATHEWS: Yes, so from an analytic
13 perspective, yes, this is feasible, we believe. But from a
14 true administrative perspective -- yeah.

15 DR. CROSSON: Okay. Carol, thank you so much
16 again. And, Dana, you can now change chairs.

17 [Pause.]

18 DR. CROSSON: And Dana is going to take us
19 through the recommendations for updates for inpatient
20 rehabilitation services.

21 MS. KELLEY: Right. After illness, injury, or
22 surgery, many patients need intensive rehabilitative care

1 including physical, occupational, or speech therapy.
2 Sometimes these services are provided in inpatient
3 rehabilitation facilities, or IRFs. Today, I will briefly
4 review Medicare's payment system for IRFs, including some
5 concerns we have about the system, and then I will present
6 our payment adequacy analysis. In general, we see a
7 continuation of trends we observed last year, when, you
8 will recall, we recommended a 5 percent reduction in the
9 payment rate.

10 In 2016, Medicare spent \$7.7 billion on care
11 provided in about 1,200 IRFs nationwide. There were about
12 391,000 IRF stays in 2016, and on average, Medicare paid
13 almost \$20,000 per case. Per-case payments to IRFs vary
14 depending on patients' condition, level of impairment as
15 measured by the IRF, age, and comorbidity. Medicare
16 accounted for about 60 percent of IRFs' discharges in 2016.

17 To qualify as an IRF, a facility first must meet
18 Medicare's conditions of participation for acute care
19 hospitals. IRFs also must have a medical director of
20 rehabilitation. In addition, an IRF must demonstrate that
21 it is primarily focused on treating conditions that
22 typically require intensive rehab. To that end, IRFs must

1 meet the compliance threshold. Under this rule, at least
2 60 percent of an IRF's patients must have one of 13
3 conditions specified by CMS. IRFs that don't meet the
4 compliance threshold are paid by Medicare under the acute
5 care hospital PPS instead of the IRF PPS.

6 There are also patient requirements for coverage
7 of an IRF stay, one of which is that patients must be able
8 to tolerate and benefit from intensive therapy, which is
9 generally considered to be three hours a day, five days a
10 week.

11 The Commission has made two observations about
12 the IRF payment system that raise concerns. First, we have
13 observed that high-margin IRFs have a different mix of
14 cases than other IRFs do. This suggests that some case
15 types might be more profitable than others. In a future
16 analysis, we plan to assess variation in costs within the
17 IRF case mix groups and differences in relative
18 profitability across the groups.

19 Our second concern is that the Commission has
20 found evidence to suggest that patient assessment might not
21 be uniform across IRFs, and this raises concerns about the
22 integrity of the payment system.

1 Let me remind you of what our previous analysis
2 of patient assessment found. As you will recall, we
3 matched IRF claims and assessment data from 2013 with data
4 from patients' preceding acute care hospital stay. Then we
5 looked at the relationship between patients' condition in
6 the acute care hospital versus that in the IRF. On several
7 dimensions, we found that patients in high-margin IRFs were
8 less severely ill during their preceding hospital stay,
9 compared with patients in low-margin IRFs.

10 But once patients were admitted to and assessed
11 by IRFs, the patient profile changed, with patients in
12 high-margin IRFs appearing to be more impaired, on average.
13 Patients in high-margin IRFs had lower motor and cognition
14 scores, indicating greater functional impairment. These
15 lower scores generally increase payment. This pattern --
16 patients in high-margin IRFs being less severely ill in the
17 hospital but assessed as more impaired in the IRF -- was
18 evident across case types. In fact, we found that at any
19 level of acute care hospital severity, patients in high-
20 margin IRFs were coded with greater impairment. While not
21 definitive, these findings suggest some systematic
22 differences in the way IRFs assess their patients.

1 The difference in motor scores between low-margin
2 and high-margin IRFs was especially wide for stroke cases
3 with no paralysis, and you can see the implications of that
4 difference on this slide, which you've seen before.

5 I want to point out two things. First, as you can
6 see in the bottom row of the chart, stroke cases without
7 paralysis had an average motor score of 35.3 in the lowest
8 margin IRFs, compared with 29.0 in the highest margin IRFs.
9 Higher scores indicate greater function and less need for
10 assistance, and generally result in lower payment. All
11 else equal, for a stroke patient those scores -- 35.3 and
12 29.0 -- result in a difference in payment of over \$4000.

13 The second thing to note is how the motor scores
14 for patients without paralysis compare with those for
15 patients with paralysis. We would expect stroke patients
16 without paralysis to have better motor function than
17 patients with paralysis, and if you look down the columns,
18 that's exactly what you see. In both low-margin and high-
19 margin IRFs, patients without paralysis have higher motor
20 scores than patients with paralysis.

21 But note: high-margin IRFs are giving their
22 stroke patients without paralysis a function score that is

1 virtually the same as the score low-margin IRFs are giving
2 their stroke patients with paralysis.

3 All else equal, the payment for these two stroke
4 cases, with a motor score of 29, would be the same, even
5 though, on average, stroke patients with paralysis have an
6 average length of stay that is more than two days longer.

7 This raises questions about inter-rater
8 reliability in the assessment process, and that's a problem
9 for any payment system. Medicare's payments should be
10 aligned with patient costs, with higher payments made for
11 patients with greater resource needs. For that to happen,
12 providers need to be reasonably consistent in how they rate
13 patients' relative resource needs. If they are not, some
14 providers will receive payments that are too high relative
15 to the costs they incur, while other providers will receive
16 payments that are too low.

17 Our findings led Commissioners to make two
18 recommendations in March 2016, which we reiterated in March
19 2017. First, MedPAC recommended that CMS ensure payment
20 accuracy through focused medical record review, and we
21 encouraged the Secretary to reassess inter-rater
22 reliability across IRFs.

1 Second, MedPAC recommended that CMS reduce
2 potential misalignments between IRF payments and costs by
3 redistributing payments through the high-cost outlier pool.
4 Expanding the outlier pool would increase outlier payments
5 for the most costly cases, and I will come back to that
6 recommendation in a bit.

7 So I'll turn now to our review of payment
8 adequacy for IRFs. We have used our established framework
9 that you've seen already many times today, so we'll start
10 by considering access to care.

11 We first look at the supply of IRFs. In 2016,
12 there were just under 1,200 IRFs nationwide, with more than
13 36,000 beds. As you can see in the facilities column on
14 the chart, only 23 percent were freestanding facilities.
15 But these facilities tend to be bigger, so they accounted
16 for half of Medicare discharges from IRFs in 2016. The
17 number of freestanding IRFs has been growing, and the pace
18 of that growth picked up between 2013 and 2016.

19 Overall, 31 percent of IRFs were for-profit
20 entities. These accounted for half of all cases in 2016.
21 The number of for-profit IRFs grew, on average, 4.7 percent
22 per year between 2013 and 2016.

1 This slide shows the number of IRF cases on a fee
2 for service basis. You can see that use of IRF services has
3 been relatively stable over the last decade. The number of
4 cases per fee for service beneficiary increased 1.4 percent
5 in 2016.

6 We also looked at the quality of care furnished
7 in IRFs, using risk-adjusted measures developed for MedPAC.
8 Overall, we found that quality has improved since we first
9 developed the measures in 2011. The risk-adjusted rate of
10 potentially avoidable readmissions during the IRF stay was
11 2.5 percent in 2016, and was 4.4 percent during the 30 days
12 after discharge. These rehospitalization rates are low
13 compared with those of other PAC settings, and that's not
14 surprising. Remember that IRF patients are selected
15 because they can tolerate and benefit from intensive
16 therapy, which means they tend to be less frail than, say,
17 SNF patients. And IRFs themselves are certified as
18 hospitals.

19 On average, IRFs' patients gain more than 24
20 points in motor function during the IRF stay, and 4 points
21 in measured cognition. But remember that function scores
22 are self-reported. Given our concerns about coding, changes

1 in function must be interpreted with caution.

2 Turning now to access to capital, as I noted
3 earlier, more than three-quarters of IRFs are hospital-
4 based units, which access needed capital through their
5 parent institutions. As you heard this morning, hospitals
6 maintained good access to capital.

7 As for freestanding IRFs, we don't have much
8 information about independents or small chains, which
9 represent about half of all freestanding facilities. The
10 other half of providers in the freestanding IRF category is
11 owned by one large chain. Market analysts indicate that
12 this chain has good access to capital. The company has
13 continued its pursuit of vertical integration, by entering
14 into joint ventures with acute care hospitals to build new
15 IRFs and by strengthening ties between its IRFs and home
16 health agencies.

17 This is a strategy we are seeing in several large
18 post-acute care companies. The companies believe that
19 providing a continuum of post-acute services will allow
20 them to respond to reimbursement pressures and make them
21 desirable participants in coordinated care delivery models
22 and bundled payment arrangements.

1 In 2016, the Medicare margin for IRFs was 13
2 percent, down from 13.8 percent in 2015.

3 Financial performance continued to vary widely
4 across IRFs. The aggregate margin for freestanding IRFs
5 was 25.5 percent. Hospital-based IRFs had an aggregate
6 margin of 1.2 percent.

7 So, why do we see such a disparity between
8 hospital-based and freestanding IRFs? We think there are a
9 number of factors that are listed here.

10 First, hospital-based IRFs are more likely to be
11 nonprofit, so they may be less focused on reducing costs to
12 maximize returns to investors. They also have fewer
13 economies of scale. They tend to be much smaller than
14 freestanding IRFs, and they have fewer total cases. Their
15 occupancy rates are also somewhat lower.

16 Hospital-based IRFs also tend to have a different
17 mix of cases. It's not clear why this is the case. As I
18 mentioned earlier, some case types may be more profitable
19 than others, resulting in higher margins for facilities
20 that admit larger shares of those cases.

21 And finally, hospital-based IRFs may assess their
22 patients differently. During conversations with people in

1 the industry, we've heard some suggest that hospital-based
2 IRFs devote less time to training assessment staff and
3 verifying accuracy of assessments, resulting in less
4 reliable measures of patients' motor and cognitive
5 function. Others in the industry have suggested
6 that freestanding for-profit IRFs are aggressively
7 assessing their patients so as to maximize payment. As I
8 noted earlier, the integrity of the payment system is
9 contingent on the inter-rater reliability of the assessment
10 tool. If hospital-based IRFs consistently assess their
11 patients as less disabled, for whatever reason, their
12 payments and margins will be systematically lower.

13 Despite the comparatively low margins, Medicare
14 payments to hospital-based IRFs exceeded marginal costs by
15 a substantial amount, 19.3 percent. This compares to a
16 marginal profit of 40.9 percent in freestanding IRFs.

17 We expect that cost growth is likely to exceed
18 payment growth in 2017 and 2018, and so we've projected
19 that the aggregate margin will fall to 11.9 percent in
20 2018. Payment growth will be limited because PPACA and
21 MACRA set payment updates for fiscal years 2017 and 2018 at
22 below market basket levels. And though cost growth in this

1 industry was very low from 2009 to 2015, cost growth was
2 higher in 2016. We have anticipated this trend will
3 continue.

4 So to summarize, we observe capacity that appears
5 to be adequate to meet demand. Our risk-adjusted outcome
6 measures have improved over time. Access to capital
7 appears adequate. We estimate that the margin was 13
8 percent in 2016, while marginal profit was 19.3 percent for
9 hospital-based IRFs and 40.9 percent for freestanding IRFs.
10 We project a margin of 11.9 percent in 2018.

11 That brings us to the update for 2019. You will
12 recall that the Commission recommended that the update to
13 IRF payments be eliminated for fiscal years 2009 through
14 2017. Then, as the aggregate margin neared historic highs,
15 the Commission recommended that the Congress reduce the IRF
16 payment rate for 2018 by 5 percent. But in the absence of
17 legislative action, CMS has been required by statute to
18 increase payments. Though cost growth picked up in 2016
19 and margins declined somewhat, we project that aggregate
20 payments will remain well above the costs of caring for
21 beneficiaries. Indications, then, are much as they were
22 last year.

1 So we've started from the Chairman's draft
2 recommendation from last year. It reads:

3 The Congress should reduce the fiscal year 2019
4 Medicare payment rate for inpatient rehabilitation
5 facilities by 5 percent. We do not expect this
6 recommendation to have an adverse effect on Medicare
7 beneficiaries' access to care or out-of-pocket spending.
8 Even with a 5 percent reduction in the payment rate, we
9 project that the aggregate margin for IRFs will remain
10 above 5 percent. This recommendation may increase the
11 financial pressure on some low-margin providers, but this
12 effect would be eased by this year's draft recommendation
13 that CMS establish IRF payments using a blend of the
14 unified PAC PPS and current IRF PPS relative weights.

15 The Chairman's draft recommendation assumes that
16 the 5 percent payment cut would be coupled with previous
17 recommendations to the Secretary to expand the outlier pool
18 and improve payment accuracy and program integrity by
19 reviewing IRF assessment and verifying the tool's inter-
20 rater reliability. As I noted earlier, our recommendation
21 from 2016 that the high-cost outlier pool be expanded would
22 further reduce potential misalignments between IRF payments

1 and costs by redistributing payments within the IRF PPS.
2 Expanding the outlier pool would increase outlier payments
3 for the most costly cases. But this is only a stopgap
4 measure until CMS can do more complete analyses of case-
5 level profitability and assessment reliability. The
6 expanded outlier pool would be funded by an offset to the
7 national base payment amount.

8 Reducing the payment rate for IRFs by 5 percent,
9 using the blended payment weights that Carol discussed
10 earlier, and expanding the outlier pool from 3 to 5 percent
11 would decrease total payments to IRFs by 5 percent.

12 Because of the blended weights and the expanded outlier
13 pool, the impact would be smaller for IRFs that care for
14 larger shares of stroke cases and medically complex cases.

15 That concludes my presentation. I'll put the
16 draft recommendation back up and I'm happy to take
17 questions.

18 DR. CROSSON: Thank you, Dana. I have -- I'm
19 going to start with one question and that is, because we've
20 been all over the place on this particular policy over the
21 years. One option here, perhaps, in addition to the update
22 recommendation would be to reprint, as opposed to text or

1 text box the previous recommendations that you just
2 referred to. So do you have a thought on -- well, does
3 anybody have a thought on the relative impact of doing so,
4 or is it generally viewed as not needed?

5 MS. KELLEY: I think, typically, we've put them
6 in text boxes, but I don't know what Jim thinks about --

7 DR. CROSSON: I mean, sometimes we've -- haven't
8 we -- sometimes we've repeated recommendations.

9 DR. MATHEWS: Sometimes there has been a
10 consensus among the Commission that's strong enough that
11 the current members of a given cohort want to collectively
12 and affirmatively re-emphasize a prior Commission
13 recommendation. In other instances, there's simply
14 momentum, you know, along the lines of don't forget we have
15 a standing recommendation that does X, Y, or Z, and I
16 believe it's the latter approach that we've used to the
17 prior IRF recommendations.

18 DR. CROSSON: Okay. Well, it's open for
19 discussion anyway.

20 Clarifying questions, other than that. Jack.

21 DR. HOADLEY: On the -- specifically on the point
22 of those two previous recommendations, they're both

1 recommendation to the Secretary, but it sounds like the
2 Secretary has taken no action in either of these cases. Is
3 there any -- has there been any indication of
4 consideration, or has it been brought up at all in notice
5 and comment?

6 MS. KELLEY: The Secretary has said, in proposed
7 and final rules, that they don't think expanding the
8 outlier pool from 3 to 5 percent is necessary, so they have
9 given that some consideration.

10 DR. HOADLEY: Specific disagreement.

11 MS. KELLEY: Yes. There has not been a reaction
12 from them that I am aware of regarding our concerns about
13 the reliability of the assessment tool.

14 DR. HOADLEY: Or notion that specifically to
15 auditing or any kind of --

16 MS. KELLEY: Right.

17 DR. HOADLEY: Okay. Thank you.

18 DR. CROSSON: Questions? Bruce.

19 MR. PYENSON: Carol's presentation, on one of the
20 first pages, the statement "lack of evidence-based
21 guidelines to base decisions about PAC," and I should have
22 asked her, but I assume that applies to IRF as well -- in

1 particular. And do you know if the lack of evidence-based
2 guidelines is because nobody has tried, or they've tried
3 and it just doesn't work?

4 MS. KELLEY: There's been a lot of research in
5 this area, and I'll ask Carol to back me up, if necessary,
6 but my recollection is that the research is really hindered
7 by selection issues.

8 Remember that IRF patients need to be able to
9 tolerate an incentive level of therapy, which means they
10 can often be more frail than patients in SNFs, and that
11 tends to cast some questions on any findings that come out
12 of comparisons between SNF and IRF patients.

13 The American Heart Association and the American
14 Stroke Association did release stroke guidelines a few
15 years ago in which they recommended IRF care for stroke
16 patients, but even in their recommendation, they
17 acknowledged that the literature is simply not definitive
18 in this area.

19 DR. CROSSON: David.

20 DR. NERENZ: Thanks, Dana.

21 Sorry if I missed it, but I don't recall seeing
22 anything in this chapter about all-payer margins or payer

1 mix. Is it there and I missed it, or do we not have that?

2 MS. KELLEY: We do have it. Sixty percent of IRF
3 discharges on average are Medicare, and I'm sorry. I can't
4 recall the all-payer off the top of my head, but I'll bring
5 that for you next time.

6 DR. NERENZ: Okay. Also, just to extend the
7 point, payer mix, I'm just curious if it varies by for-
8 profit, not-for-profit, hospital-based, freestanding. Do
9 we have that kind of information as well?

10 MS. KELLEY: Freestanding tend to have a higher
11 Medicare share, but the difference is not stark, and I can
12 bring that for you next time as well.

13 DR. NERENZ: Okay. Because these are required to
14 meet the conditions of participation of hospitals, is there
15 any formal obligation, say, to take uninsured patients or
16 to take Medicaid patients? How does that work?

17 MS. KELLEY: No. And the Medicaid share right
18 now is, on average, about 19 percent. It has come up a
19 little bit, which is probably due to the expansion of
20 Medicaid, but no, they do not have the same requirements.

21 DR. CROSSON: Yes, Pat.

22 MS. WANG: The information that you provided on

1 Slides 13 and 14 about the different financial performance
2 of for-profit versus not-for-profit, hospital-based versus
3 freestanding, is so dramatic that I'm wondering if you have
4 -- it sounds like different provider types.

5 On Slide 14, the cost increases in not-for-profit
6 versus freestanding, it is dramatic. I mean, to the extent
7 that those are hospital-based, is it a cost allocation
8 issue? But just overall, we often see a different spread
9 like that, but in this case, it almost seems like these are
10 two different provider types. If you can comment?

11 MS. KELLEY: I don't think we know the answer
12 exactly, but there are a couple of things going on here
13 that can inform our thinking about it.

14 The first is that when we've looked at cost
15 allocation issues, we don't see a huge difference in
16 overhead cost. The costs are higher in hospital-based IRFs
17 across the board, and they're quite a bit higher.

18 Which brings me to my second point, which is that
19 from about 2009 to 2015, cost growth in freestanding
20 facilities was incredibly low, even negative in some years.
21 So they have held the line on their costs to an extent that
22 is pretty remarkable, I think, whereas hospital cost growth

1 in IRFS, anyway, has been above market basket for sort of
2 that earlier period and then a little bit below as we get
3 out closer to the current day, but still much what you
4 would expect.

5 MS. WANG: I'm just trying to recall offhand from
6 the chart that Carol just showed if the PAC PPS were
7 implement, is there a more dramatic shift of payment in the
8 IRF world from one provider type to the other? I just
9 don't remember.

10 MS. KELLEY: It's not dramatic. It would move
11 dollars towards nonprofit hospital-based facilities, but
12 it's not a dramatic switch due to the blended rate.

13 DR. CROSSON: Okay. Seeing no more questions,
14 we'll now move to the recommendation on page 18 and
15 entertain a discussion with respect to the recommendation.

16 Jack.

17 DR. HOADLEY: I guess I would make one comment to
18 the question of the reprinting of these recommendations. I
19 mean, it does seem like we've done different things and
20 that there's value sometimes in doing more of a formal
21 reprint to emphasize. I mean, this seems like this might
22 be one of those cases where it feels like there's a pretty

1 -- I mean, the numbers on that one chart that show the
2 stroke scores are just so dramatic, and it feels like --
3 especially, I'm thinking of the first of the two, but if we
4 do -- I guess we should do both -- to do that kind of
5 auditing. And given that the Secretary has not responded,
6 maybe that's worth reemphasizing that way.

7 But otherwise I'm certainly supportive of the new
8 recommendation as well.

9 DR. CROSSON: I think I agree with that.

10 Dana pointed out earlier in the presentation in
11 dollar terms how what appear to be relatively small coding
12 differences move -- well, I mean, I think you said \$4,000,
13 and the average admission was \$19,700.

14 MS. KELLEY: Yes.

15 DR. CROSSON: So, I mean, I don't know for sure,
16 but it would seem to me that if that's the case, that that
17 could go in part to explain the differences that you just
18 described.

19 It seems rather subject to manipulation -- I'm
20 not right?

21 MS. KELLEY: No, no.

22 DR. CROSSON: Oh, okay. Good.

1 So, anyway, I was sort of seconding Jack, but go
2 ahead, Brian.

3 DR. DeBUSK: I was just thinking, to that end,
4 would we want to make a recommendation as part of Chart 18
5 that says we'd like to narrow or that we'd like to be more
6 specific in some of these coding practices? I mean, is
7 there an opportunity to tighten that up?

8 When you rattled off those numbers, it made
9 perfect sense. I mean, that was 20 percent.

10 DR. CROSSON: Right.

11 DR. DeBUSK: And we're looking at the chart, and
12 it's a delta of about 20, 25 percent. That may be the
13 issue.

14 DR. CROSSON: It's suspicious, although not
15 proven.

16 Alice, on this?

17 DR. COOMBS: Yeah.

18 So this was a specific thing that drive us to
19 this corridor, I think, is watching that slide a few ways
20 back to say that there's some inconsistency with how we
21 place the severity of illness in certain categories, and
22 this led to all strokes are not the same. And that just

1 because you have a DRG that says stroke, some strokes have
2 little -- have major disabilities.

3 And so from that, we said let's look at resource
4 utilization because that has a lot more to do, rather than
5 the diagnosis of stroke, because some people may have
6 minimal residual and don't require three hours of
7 rehabilitative interventions.

8 So this is the very thing that we did to look at
9 neutrality in terms of resource utilization, so that if you
10 had inputs that were necessary, that were equivalent across
11 a continuum, and that's when we came up with some of the
12 issues regarding the complexities and CCI, specifically
13 because of this, and that chart just brings home the
14 message of different bars and different benchmarks for
15 different entities in the industry because clearly someone
16 with paralysis has a different functional status than
17 someone without paralysis.

18 So from that, we deliberate that whole corridor
19 before we started, and to say that IRFs -- there's a
20 tremendous overlap between IRFs and SNFs and LTCHs just
21 because of this very issue of resource utilization based on
22 DRGs. And we just can't say just because it's a stroke

1 that it should go to an IRF versus an LTCH. It really is
2 the syndrome and the utilization of the resources. I
3 support the Chairman's recommendation.

4 DR. CROSSON: Thank you.

5 But specifically to the addition of the previous
6 recommendations?

7 DR. COOMBS: Yes.

8 DR. CROSSON: Yeah. Okay. All right.

9 Kathy.

10 MS. BUTO: I don't remember who said it. Maybe
11 it was Jack mentioned going back to the previous MedPAC
12 recommendations, and I actually think I'm worried about --
13 it may not be fraud and abuse, but it at least looks like
14 up-coding in the context of some of these cases. That we
15 did recommend focused medical review, and I'm wondering
16 whether we ought to actually suggest that and the Secretary
17 should consider some sort of coding adjustment a la what is
18 done in other settings. It certainly points in that
19 direction, so not just focus medical review and we're going
20 to be watching over you, but really this may lead to an
21 adjustment that we make on a regular basis, something along
22 those lines.

1 DR. CROSSON: Jim.

2 DR. MATHEWS: If we could, it's something I'd
3 like to reserve the right to think about a little bit more.

4 While on the one hand, there do seem to be these
5 pronounced differences in coding among high-margin compared
6 to low-margin IRFs, I am not sure from a clinical
7 perspective we fully understand the nuance of what's going
8 on here, which is part of the reason we made the
9 recommendation last year -- two years ago? -- two years ago
10 that there should be some medical review.

11 The patterns we see are very pronounced and very
12 indicative, but from a clinical perspective, I don't know
13 that we have 100 percent of the picture in the same way we
14 did, say, for example, when we looked at hospital up-
15 coding, or now that we're looking at MA coding, where we
16 have a much greater understanding of what's going on, here
17 there seems to be something going on. We don't quite know
18 what it is.

19 DR. CROSSON: So, Jim --

20 MS. BUTO: Oh, I definitely think you want to
21 reserve final judgment on what to do, but it's striking
22 that coding in the hospital is in one direction --

1 DR. MATHEWS: Yes.

2 MS. BUTO: -- not so severe, and then once they
3 get to the IRF, it goes the other -- I mean, this disparity
4 is what I think struck me.

5 DR. MATHEWS: Yeah. I don't disagree with that
6 at all, but I'd like to, on behalf of the staff, understand
7 it a little bit better before we make a recommendation to
8 the Secretary that says, "You need to make this kind of
9 coding adjustment, and here is why."

10 DR. CROSSON: So it's the coding adjustment you'd
11 like to hold in abeyance?

12 DR. MATHEWS: Correct.

13 DR. CROSSON: Okay.

14 Jon.

15 DR. CHRISTIANSON: Yeah, I agree with that. When
16 I looked on Slide 6, these are like so many of the
17 measures, where provider self-reported measures, there
18 seems to be a clear incentive to sort of maximize revenue.

19 And you look at 6, and I'm wondering why there
20 should be that pattern. Why wouldn't everybody have
21 exploited that there? Right? I mean, the fact that you
22 have this 29.2, 29 thing, it doesn't make any sense to me

1 if everybody is out there working to maximize payment. So
2 I do think there's more that we need to understand about
3 this before we talk about it across the board kind of
4 attack on this.

5 MS. BUTO: Suggesting that we go there, I'm was
6 just saying --

7 DR. CHRISTIANSON: No, I think I understand.

8 MS. BUTO: -- we ought to say we might go there.

9 DR. CHRISTIANSON: I'm with you on that. I'm
10 just trying to reinforce what Jim said because I think
11 there's some things here that I would like to better
12 understand about why we're not seeing a certain pattern
13 consistently across different providers.

14 DR. CROSSON: Yes, Brian. Bruce.

15 I get out the first two letters, and then I'm
16 lost.

17 [Laughter.]

18 MR. PYENSON: Bro.

19 I have a process question. It seems to me in
20 this arena, the lack of evidence-based guidelines is a real
21 hindrance to the kind of understanding that we're talking
22 about of coding and a lot of other things.

1 Is there a way we can suggest that to CMS or HHS
2 that tackling this issue is important; it's not a reason to
3 delay any of the recommendations. But this is one area
4 where development of evidence-based guidelines would
5 probably be very, very helpful.

6 DR. CROSSON: It sounds reasonable to me. I
7 think that could be added to the text. Sure.

8 Jack.

9 DR. HOADLEY: To follow on this last discussion,
10 I mean, it seems like we could probably -- or you could
11 consider some text language that could say, depending on
12 what we learn from these reviews, consider the need for
13 some kind of coding adjustments. I don't know whether some
14 of the overall PAC coding issues would begin to mitigate
15 some of this, but we could put some language in that talks
16 about some potential consequences down the road, depending
17 on what we learn from the medical reviews. And then that
18 would sort of help get to Kathy's point.

19 DR. MATHEWS: And speaking for myself, I think
20 there are two separable issues here. There's what's going
21 on with respect to functional status coding within the IRF
22 setting as a silo, and we'd like to better understand that.

1 And then to address Bruce's comment or inquiry
2 about the development of evidence-based guidelines as to
3 when a patient needs post-acute care and if that
4 determination is made, what the appropriate setting is, and
5 that is a huge, huge undertaking. You're looking at
6 millions of patients, tens of thousands of providers across
7 four different PAC settings, not even contemplating PAC
8 services provided in ambulatory settings, physical therapy,
9 that kind of thing. And so that is one approach. You
10 could head down that path and say you should develop for
11 stroke patients, this decision tree; for hip and knee
12 replacement patients, here is a decision tree for where
13 they end up to get their rehabilitative care services.

14 But I would make two points before we start
15 heading down that path. One, as we try and move more
16 providers into risk-bearing arrangements, A-APMs,
17 accountable care organizations, those kinds of decisions
18 will need to be made at the level of the local provider or
19 local organized delivery system, and in that sense, they
20 may be able to use their own local market intel to be able
21 to determine here is a highly effective provider,
22 irrespective of whether they're a SNF or an IRF or a home

1 health agency and send patients there. That's one point.

2 The second is some of this may be mitigated by
3 the continued development and implementation of a unified
4 PAC PPS, where the label on the pile of bricks or on the
5 side of the minivan in the case of home health becomes less
6 important, and again, the payments are based on the
7 clinical needs of the patient, as determined by patterns of
8 care extracted in the aggregate across all settings rather
9 than trying to say this kind of patient needs to go to this
10 kind of inpatient rehabilitation facility, so two alternate
11 approaches here short of the kind of resources that would
12 need to be brought to bear to a true robust set of
13 evidence-based guidelines.

14 DR. GRABOWSKI: If I could just pick up on that.
15 Jim's answer was great.

16 I think -- and Dana, you said this earlier -- I
17 don't think we have the evidence yet. It's really due to
18 the selection issue, the kind of individual patient that's
19 been discharged in an IRF is very different than the
20 patient that's been discharged to SNF, and so it's been
21 very hard, at least historically, to kind of make that
22 comparison and decide if you have a moderate stroke, are

1 you better served being at an IRF versus a SNF.

2 We should do that research, and I think --

3 MR. PYENSON: I'm not sure it's all that hard,
4 and I'm going to --

5 DR. COOMBS: It is.

6 DR. GRABOWSKI: It is.

7 [Laughter.]

8 MR. PYENSON: There are some parts of the country
9 where an IRF is not nearly as available as others, but I
10 suspect -- I didn't want to give my guess at what's going
11 to happen. But I suspect the statistical uncertainty and
12 the fox of results mean that it is not possible to do that,
13 to create decision trees. It really depends on the quality
14 of the service, and I think that would be a very important
15 finding because then you could skip all these other
16 arguments and move to the unified basis. So that's, I
17 think, a direction that's consistent with the unified PAC.

18 DR. CROSSON: I think we're getting a little far
19 afield here.

20 My sense is that -- and I agree that trying to
21 develop clinical guidelines that suggest that someone with
22 a particular condition should go to a particular kind of

1 entity in the face of what we're doing doesn't make any
2 sense.

3 However, I do think -- and this may not be our
4 role or even Medicare's role. From a clinical perspective,
5 trying to support decision-making that says a patient with
6 this particular type of condition should receive this
7 particular set of services from whoever is able to do that,
8 assuming that that's not already adequate in the
9 environment -- and it may or may not be because the
10 implication of our unified PAC PPS is that we're asking
11 people to think differently. And so it's entirely
12 conceivable that there's a body of work there that could be
13 done.

14 I'm not sure it's in our province necessarily to
15 do that, but I understand the point you're making.

16 Okay. I think this. I think despite the fact
17 that we've had conversations about various points that
18 might be altered in the text, I think I have a consensus
19 saying that we should reprint the previous recommendations.
20 Is there any objections there?

21 No objections. Bobblehead consensus. So I'm
22 going to suggest that in January, we come back with three-

1 part recommendations, and without objection we take it
2 through the expedited voting process in January, okay?

3 Thank you very much, Dana.

4 Oh, and by the way, to the extent that Dana and
5 others make changes in the text, remember you're going to
6 get the opportunity to have one final review of that
7 information. It will come out in the January mailing.

8 Okay. Got a little sign language going on

9 [Pause.]

10 DR. CROSSON: Okay. Stephanie is all set and is
11 going to take us through a discussion of updates for LTCHs.

12 MS. CAMERON: Good afternoon. Today we are here
13 to discuss how payments to LTCHs should be updated for
14 fiscal year 2019. We will discuss changes in policy that
15 are current law. Then using the established framework, we
16 will evaluate the adequacy of Medicare payments to LTCHs.

17 First, I will summarize some background
18 information that was included in your mailing materials.
19 To qualify as an LTCH under Medicare, a facility must meet
20 Medicare's conditions of participation for acute-care
21 hospitals and have an average length of stay for certain
22 Medicare cases of greater than 25 days. Care provided in

1 LTCHs is expensive. The average Medicare payment in 2016
2 was over \$41,000 across all cases and close to \$47,000
3 across cases that qualify to receive the full LTCH PPS
4 payment rate that I will discuss momentarily. Medicare
5 pays LTCHs on a per discharge basis with an upwards
6 adjustment for cases with extraordinarily high costs.
7 LTCHs also have a downward payment adjustment for cases
8 with extremely short lengths of stay.

9 Beginning in fiscal year 2016, an LTCH discharge
10 either needed to have three or more days in the referring
11 hospital's ICU or receive an LTCH principal diagnosis that
12 includes prolonged mechanical ventilation to qualify for
13 the full LTCH standard payment rate. Discharges that don't
14 meet these criteria receive a site-neutral payment equal to
15 the lesser of an IPPS comparable rate or 100 percent of the
16 costs. As you'll recall, the criteria to qualify for full
17 LTCH standard payment rate are consistent with the
18 direction of the Commission's 2014 and 2015 recommendation
19 for chronically critically ill beneficiaries.

20 Although the dual payment policy began in fiscal
21 year 2016, the multi-year phase-in and range of hospital
22 cost report periods will blend into claims and cost report

1 data over the next several years. We don't expect to see
2 the full effect of implementation until our December 2020
3 and 2021 analyses.

4 I will now turn to the question of how payments
5 to LTCHs should be updated for fiscal year 2019. To
6 determine the update recommendation, we review payment
7 adequacy using our established framework consistent with
8 what you've seen in other sectors throughout the day today.

9 First, supply. We have no direct indicators of
10 beneficiaries' access to needed LTCH services, so we focus
11 on changes in occupancy, capacity, and use. As you know,
12 historically, this product has not been well defined, and
13 the absence of LTCHs in many areas of the country and the
14 variation in availability across markets makes it
15 particularly difficult to assess the adequacy of supply.

16 Here we show the cumulative growth of LTCHs and
17 beds since 2006. From 2012 through 2015, the number of
18 facilities and beds calculated based on the cost report
19 data is inaccurate because of a larger than average number
20 of LTCHs that changed their cost reporting periods, as
21 indicated by the dashed lines. We anticipate that this
22 cost report issue has been resolved and that the number of

1 beds and LTCHs in 2016 reflect a more accurate depiction of
2 supply. As you can see, the number of facilities and beds
3 has decreased since 2012. The number of beds has declined
4 more quickly because, on average, larger facilities have
5 closed while smaller facilities have opened.

6 In 2016, LTCH occupancy rates averaged around 66
7 percent, suggesting that LTCHs have excess capacity in the
8 markets they serve.

9 Using claims data which does not have the same
10 data issues I discussed on the previous slide, this chart
11 shows what's happening with LTCH cases per 10,000 fee-for-
12 service beneficiaries. Controlling for the number of
13 beneficiaries, the number of LTCH cases declined after 2011
14 when volume peaked at 38.3 cases per 10,000 beneficiaries.
15 Volume declined more rapidly from 2015 to 2016 compared to
16 previous years where the 4.2 percent decrease in volume
17 resulted in a 12-year low of 32.7 LTCH cases per 10,000
18 fee-for-service beneficiaries. Given the reduction in the
19 number of LTCHs and LTCH beds and the implementation of the
20 patient-specific criteria, this decline in service use is
21 not unexpected, nor does it represent an undue reduction in
22 access to medically necessary LTCH-level care and instead

1 reflects intended industry change.

2 Now, quality. LTCHs began submitting quality
3 data on a limited number of measures to CMS in fiscal year
4 2013. CMS has expanded the number of measures required for
5 reporting since and began publicly reporting two of these
6 measures last December. But because of the Commission's
7 interest in understanding changes in the quality of care
8 provided to Medicare beneficiaries over time, we continue
9 to rely on claims data to assess gross changes in quality
10 of care in LTCHs. Between 2012 and 2016, mortality and
11 readmission rates were stable or declining for most of the
12 common diagnoses. The aggregate mortality rate reminds us
13 of how sick some patients in LTCHs are. On average, about
14 one-quarter of LTCH patients die in the facilities or
15 within 30 days of discharge, with a wide variation across
16 the top conditions including close to 50 percent for
17 patients with septicemia and prolonged mechanical
18 ventilation use. During this same time, the unadjusted
19 aggregate 30-day readmission rate was 9 percent.

20 Access to capital allows LTCHs to maintain and
21 modernize their facilities. If LTCHs were unable to access
22 capital, it might reflect problems with the adequacy of

1 Medicare payments since Medicare accounts for about half of
2 LTCH total revenues. However, this year, and in recent
3 history, the availability of capital says more about the
4 uncertainty regarding the regulations governing LTCHs, the
5 effect of the moratorium which recently ended, and
6 uncertainty regarding the industry's ability to comply with
7 the new patient-level criteria than it does about payment
8 rates.

9 Since the phase-in of the patient-level criteria
10 began in October of 2015, LTCHs have been working toward
11 adapting their admission patterns, costs, and case mix to
12 mitigate the effect of the payment reduction for cases that
13 don't meet the new criteria. Major chains have been
14 diversifying their portfolios and have been strategic in
15 their purchase, sales, and closure of LTCH facilities in
16 more competitive LTCH markets. The Commission expects
17 continued industry consolidation, limited need for capital,
18 and limited growth opportunities until after the LTCH
19 patient criteria becomes fully implemented and LTCHs adjust
20 accordingly. There is also a degree of long-term
21 uncertainty associated with the industry-wide shift toward
22 using providers with lower costs of care through

1 accountable care organizations and the acute-care hospital
2 VBP program which may have long-run implications for LTCH
3 use and capital investment.

4 Turning now to LTCHs' per case payments and
5 costs, LTCHs historically have been very responsive to
6 changes in payment, adjusting their cost per case when
7 payments per case change. From 2008 through 2016, both the
8 average annual cost and average annual payment growth
9 equaled about 1.6 percent. Between 2015 and 2016, growth
10 in the Medicare payment per case was stagnant; accordingly,
11 the average cost per case increased by about 1 percent,
12 which represents the lowest increase in per case cost since
13 2011.

14 Increase in cost growth relative to payment
15 growth between 2015 and 2016 resulted in a 2016 aggregate
16 Medicare margin of 4.1 percent and a 6.3 percent margin for
17 qualifying cases.

18 As you can see, there is a wide variation in the
19 Medicare margins, similar to what we see in other settings,
20 with the bottom quarter of LTCHs having an average margin
21 of minus 17.5 percent and the top quarter having an average
22 margin of positive 17.7 percent across all Medicare fee-

1 for-service cases. Consistent with other sectors, the for-
2 profit facilities, which account for 87 percent of cases,
3 have a higher average margin compared to nonprofit
4 facilities. Across all cases, for-profit LTCHs had an
5 aggregate average margin of 5.7 percent while nonprofit
6 facilities have a margin of negative 4.7 percent.

7 LTCH marginal profit across all cases was close
8 to 20 percent in 2016, similar to the past two years. We
9 contend that LTCHs have a financial incentive to increase
10 their occupancy rates with Medicare beneficiaries.

11 Looking more closely at the characteristics of
12 established LTCHs with the highest and lowest margins, this
13 slide compares LTCHs in the top quartile for 2016 margins
14 with those in the bottom quartile. As you can see in the
15 top line, high-margin LTCHs tend to be larger and to have
16 higher occupancy rates, so they likely benefit from more
17 economies of scale. Low-margin LTCHs had standardized
18 costs per discharge that were 30 percent higher than high-
19 margin LTCHs.

20 High-margin LTCHs have fewer high-cost outlier
21 cases and fewer short stay cases. High-margin LTCHs are
22 more likely to be for-profit based on their demonstrated

1 ability to restrain costs in this sector and across the
2 other provider types we've seen today.

3 We project that the 2016 LTCH margin for cases
4 that qualify to receive the full LTCH standard payment rate
5 of 6.3 percent will decline in 2018. We expect cost growth
6 to be higher than current law payment growth since updates
7 to payments in 2017 and 2018 were reduced by PPACA-mandated
8 adjustments equaling over one percentage point per year.
9 Using historical levels of cost growth, we project that
10 LTCHs' Medicare margin for qualifying cases paid under the
11 LTCH PPS will be 4.7 percent in fiscal year 2018.

12 In sum, occupancy rates across the industry have
13 remained stable. Although growth in the volume of LTCH
14 services per fee-for-service beneficiary declined, this
15 decline is in large part from the implementation of the
16 patient-level criteria as intended by law. We have little
17 information about the quality of care in LTCHs, but
18 unadjusted mortality and readmission rates appear to be
19 stable or improving. The effect of fully implementing
20 patient-specific criteria will limit growth in the near
21 term. Our projected margin for qualifying cases paid under
22 the LTCH PPS in 2018 will be 4.7 percent, assuming the

1 current underlying cost structure for these cases.

2 CMS historically has used the market basket as a
3 starting point for establishing updates to LTCH payments;
4 therefore, we make our recommendation to the Secretary.

5 And with that, the Chairman's draft recommendation reads:

6 The Secretary should eliminate the fiscal year 2019
7 Medicare payment update for long-term-care hospitals.

8 Eliminating this update for 2019 will decrease
9 federal spending relative to current law.

10 We anticipate that LTCHs can continue to provide
11 Medicare beneficiaries with access to safe and effective
12 care and accommodate changes in cost with no update to
13 payment rates for qualifying cases in LTCHs in fiscal year
14 2019.

15 And with that, I will turn it back to Jay.

16 DR. CROSSON: Thank you, Stephanie. We have
17 clarifying questions. David.

18 DR. NERENZ: Essentially, the same questions with
19 Dana. Do we have all-payer margins or payer mix data here
20 the way we might for the IRFs?

21 MS. CAMERON: Sure. So there is a little bit of
22 a difference with some of the data for LTCHs generally, and

1 that is, what I can tell you is that the all-payer margin
2 is about 3 percent. It is slightly higher for nonprofit
3 LTCHs than it is for for-profit LTCHs. But, on average,
4 it's about 3 percent.

5 DR. NERENZ: If I can just stop you, so that's
6 actually a flip of --

7 MS. CAMERON: That is a flip.

8 DR. NERENZ: What does that mean?

9 MS. CAMERON: That essentially means that there
10 are revenues coming into for-profit margins that are not
11 similar as coming into -- excuse me. There are revenues
12 coming into nonprofit margins that are different from those
13 coming into for-profit margins. I don't know if that's
14 from higher commercial rates. I don't know if that's from
15 other sources of revenue like donations and charitable
16 contributions.

17 DR. NERENZ: Okay. Well, if we could know more -
18 - I mean, that really changes my thought about a
19 recommendation, and it would be important for me to know
20 that or, I assume, for us in general. Don't just do it for
21 me, but if others would care about that, I think that's a
22 very important thing that you just said.

1 MS. CAMERON: Okay.

2 DR. CROSSON: Other clarifying questions? Jack.

3 DR. HOADLEY: I'll do another similar question to
4 what somebody else asked for Dana. The differences in
5 margins across the different categories, urban, rural, for-
6 profit, not-for-profit, how much does the consolidated PAC
7 PPS sort of narrow those differences?

8 MS. CAMERON: It does narrow them a bit, so the
9 PAC PPS would lower the for-profit a little bit. It would
10 bring up the nonprofit. It would have -- it appears at
11 this point it would actually decrease the margins in the
12 rural areas and increase them in the urban areas. But what
13 I will say -- and I don't know if you're considering that
14 in context of the negative rural margin -- that, you know,
15 there are very rural LTCHs. They make up 5 percent or less
16 of Medicare payments to LTCHs. And when you get down to a
17 number of facilities, you know, fewer than 20, one or two
18 facilities in particular can really sway that margin.

19 So, you know, I think while we do look at these
20 on the basis of kind of these categories, I would urge
21 caution because there are two LTCHs in particular that have
22 very low margins that appear to be driving that negative

1 margin.

2 DR. HOADLEY: Does some of that -- I mean, your
3 split on for-profit and not-for-profit is 87 percent of
4 cases versus 12. Is there a similar issue there --

5 MS. CAMERON: There are --

6 DR. HOADLEY: -- or is that assumed to be less?

7 MS. CAMERON: I think that's less of an issue --

8 DR. HOADLEY: Okay.

9 MS. CAMERON: -- because there are - as a
10 percentage, there are, I believe, about 20 and 25 percent
11 of LTCHs themselves are nonprofit; whereas, you know, going
12 from 5 percent to kind of the 20 percent, that is a
13 difference.

14 DR. HOADLEY: Okay. Thank you.

15 DR. CROSSON: Alice.

16 DR. COOMBS: I think we did this on one of the
17 other PACs. Did we do a case mix difference between the
18 nonprofits versus the for-profits.

19 MS. CAMERON: We do, yes. And the case mix is
20 slightly higher. The case mix index is slightly higher in
21 the for-profit facilities.

22 DR. COOMBS: Okay, but it's not dramatic like the

1 other one we saw earlier?

2 MS. CAMERON: No.

3 DR. CROSSON: Yes, David?

4 DR. GRABOWSKI: I've always been interested with
5 LTCHs just that there's only 400 of them in the country,
6 and they're very geographically focused, and there are lots
7 of markets in the U.S. without LTCHs.

8 This really picks up on Bruce's comment from
9 earlier, but have you -- so you say in the chapter that in
10 those markets where there are no LTCHs, individuals
11 typically end up staying longer in an acute-care hospital
12 or maybe going to a skilled nursing facility. Have you
13 tracked those individuals and looked at anything around
14 their costs or around their outcomes and even anecdotally,
15 as part of a prior MedPAC report or analysis? I've always
16 been curious by that issue, and it's really worth thinking
17 about. Obviously, to Jim's comment earlier, as we move
18 toward site neutrality, some of this gets leveled out, and
19 hopefully in risk-bearing models like the APMs this gets
20 addressed. But I'm wondering if you've thought about this
21 at all. Thanks.

22 MS. CAMERON: We have thought about it. There

1 are a few things that make it extremely difficult to make
2 comparisons on discharges from acute-care hospitals that go
3 to different settings and discharges that go to LTCHs. And
4 one of the issues is there's such a small number of
5 proportion of beneficiaries that go to LTCHs generally.

6 When you look at Medicare beneficiaries in acute-
7 care hospitals, I'm rounding but you're looking at about 10
8 million. Here we're looking at about 125,000. And then
9 when you think about on a DRG basis the discharges from an
10 acute-care hospital, the pathway to an LTCH based on kind
11 of a DRG basis, we could certainly pick some of our
12 favorite DRGs, you know, or DRG groupings like vent, for
13 example, where there are kind of a larger portion of
14 beneficiaries that go to LTCHs in that category. But I do
15 think it's very difficult to kind of tease out whether
16 you're a similar beneficiary in an acute-care hospital and
17 how that pathway works.

18 DR. CROSSON: Pat, and then John.

19 MS. WANG: On that point, I think that the
20 unified PAC PPS is absolutely the right direction, but to
21 me, the sort of thing to keep in mind is that the post-
22 acute care delivery system looks really different in

1 different areas. I mean, it's not like a hospital is a
2 hospital is a hospital. And, you know, my observation, my
3 experience is that the post-acute care system grows up to
4 meet needs but maybe in different ways. So maybe the areas
5 that don't have LTCHs have more IRFs, or nursing homes that
6 will take ventilator-dependent patients, whereas the places
7 that are more dependent on LTCHs there is no place else.
8 If you need to place somebody long term who is vent-
9 dependent, there is no other alternative.

10 And so the transition to the PAC PPS, I think, is
11 important to keep in mind because I don't think that
12 facilities just can flip overnight and suddenly a nursing
13 home decides, oh, why, I guess I better put up a vent unit
14 now because that's like a really big deal.

15 So it's just -- it's a thing to remember, I
16 think, about moving in the direction of payment
17 rationalization, is that the delivery system in this area
18 is so different. And Bruce, you know your comment or your
19 question before was a great one, but I think it's even
20 harder to do when you have such diversity of types of
21 providers who perform these services.

22 MR. PYENSON: It might be impossible to do.

1 MS. WANG: Yeah, it might be impossible.

2 DR. CROSSON: Jack.

3 DR. HOADLEY: Yeah. I'd very much reinforce what
4 you're saying. I mean, I was part of a project about 10
5 years ago that where we interviewed -- did interviews in
6 communities that had LTCHs and those that didn't, for
7 MedPAC, and we heard exactly some of those things, in
8 particular, a nursing home that would develop a ventilator
9 capacity because there was no LTCH and there was a need for
10 that in that community. And, you know, there might have
11 been such a nursing home in another community that had an
12 LTCH, but if there was a particular need to develop it then
13 that's what developed, or if there wasn't, then the
14 hospitals responded by, you know, keeping people until they
15 were ready to go to the facilities that were available.

16 So, yeah, I think it -- you know, that is --
17 that's only qualitative evidence but it's certainly
18 evidence that points in that direction.

19 DR. CROSSON: Jon.

20 DR. CHRISTIANSON: I actually had a request of
21 David. When you were talking about the additional
22 information that you wanted to have, I wanted you to keep

1 talking and sort of walk through. That information is
2 going to be very important in how you viewed the
3 recommendation, and, you know, work that out for me a
4 little bit.

5 DR. NERENZ: Well, yeah, and I don't know, since
6 we're scheduled to six how much longer you want me to talk.
7 I was trying to keep it concise.

8 DR. CHRISTIANSON: Well, if it was just me, as
9 long as you want.

10 DR. NERENZ: No, it's pretty brief. You know,
11 through a number of these threads -- and we see it here, we
12 see it elsewhere, we see this distinction, say, between
13 for-profit and not-for-profit, and in a couple of cases
14 then we see how that plays out in terms of all-payer
15 margin, and some things balance but maybe they get
16 exaggerated. And in this case I was just astonished,
17 frankly, to say that if you look at the all-payer margins
18 you see this total reversal.

19 And when it comes down to the recommendation is
20 that the recommendation does not, and it cannot distinguish
21 between for-profit and not-for-profit, and it can't
22 distinguish between freestanding. So I have to look at one

1 number and say, how is that one number going to affect
2 these different segments? And perhaps just based on where
3 I come from, I always get nervous about what it's going to
4 do to the people who already have negative margins, because
5 unless we just, you know, want to punish them for being
6 badly managed, or we want to, I don't know, do something
7 with some desired behavioral effect, I worry about that.
8 But then if you tell me that their all-payer margin is
9 actually pretty good, then I worry less.

10 So it's no more complicated than that, but I
11 think the dynamic looks different here than what we've seen
12 in some of the other payment areas.

13 DR. CHRISTIANSON: So worry about it in the sense
14 that you would -- take that one step further. You would be
15 more amenable to a recommendation that did X?

16 DR. NERENZ: No. In this case I'm inclined to
17 support the recommendation, but I can do that and lose less
18 sleep because if -- the people I would worry about would be
19 the ones currently holding the negative margins, because I
20 just tend to believe they are not, in fact, that badly
21 managed. I think there's something else going on. I'm
22 never quite sure what that is. I tend to think it's

1 because they may have some stronger mission components.
2 They may be doing some things that add cost, that, you
3 know, we have a hard time picking up. I just don't that.
4 You know, we typically don't see that data.

5 So every time we look at these updates I find
6 myself being fairly comfortable with them as applied to the
7 subsets that have high margins. Okay. But then when we
8 look at those who have very small or negative margins and
9 say we're going to take people who already are struggling
10 in this payment stream, we're going to make them struggle
11 more -- well, I mean, it depends on the recommendation.

12 So, no, I'm going to end up supporting this, but
13 I find it relevant to that decision to know the all-payer
14 margins.

15 DR. CHRISTIANSON: Yes. So this is something
16 that you are concerned about sort of generically as we go
17 from recommendation to recommendation.

18 DR. NERENZ: All day long, and tomorrow.

19 DR. CHRISTIANSON: Yeah. Okay. That's what I
20 wanted to understand too.

21 DR. CROSSON: Okay. Warner.

22 MR. THOMAS: If I can just add on to that

1 comment. I think one of the things that would be helpful
2 is that it appears that we analyze and/or look at
3 information differently based upon the different service
4 that we're analyzing. So I think just this comment about
5 David. I mean, if we have the all-payer information, if we
6 have rural versus for-profit, I mean, I think we ought to
7 look at it all consistently across all of the services, and
8 share all of that data.

9 I mean, we look at the all-payer data, say, in
10 hospitals, but we haven't looked at it in other services.
11 So I think it would just be helpful to have it consistent
12 across all of the services that we analyze.

13 DR. CROSSON: Okay.

14 MS. CAMERON: And just to be clear --

15 DR. CROSSON: Yeah.

16 MS. CAMERON: -- both all-payer margins for for-
17 profit and nonprofit were positive. I wanted to make sure.
18 You know, the average was 3.1. I can't exactly remember
19 the numbers -- one -- but it was hovering 4 and 2. It
20 wasn't a negative and a positive, just to be clear. And
21 when you said "flipped" it made me a little nervous.

22 DR. NERENZ: No, and I understand. I got that

1 completely. I just used "flipped" in a different sense.
2 There was a group of places that went from negative --
3 which was the only number we saw -- to positive -- which is
4 the number we didn't see.

5 DR. CROSSON: Okay. I think we've come to the
6 end of the comment period. I have to admit I'm a little
7 bit uncertain here as to whether we go to expedited voting
8 on this issue or whether David and Warner, you want to see
9 more data in January before we do that or not.

10 DR. NERENZ: No. I got -- the simple answer is
11 no. I said I'm willing, and was willing, to support the
12 recommendation. But I just think this issue of seeing the
13 all-payer margins is important to round out the whole
14 picture. That would not change my vote. Therefore, I
15 think we could go expedited.

16 DR. CROSSON: Okay. So, Stephanie, is that
17 something that you can access and put into the paper for
18 January?

19 MS. CAMERON: Yes.

20 DR. CROSSON: Okay. All right. Okay.

21 MR. THOMAS: I would agree with David. I'm the
22 same. I mean, it's not going to change how I view the

1 recommendation, but I would like to see the data consistent
2 across each -- and not just as it relates to LTCH but all
3 of the disciplines we've been looking at.

4 DR. CROSSON: Okay. Good. So then seeing no
5 objection, we will move this forward in January on
6 expedited voting process. And that's the end of the issue.
7 Thank you, Stephanie.

8 [Pause.]

9 DR. CROSSON: Okay. Evan, we're off and running.
10 This is the last presentation of the day on home health
11 services, recommended update. You're up.

12 MR. CHRISTMAN: Very well. Good afternoon. Now
13 we will review the framework as it relates to home health.

14 As an overview, this presentation will cover the
15 basics of the benefit, the current issues the Commission
16 has identified, and the bulk of it will review the payment
17 adequacy framework.

18 As a reminder, Medicare spend \$18.1 billion on
19 home health services in 2016, and there were over 12,200
20 agencies. The program provided about 6.5 million episodes
21 to 3.4 million beneficiaries and accounted for about 5
22 percent of fee-for-service spending.

1

2 Before we continue, I just wanted to remind you
3 of some of the issues with the home health benefit. Home
4 health is an effective service when appropriately targeted
5 and can be an important service for serving frail,
6 community-dwelling Medicare beneficiaries. However,
7 eligibility for the benefit is poorly defined and does not
8 encourage efficient use.

9 As I will note in a minute, there has been rapid
10 growth in episode volume, which raises particular concerns
11 in the current fee-for-service environment.

12 The benefit also has an unfortunate history of
13 program integrity problems. The Secretary and the Attorney
14 General have made a number of efforts to address fraud in
15 the benefit, but many patterns of unusual utilization
16 suggestive of fraud remain.

17 We have also noted significant geographic
18 variation in this service, which program integrity and the
19 broad benefit definitions likely contribute to.

20 In terms of the payment system, the Commission
21 has noted two problems. First are issues with the
22 incentives in the current system. The PPS uses the number

1 of therapy visits provided in an episode as a payment
2 factor. Payments increase as more therapy visits are
3 provided, sometimes increasing by hundreds of dollars for a
4 single additional visit.

5 The share of episodes qualifying for these
6 payments has increased every year in the PPS. This trend
7 and the fact that more profitable HHAs tend to favor
8 therapy episodes raise concerns that the financial
9 incentives of the payment system were influencing care.
10 MedPAC recommended the elimination of therapy as a payment
11 factor from the PPS in 2011.

12 CMS recently proposed removing these thresholds
13 as one component of a larger payment reform, but it has
14 withdrawn this proposal, and it is not clear when or if
15 they will address this vulnerability.

16 The second issue is the high level of payments.
17 Medicare has overpaid for home health since the PPS was
18 established. The fact that home health could be a high-
19 value services does not justify these high payments.

20 As discussed in the paper, Medicare margins have
21 averaged better than 16 percent in the 2001 to 2015 period.
22 These overpayments do not benefit the beneficiary or the

1 taxpayer.

2 We begin with supply. As in previous years, the
3 supply providers and the access to home health appears to
4 be very good. Eighty-six percent live in an area served by
5 five or more home health agencies. Ninety-nine percent of
6 beneficiaries live in an area served by one home health
7 agency.

8 Turning to the number of agencies, we have
9 reached over 12,200 by the end of 2016. Though there was a
10 net decline of about 140 agencies relative to the prior
11 year, the overall supply of agencies has increased by about
12 60 percent since 2004.

13 The recent decline is concentrated in a few
14 areas, such as Texas, Florida, and Michigan, that have been
15 the target of efforts to reduce fraud. These areas
16 experienced higher growth in utilization and supply in
17 prior years.

18 Next, we look at volume. Overall, the volume of
19 episodes and the number of beneficiaries did not change
20 significantly in 2016 relative to the prior year.
21 Cumulatively, however, the volume of services has increased
22 substantially. The number of episodes is about 60 percent

1 higher compared to 2002 and 2016. The number of users is
2 almost 40 percent higher, and total spending is up over 80
3 percent. This substantial growth coincides with a period
4 of high payments under Medicare, and margins for home
5 health have ranged between 10 and 23 percent since the
6 advent of PPS in 2000.

7 Our next indicator is quality. I have split the
8 quality measures into two groups. The first group of
9 measures are based on self-reported data collected by HHA
10 staff at the start and end of home health care.

11 The second group of measures are claims-based
12 measures that use Medicare claims to detect the incidence
13 of hospital or emergency care use during a home health
14 episode.

15 The first group shows that the frequency of
16 patient improvement in walking or transferring was steady
17 until 2016, when both measures experienced a significant 10
18 percentage point or more jump.

19 In contrast, hospitalizations and ER use have not
20 changed significantly in most years and do not show the
21 same substantial improvement in 2016 as the functional
22 measures. The contrast in these two groups of measures is

1 striking, and though many factors may explain them, it is
2 important to keep in mind that methodological differences
3 in the collection of these measures may potentially account
4 for at least some of the divergent trends.

5 In addition, the trends may reflect Medicare's
6 implementation of a VBP demonstration in nine states in
7 2018. Under the demonstration, how well agencies performed
8 in 2016 relative to 2015 on 20 measures, including the four
9 listed here, will determine whether they receive a bonus or
10 penalty next year.

11 Though the jump in functional measures observed
12 here was nationwide and not just in the nine states, there
13 is some evidence that the jump was higher in states where
14 VBP will apply.

15 Next, we look at capital. It is worth noting
16 that home health agencies are less capital-intensive than
17 other health care providers. Also, few are part of
18 publicly traded companies.

19 Financial analysts have concluded that the
20 publicly traded agencies have adequate access to capital,
21 and we have seen a recent uptick in mergers and
22 acquisitions. And it appears that firms are increasing

1 their capacity in this sector.

2 Turning to margins for 2016, we can see that
3 margins for this year were 15.5 percent, not much of a
4 change relative to 2015. The trend by type of provider is
5 also similar to prior years, with for-profits having higher
6 margins than nonprofits and urbans having higher margins
7 than rurals, but the differences are mostly relatively
8 small.

9 The marginal profit for home health agencies was
10 17.4 percent in 2016. I would also note that these data
11 rely upon the home health cost report, which have been
12 found to overstate costs in past audits.

13 The Patient Protection and Affordable Care Act
14 mandated four years of payment reductions in 2014 through
15 2017, commonly referred to as "rebasing." However, the
16 PPACA offset these reductions with an annual market basket
17 update. The net effect was that payments were reduced by
18 less than 1 percent a year, and the Commission has
19 expressed concerns that this rebasing will not sufficiently
20 reduce payments.

21 The margin results for 2014 through '16 bear this
22 out. Margins in all years of rebasing have exceeded 10

1 percent, and in the last two years, they have been almost 3
2 percentage points higher than the margins in effect in
3 2013, the year before rebasing began.

4 The double-digit margins we report for these two
5 years -- for these years contrast with an earlier estimate
6 of the policy's impact produced by the home health
7 industry.

8 In 2013, an industry analysis projected that
9 margins for 2014 would be 5 percent and margins for 2015
10 would be 1 percent, for example. This obviously contrasts
11 with the actual results for these years, which are well
12 above these estimates.

13 This year, we also examined the performance of
14 relatively efficient home health agencies. Recall that we
15 defined relatively efficient providers as those that are in
16 the lowest third of providers in cost are the best
17 performing third of providers for quality, without having
18 extremely low performance on either measures. About 9
19 percent of agencies met this standard.

20 Relatively efficient providers had an average
21 cost per episode that was about 6 percent lower than other
22 agencies and median Medicare margins that were about 8

1 percent higher. Relatively efficient providers were
2 typically larger in size with the median efficient provider
3 about 60 percent larger than the median for other agencies.

4 Relatively efficient providers also had lower
5 hospitalization rates. They provided about the same mix of
6 nursing, therapy, and AIDS services to their patients, and
7 they also delivered similar numbers of outlier and low-use
8 episodes.

9 Efficient providers tended to serve a more urban
10 mix of patients compared to other providers.

11 We estimate margins of 14.4 percent in 2018.
12 This is a result of several payment and cost changes. For
13 payment changes, we included the payment updates for 2017
14 and 2018, and we also included the coding reductions of
15 slightly less than 1 percent in 2017 and 2018 CMS has
16 implemented.

17 On the cost side, cost growth has been
18 historically low in home health, and we assumed a cost
19 growth of one-half percent a year, which is above the long-
20 term average.

21 Turning back to our framework, here is a summary
22 of our indicators. Beneficiaries have very good access to

1 care in most areas. The number of agencies is high,
2 reaching 12,200 in 2016. The volume and utilization was
3 flat overall. The functional measures showed improvement
4 in 2016, with the caveats discussed earlier, and the rates
5 of hospitalization and ER use were mostly unchanged.
6 Access to capital is adequate. The margins for 2016 are
7 15.5 percent, and the estimated margins for 2017 are 14.4
8 percent.

9 I would note that these are average margins, and
10 our review of the quality and financial performance for
11 relatively efficient providers suggest that better
12 performing agencies can achieve good outcomes with profit
13 margins that are significantly higher than other agencies.

14 This brings us to the draft recommendation for
15 2018. This recommendation has two parts. First, bringing
16 the level of payment down; and second, it ends the use of
17 therapy as a payment factor, which would be budget-neutral
18 but redistributive.

19 Also, recall during Carol's session that we are
20 considering our recommendation for Medicare to blend the
21 home health PPS-specific payment weights with a set of
22 cross-sector payment weights. This would also be budget-

1 neural and redistributive.

2 The recommendation reads, "The Congress should
3 reduce Medicare payments to home health agencies by 5
4 percent in 2019 and implement a two-year rebasing of the
5 payment system beginning in 2020. The Congress should
6 direct the Secretary to revise the PPS, to eliminate the
7 use of therapy visits as a factor in payment
8 determinations, concurrent with rebasing.

9 The impact of this change would be to lower
10 spending relative to current law. The impact to
11 beneficiaries should be limited, and it should not affect
12 provider willingness to serve beneficiaries.

13 Like the proposed recommendation to blend the PAC
14 PPS in setting specific weights, eliminating therapy as a
15 payment factor would be budget-neutral in aggregate but
16 redistributive among providers. Nonprofit agencies would
17 see their aggregate payments increase due to the
18 elimination of the therapy thresholds, while for-profit
19 agencies would see a decrease.

20 This completes my presentation, and I look
21 forward to your questions.

22 DR. CROSSON: Thank you, Evan.

1 We are open for clarifying questions.

2 Yes. Warner, Dana, and then David.

3 MR. THOMAS: So I have, I think, a kind of
4 similar question I had before. For MA payments and
5 commercial payments for home health, how do they usually
6 compare to traditional Medicare?

7 MR. CHRISTMAN: Okay. Maybe just to fast forward
8 here, the overall margins for home health are in the mid-
9 single digits. I can't pull it out of my head exactly, but
10 they are lower than the Medicare margins.

11 And Medicaid is a big player in this, but you
12 asked specifically about MA, and that's a really good
13 question. In the MA realm, the plans and the providers
14 negotiate a rate, and my understanding is there's sort of
15 two sets of practices going on. One is that often plans
16 will negotiate. They won't pay on a 60-day episode.
17 They'll pay on a visit basis, and it has been a
18 longstanding concern of the industry that the rates that
19 they can get from the MA plans on a per-visit basis average
20 out to less than what they get from fee-for-service. So
21 that's been one issue.

22 And I would just add that there has been -- I

1 don't think it's overtaken, become the most common
2 practice, but there have been some plans that, as I
3 understand it, are flipping over to an episodic payment. I
4 don't know that they pay the Medicare rate, but they're
5 going to a bundle. But on average, the payments are lower.

6 MR. THOMAS: So what we've been looking at are
7 margins just specifically on Medicare, correct?

8 MR. CHRISTMAN: Medicare fee-for-service.

9 MR. THOMAS: Okay. And not the -- okay.

10 And then is this all home health agencies?
11 Because I know there's different designations. There's
12 freestanding. There's hospital-based.

13 MR. CHRISTMAN: Right. So this is the
14 freestanding, and this is about 85 percent of agencies.

15 For the 15 percent of facility-based agencies,
16 the average margin is about negative 15 percent. It's a
17 little worse than what it's been in recent years. When we
18 have looked at the differences between facility-based and
19 freestanding agencies, we haven't really found a big
20 difference in the patients they serve. The most striking
21 difference we have found is in their cost per visit. The
22 cost per visit for the facility-based agencies, which are

1 mostly hospitals, is astronomically higher than what we see
2 on the freestanding side.

3 MR. THOMAS: So the payment recommendation here
4 would apply to all, though?

5 MR. CHRISTMAN: Right.

6 MR. THOMAS: Freestanding as well as hospital-
7 based?

8 MR. CHRISTMAN: Right. And so an important
9 wrinkle to keep in mind with this is that pulling --
10 there's two parts, and there's the rebasing that cuts the
11 overall rate, and then there's pulling out the therapy
12 thresholds. And the redistributive part of pulling out the
13 therapy thresholds is important because it has the effect
14 of moving money from providers that do lots of therapy to
15 providers who do less of therapy and more of nursing, and
16 that is typically hospital-based agencies. They typically
17 -- I'm not going to say it makes up the 15 percent margin
18 they've got right now, negative margin, but it moves money
19 towards them.

20 MR. THOMAS: Going to David's point on the last
21 discussion, is there anything else that you can identify in
22 those differences in the agencies as far as payer mix or

1 things like that, that would drive the hospital-based
2 versus freestanding or just the differential in the
3 profitability of entities?

4 MR. CHRISTMAN: When we have looked at the
5 factors that explain the differences and profitability
6 among agencies, we haven't found a big difference in
7 patients. I kind of have become a broken record on this,
8 but it is striking. The biggest difference in the cost per
9 visit.

10 MR. THOMAS: Okay.

11 MR. CHRISTMAN: Not even the payments. The
12 payment difference isn't that great. It's definitely
13 better for agencies that do more therapy, but the cost
14 difference is really a much greater variance than that.

15 MR. THOMAS: Okay. Thank you.

16 DR. CROSSON: Dana.

17 DR. SAFRAN: Thank you. Thanks for this clear
18 work.

19 My question kind of could have related to any of
20 the post-acute topics that have been discussed, so I'm just
21 asking it now since I just arrived. But is there any part
22 of the analysis that you do that tells us the extent to

1 which any of these are substituting for other services?

2 So as we're looking at the increased utilization,
3 which if I remember right was kind of happening across the
4 board in all of these, we don't know whether there are
5 substitution effects happening or at least not from what
6 I've read, and I just wonder if that's part of the analysis
7 or enters into our thinking.

8 MR. CHRISTMAN: I would say in aggregate across
9 the four sectors, I don't think we've done an analysis that
10 really has looked at shifts and volume among the sectors.
11 I think sometimes issues have arisen where it becomes quite
12 clear. When CMS got more rigid about enforcing the 60
13 percent rule, there were a lot of patients who moved out of
14 IRFs, and it appears at that point, we saw them move into
15 home health, some of them. But you get into an interesting
16 game where a lot of IRF patients, it's a very small number
17 of home health patients. So it's not a big piece of -- I
18 can't say it's a significant piece of the trend.

19 But obviously, when we don't have clear
20 guidelines about where people belong and it's a struggle to
21 measure severity across sectors, people have done dives at
22 the work that you're talking about. But it's always a

1 challenge.

2 DR. CROSSON: David.

3 DR. NERENZ: Warner asked the question I was
4 going to ask about freestanding hospital-based.

5 Let me just extend that, though, and this may go
6 beyond what you can do for January. When you say the costs
7 are higher, cost per visits higher in the hospital-based, I
8 certainly would want to know why that is and not, you know,
9 a plan where I was before. And I've said this for years,
10 actually, around this table. I always find it really hard
11 to believe that the managers of hospital-based facilities
12 are uniformly incompetent, lazy, careless. I just don't
13 believe that. So I want to know why, but we may not be
14 able to know why.

15 MR. CHRISTMAN: Well, I appreciate you ending on
16 that.

17 [Laughter.]

18 MR. CHRISTMAN: I don't think we've ever -- we've
19 never really gotten to, I think, an ironclad answer on
20 that, but the two things I would note, specifically for
21 home health, is that sometimes you get into the issues that
22 this is a SNF On a hospital floor, and somehow it's getting

1 the hospital level of cost.

2 Obviously, in home health, you don't have that.
3 It's the beneficiary's home, and when we've had this
4 conversation, I think the pieces that have come back to you
5 are overhead, administrative overhead and such from the
6 system or the hospital the agency is a part, maybe that's a
7 piece of it.

8 But I think you also sometimes get into an
9 interesting dynamic that hospital-based agencies may have a
10 different approach to a lot of things because they're part
11 of a hospital, and I think the canonical example, as I
12 remember talking to a manager at one that said that she had
13 to offer higher wages because if she didn't, it was easier
14 for other departments of the hospital to come and take her
15 nurses.

16 And so it's a different dynamic because they are
17 a part of a larger organization than a freestanding agency.

18 DR. NERENZ: Even an example like that is
19 helpful. I think there are probably many other wrinkles to
20 the story, but that's the kind of thing I was looking for.

21 DR. CROSSON: Paul and then Jack.

22 DR. GINSBURG: I would be very interested, I

1 think for the future, not for this round, in learning more
2 about how MA plans approach home health, how they manage
3 it, because from your paper, it's clear that fraud has been
4 a significant issue in the home health benefits showing
5 that there's a long way to go as far as finding a way of
6 managing it well. This could be -- I presume this is one
7 of the big advantages. I think post-acute care in general
8 is one of the advantages that Medicare Advantage has over
9 fee-for-service Medicare.

10 Some of the techniques being used could be very
11 instructive to modifying the fee-for-service program.

12 DR. CROSSON: Jack.

13 DR. HOADLEY: So you talked a little bit at the
14 beginning about CMS having this new proposal and then
15 withdrawing it. Do we have any more insight on -- and I
16 know you said in the paper they just needed to review more
17 comments, but do we have any more insight on concerns that
18 were raised or what they're -- you know, is something where
19 it feels like they would go forward in another year?

20 MR. CHRISTMAN: I guess I would honestly confess
21 that, you know, my Magic 8 Ball says, "Future is highly
22 uncertain." You know, the two main complaints were, as

1 it's discussed in the paper, CMS implemented this in a way
2 that was going to take money out of the system, and I think
3 that produced a very strong reaction. And the second piece
4 is there's always, you know, redistributive aspects of
5 these proposals that, you know, the industry generally has
6 a hard time dealing with. And I would say, you know, those
7 were sort of the two main industry complaints. I think
8 they were -- they also had a complaint that they felt like
9 they didn't have enough information to evaluate the whole
10 system, but I would say in my experience CMS put out as
11 much information on a new payment system change as they
12 always do.

13 So, you know, CMS just -- they didn't even
14 respond to the comments on the payment system and the rule
15 in any detail. They just kind of said we're going to look
16 at these comments and make some decisions. But they didn't
17 really give you a road map forward.

18 DR. HOADLEY: And are there any lessons from that
19 back-and-forth for what we're talking about?

20 MR. CHRISTMAN: I guess, you know, for me, I
21 think in the back-and-forth I'm not sure there's too much
22 for me to react to. I guess what I would take away is just

1 that, you know, it was great to see CMS recognizing the
2 issue that therapy thresholds have posed, and they have
3 tried a series of administrative changes to tighten
4 supervision and change the pricing to make it a little
5 harder to game. But I think that pulling therapy out of
6 its entirety is a recognition that those efforts have not
7 succeeded as well as one would hope. So I really don't see
8 -- I don't really know where they're going to go from here.

9 DR. CROSSON: Questions? Warner.

10 MR. THOMAS: Have we modeled the recommendation
11 of the 5 percent reduction into the industry? Because I
12 think, you know, Medicare's a pretty significant component
13 of home health revenues. So have we modeled a 5 percent
14 impact on kind of total margin? Do we have an estimate of
15 that?

16 MR. CHRISTMAN: I mean, I would say currently
17 it's not wrong to think of it as taking 5 points off their
18 margin.

19 MR. THOMAS: Total margin.

20 MR. CHRISTMAN: Off their Medicare margin. Now,
21 we could think about how to grind that down to the total
22 margin, but I guess, you know, the -- I guess I'm trying to

1 understand what the significance is of the total margin
2 that you're aiming for.

3 MR. THOMAS: Well, I mean, because you're saying
4 that the total -- the all-payer margin you're saying was
5 mid-single digits.

6 MR. CHRISTMAN: Right.

7 MR. THOMAS: So, you know, 5, 6 percent? So if
8 you take 5 percent, it pretty much will take it to a
9 breakeven. So I guess I'm just trying to figure out is
10 that what we're talking about here.

11 MR. CHRISTMAN: Well, yeah, I mean, if it just
12 took out 5 points, then if total margins were at 5 percent,
13 they'd be closer to zero. But I guess the point I want to
14 make that makes home health incredibly hard is that the
15 cost side has in the past proven to be quite flexible, and
16 then when they receive a payment change, they adjust their
17 cost structures. So, you know, statically, I can say
18 taking 5 points out of their payments reduces their margins
19 by 5 points. In reality, you know, as you see in the table
20 in there at the beginning, you know, you can see that they
21 took visits down by something like 25 percent in two years
22 when they went from a per visit payment system to the 60-

1 day PPS. And then there's a long history that I could ruin
2 everyone's afternoon with of how they have changed the
3 exact number of therapy visits they provide as the specific
4 payment amounts for each thresholds were altered. This is
5 a very nimble industry.

6 So if there's something specific you want us to
7 think about, we can drive towards that. But I guess, you
8 know, it is always a little bit uncertain when you're
9 projecting these margins. Every time I've done this, just
10 about every time, I've always been too low in what I
11 expected their margins to be in the future.

12 MR. THOMAS: It's really just a question to try
13 to understand what the -- because we don't have the -- you
14 know, we don't have the all-payer margin in here, so I
15 think to understand that and what the impact may be. So
16 thanks.

17 DR. CROSSON: Okay. I think we're done
18 with the questions. Let's move on to the recommendation on
19 Slide 16, and we'll open for discussion on the
20 recommendation. Yes, David?

21 DR. GRABOWSKI: I'll start by saying I'm
22 supportive of the Chairman's draft recommendation. I just

1 -- and I don't know if it's a call-out to a previous
2 recommendation, but I wanted to make the point that not all
3 home health care, as Evan did in the chapter, is post-acute
4 care. And home health not preceded by a hospitalization
5 has often been thought by the Commission to be lower value,
6 and I believe you've written in the past or at least
7 recommended that potentially we could adopt cost sharing
8 around that home health care use not preceded by a
9 hospitalization. I don't know if there's a way to call
10 back to that or to include that here, but I think that's
11 really important.

12 This is one of the few parts of the Medicare fee-
13 for-service system that doesn't have cost sharing. That's
14 a place, to build on Paul's point earlier, where you could
15 really leverage some of the tools that are used in Medicare
16 Advantage and apply them here. And I think that would be a
17 nice step forward. As a new member, I don't know how that
18 gets fit into your draft recommendation, whether that's a
19 call-out to a previous recommendation or part of this.

20 DR. CROSSON: Well, as we discussed a little bit
21 earlier, we've done it in different ways. Sometimes we'll
22 take it and just insert it into the text as "by the way."

1 Sometimes we'll put it in a text box for emphasis. And
2 then sometimes, as we just did, or recommended we should
3 do, we reprise the recommendation as part of the current
4 recommendation.

5 Evan, when did we make that recommendation?

6 MR. CHRISTMAN: It was either 2010 or 2011. And
7 we could add some discussion to the chapter where we talk
8 about our recommendations and just kind of say, you know,
9 mention this is something we've done in the past, I think
10 would be one move. We could also put in a text box or
11 something to reiterate that we've made the recommendation.

12 DR. CROSSON: Jon.

13 DR. CHRISTIANSON: In the literature, for home
14 health care that's not preceded by a hospitalization, is
15 there indication that home health care for some patients
16 reduces the probability of a subsequent hospitalization?

17 DR. GRABOWSKI: So I haven't seen that research.
18 It would be interesting. I was basing that largely on kind
19 of Evan's work and others that I think there's a perception
20 that it's lower value relative to kind of the home health
21 that follows a hospitalization.

22 DR. CHRISTIANSON: I agree with that. I just

1 wanted to --

2 DR. GRABOWSKI: It would be interesting to look
3 at the literature. And I don't know, Evan, if you want to
4 speak to the work you've done.

5 MR. CHRISTMAN: I think it was sort of a couple
6 of things. One is that if you -- again, the table in the
7 paper, what we call the "community admit episodes" have
8 more than doubled in this period, and this is the period of
9 rapid supply expansion where the number of agencies went up
10 by 60 percent, and the high margins, and the sense that,
11 yes, this was a little bit more of a discretionary part of
12 the benefit. When we talk to people about why these folks
13 are in the system, we hear a variety of reasons, some of
14 them, you know, very valid sounding but at the same time,
15 lots of variations. So that was one piece.

16 I think a second piece was that applying cost
17 sharing to the post-acute episodes raised a variety of
18 issues because right now for a lot of beneficiaries, there
19 is effectively no cost sharing for going into the
20 institutional settings. And if you created it for post-
21 acute without addressing that, you could have a situation
22 where a patient could pay a \$50 or \$150 co-pay for going to

1 home health or zero for going to an IRF. And it's sort of
2 implicated that if you wanted to do that for home health,
3 you had to address the other sectors, and I think at that
4 point the Commission was not looking at that.

5 Those were sort of the two corners, I think, that
6 led us to the community admits.

7 DR. HOADLEY: What was the recommendation that
8 was being referred to from 2010 or whatever?

9 MR. CHRISTMAN: There is a recommendation that
10 says Medicare should apply cost sharing to home health
11 episodes not preceded by a hospitalization or prior
12 institutional PAC stay. And it's about two-thirds -- you
13 know, in our universe you can think of them as community
14 admits, and it's about two-thirds of episodes today.

15 DR. CROSSON: You know, I'm trying to come up
16 with a good explanation for why I think differently about
17 this one. My sense is that the recommendation was
18 significantly long ago. To me, it feels a little bit
19 complex, and I'm a little bit concerned about bringing it
20 forward as a recommendation in January without a more
21 robust consideration with this new Commission that has not
22 looked at this issue before -- or this current Commission.

1 But I would be -- I think I would be okay, because it's
2 historically true, to bring it forward, for example, as a
3 text box in the rewrite in January. But I want to test
4 that idea. What do people feel about that? Jack?

5 DR. HOADLEY: I mean, I agree, I don't think we
6 should -- I mean, unlike something like we did a couple
7 minutes ago on the previous thing about the additional
8 auditing or whatever, that was sort of an incremental step
9 within a payment system. This, which starts to implicate
10 beneficiary cost sharing, is a much bigger -- you know, a
11 different style of issue, and so I agree we should not try
12 to go back and reprint that. Obviously, like you said, we
13 can reference it as a historical event.

14 I might even -- if it was just up to me, I
15 probably would not reference that because, as you say, we
16 have not gone back, I certainly haven't gone back and tried
17 to think about, you know, how I would think about that
18 particular issue.

19 DR. CROSSON: Kathy?

20 MS. BUTO: I'd want to know more about the
21 patients. For instance, if somebody's qualifying for home
22 health care, essentially homebound, hasn't been in a

1 hospital, is it for something like treatment of pressure
2 ulcers where you've got an episode -- I mean, how frail is
3 the individual? And do you really want to be just sort of
4 willy-nilly talking about applying a co-pay to that, co-
5 insurance to that? And things have changed since whenever
6 it was, seven years ago, when we first made the
7 recommendation. So I'd want to know more about the patient
8 characteristics before even considering a text box. I
9 don't think I'd do it right now until we had more
10 information about the patients.

11 DR. CROSSON: Okay. Alice.

12 DR. COOMBS: I was out, but I got the gist of it.
13 Thank you. So we actually visited this I think three --
14 Rita, three, four years ago? And one of the concerns was
15 that if you -- this is a very needed service, and you don't
16 want to have a default decisionmaking where someone says,
17 well, you know, this is going to stress out the non-LIS who
18 are maybe on the margins in terms of being able to get
19 services. Not that you can qualify for one -- so that if
20 you don't qualify for one, you would want this kind of
21 service to be available because it could escalate, where if
22 you didn't have this kind of intervention, that you might

1 have more costly services that would be required in lieu of
2 that. And providers will make that decision in an office
3 where they say, well, the co-pay's going to be difficult
4 for them, for home health. Is there some other kind of
5 decision that we can do to help the patient out? And so
6 it's not just the patient making the decision, but it's
7 also the provider projecting onto the patient with the
8 multiple comorbid conditions. So we actually revisited
9 this, I think it was four years ago.

10 DR. REDBERG: Right, it penalizes the patient. I
11 mean, like Alice said, home health service is very needed
12 when it's needed, and we're trying to get at the fraud or
13 the overuse, and that's not -- the co-payment is just going
14 to penalize the beneficiary, but I don't think it's --
15 they're not the ones that generally are initiating the
16 fraud and overuse kind of visits. So, you know, it's the
17 problem we have that when the service is needed, it's
18 great, but then there's a lot of evidence that there are
19 services that aren't needed. But this isn't going to be
20 the solution --

21 DR. CROSSON: Yeah --

22 DR. REDBERG: -- capitation, the prospective

1 payment system. Not this.

2 DR. CROSSON: I'm sorry. Thank you for bringing
3 this up. I think we will revisit this issue again. But I
4 think based on this discussion, we probably will not
5 include it in this chapter at this time.

6 Okay. Warner, you have got your hand up?

7 MR. THOMAS: Are we on Round 2 or Round 1 [off
8 microphone]?

9 DR. CROSSON: There you go. We're in Round 2.
10 We're on the recommendation.

11 MR. THOMAS: Yes, so just real briefly because I
12 -- my concern here is that -- and I realize there's a lot
13 of challenge around the home health industry overall. I
14 know there's fraud and abuse issues and what-not. My
15 concern with the recommendation is, just as we were saying,
16 if you look at the total all-payer margin, we're talking
17 about an industry that's in the mid-single digits, and
18 we're talking about a 5 percent reduction. And, you know,
19 then we're talking -- and that's for traditional Medicare,
20 and then MA and commercial is usually below traditional
21 Medicare. So I think that puts tremendous pressure on, you
22 know, a service that, frankly, is critical to the industry.

1 Now, I hear your point about it's flexible,
2 they've been adjusting the cost structure. I just would
3 caution us to think more about looking at the total picture
4 of the industry and the total margin, not just Medicare.
5 And that's why I think, going to David's point earlier, I
6 think we need to do that everywhere and not just where
7 commercial, you know, lifts the margin but also where
8 commercial or MA decreases the margin. I think we need to
9 look at it on both sides, not just one.

10 DR. GINSBURG: If I could follow up on that, I
11 think that when we -- I don't know what percentage is
12 Medicare fee-for-service of this industry, but if Medicare
13 cuts its rates and its margins much higher, it doesn't mean
14 everyone else is going to cut their rates. So we're not
15 talking about wiping out the mid-single-digit total margin
16 by cutting the Medicare rates. And, you know, I think the
17 flexibility of the industry, the profitability of the
18 industry is very important, and it shows that there is some
19 ability to pay less.

20 MR. THOMAS: Just an addition -- well --

21 DR. CROSSON: Go ahead [off microphone].

22 MR. THOMAS: Just a comment on that. And I agree

1 that it does not mean that that's necessarily the case,
2 although MA traditionally follows Medicare, traditionally,
3 and, I mean -- well, in markets I've been in that, I've
4 seen that.

5 DR. GINSBURG: I mean, on MA, MA cannot pay more
6 than traditional.

7 MR. THOMAS: Right.

8 DR. GINSBURG: But when Medicare overpays, they
9 do pay less.

10 MR. THOMAS: Yeah. But I think also when
11 Medicare reduces, many times they reduce fees. So I would
12 just -- I'm not saying that it shouldn't be considered. I
13 just think it's not just -- you know, a 5 percent
14 reduction, significant, and this is a critically important
15 service. And what I worry about is that we continue to,
16 you know, adjust our cost structure, and I worry at some
17 point we get to a point where it's a service issue with
18 patients. And, frankly, one of the challenges you have in
19 home health, it's very difficult to measure service and
20 measure quality when it's being done in the home. And I
21 just get concerned about that for beneficiaries. And it
22 doesn't include 15 percent of the home health agencies

1 which are hospital-based.

2 DR. CHRISTIANSON: So I share all of the concerns
3 you have. I guess one thing to bring up is that we've had
4 this generic discussion over the years around, well, for
5 instance, if the private sector isn't paying real well for
6 home health care and we're worried about it we should
7 therefore pay more from Medicare, and that's a real
8 slippery slope we don't want to go down. And I'm not
9 suggesting you're saying that, Warren. I'm just saying it
10 gets us to the edge of that, I think.

11 We do need to look at the whole picture, but if
12 the whole picture suggests we wish the private sector were
13 paying more or we need to pay more from Medicare because
14 the private sector isn't paying more, then there's a little
15 bit of a self-fulfilling prophecy potential there that we
16 need to be careful to avoid, I think.

17 MR. THOMAS: And I totally agree with that, and I
18 think it is a slippery slope, and I'm not necessarily
19 advocating that. However, we just had a discussion earlier
20 today where we said, well, Medicare's not paying hospitals
21 enough, but it's okay because commercial pays more. So I
22 just think, you know, we need to kind of look at the whole

1 picture in all components of the payment system. That's
2 all.

3 DR. CHRISTIANSON: I didn't say that [off
4 microphone].

5 MR. THOMAS: No, I'm not saying that you said
6 that, but that's essentially the conclusion we came to this
7 morning, is that we see Medicare margins for efficient
8 inpatient hospitals at negative 1 and negative 9-point-
9 something for all. And yet we said, well, the all-payer
10 margin's 5 to 6 or 7 percent, so it's okay. It's just to
11 me I think we've got to look at this consistently. That's
12 all.

13 DR. CROSSON: Okay. Warner, respectfully, I
14 don't think that's what we said. I think what we said was
15 that hospitals' attention to cost structure and, therefore,
16 its ability to be profitable in Medicare was in many cases
17 a function of the high rates of payment that were going on
18 in the commercial environment. But I don't believe what we
19 said was, therefore, we should pay less. I think what we
20 were saying was that if we were to pay more, we were simply
21 chasing a phenomenon that was going on in the commercial
22 world, which is -- you know, you can say that's the same

1 thing, but it's actually, you know, philosophically a
2 little bit different.

3 I think, you know, as I've listened to the
4 discussion today, particularly this afternoon, it kind of
5 recalls for me a number of discussions that we've had over
6 the years on the Commission, particularly in the earlier
7 time when I was on there. And it gets to the basic
8 question that I think Jon was getting to, which is how
9 should we think about -- I mean, we're a Medicare
10 Commission, right? And our role here really is to
11 determine what Medicare should be paying based upon our own
12 analysis of all the quality and everything else that people
13 have brought forward.

14 We have in recent years brought forward the
15 notion of all-pay margins or commercial margins because
16 people were interested in them, and I think we heard that
17 today. We'd like to know, you know, what's going on. But
18 I don't think we've ever as a Commission come to the
19 conclusion that the relationship between Medicare margins
20 and commercial margins, whichever way it goes, whether, you
21 know, commercial is higher, Medicare is lower, Medicare is
22 higher, commercial is lower, as we find in this case,

1 should be a determining factor in making our own judgment.

2 Now, people can have a different point of view
3 about that, but in the past -- and I think, you know, just
4 over the time I've been on the Commission, even though it
5 was interrupted for a few years, there's been kind of an
6 increase in the focus on, you know, non-Medicare margins.

7 I think that what we need to do here, not today
8 but when we have the time together as a Commission, is to
9 sit down -- and we've done this twice in the last 15 years
10 or so that I've been in a relationship to MedPAC. We need
11 to go over that again so that we understand, you know, what
12 we believe. You know, should we be -- to what degree,
13 other than just information, to what degree should we be
14 taking into consideration the payment levels outside of
15 Medicare when we determine what we think Medicare should be
16 paying? It's very complicated, and it's an area where
17 people can disagree. And we've heard today, you know, a
18 little bit about disagreements in both directions. And I
19 do think there was a period of time earlier on the
20 Commission where we were kind of saying let's not even look
21 at those margins, and I don't agree with that. I think we
22 need all the information -- as some of you asked for, we

1 need all the information in front of us. But I do think
2 that we need to have a serious discussion, when we have the
3 time to do that, about, you know, what we think now about
4 the level or the degree to which non-Medicare payers should
5 have an influence over what Medicare pays. Is that fair
6 enough?

7 MR. THOMAS: Yeah, I think that's fair, and I
8 guess part of my point is I think it would be helpful to
9 look at, as I was saying earlier, information consistently
10 across all the disciplines. So if we're going to look at
11 non-payer -- or excuse me, all--payer profitability, let's
12 look at it across all disciplines and have it very
13 transparent.

14 You know, I think the other thing is that -- and,
15 you know, I know we haven't talked about this a lot today,
16 but it also goes to ancillary services or components of a
17 system such as device and drug companies and margins there.
18 And I know that's kind of going down another path, but they
19 are considerations or should be considerations of the
20 program, in my opinion, given we do all this payment
21 adequacy, we're spending a whole day on this, which I think
22 is very important, and yet we don't do the same sort of

1 diligence, I think, on margins and other components of the
2 industry, which is significantly higher than anything that
3 we've looked at today. So I would just encourage us to
4 have transparency across all of those areas, and --

5 DR. CROSSON: So I agree with you about the
6 transparency and providing the information. As I said a
7 couple minutes ago, I do worry, though, that we become
8 overly focused on what is going on outside of our province
9 in Medicare. So we need to have a discussion about that.

10 In terms of drugs and devices, as you know, for
11 the first time that I'm aware of, we have begun to go down
12 the path of trying to understand the device industry and
13 both on the Medicare Part D and Part B side, we do have
14 recommendations that we have brought forward, which I think
15 would have, if they are implemented by Congress, a pretty
16 significant impact on the cost of drugs. So I don't think
17 that we've been ignoring that. It's just that because
18 Medicare does not pay directly for these things, in this
19 particular part of our Commission work, in December and
20 January, we deal with those things where Medicare pays
21 directly and the issue of updates are not updates.

22 Okay. David and Kathy and then Pat.

1 DR. NERENZ: On this slide of discussion, which I
2 think is very interesting, and certainly most of us don't
3 have that track record with history of the Commission the
4 way you do, about how we've looked at these things.

5 I guess what I'd say is I find myself somewhat in
6 the middle. I don't want us to be drawn in one direction
7 or another, strictly because of what other payers are
8 doing, and I don't think we should. But every time we look
9 at one of these, what I'm really trying to do is think of
10 what's going to happen to beneficiaries if we do this or
11 that, whatever it is we're considering? And the
12 intermediate step is, what are the providers going to do?

13 Now we're speculating, in many cases -- we don't
14 have a track record, we don't always know, but we have to
15 guess, because eventually we're going to put our hands up,
16 or not, and say, yes, I like this, or no, I don't. And
17 that's the frame I put on it. But the thing is, when I'm
18 trying to think what will providers do and then what will
19 happen to beneficiaries, I have to take into account the
20 larger environment. If, you know, the whole payer mix is
21 X, you know, the direction, I think, may go here, with some
22 effect on beneficiaries. If it's a different all-payer

1 environment, now the direction may go there with a
2 different effect.

3 And I'm still worried about Medicare
4 beneficiaries. That's who I'm thinking about. It's still
5 Medicare, but I just can't step away from what's the rest
6 of the ecology that's going on.

7 DR. CROSSON: Yeah, I think that's fair enough,
8 and we try to do two things. Number one, you know, we try
9 to assess access and quality and those things, and they're
10 -- you know, they're imperfect. You know, they're kind of
11 the best we can do, and it varies by payment area,
12 depending on what data is available.

13 And the other thing, and I think Evan did that
14 today, is to try to look at kind of what's happened in the
15 past when there have been similar or kind of similar change
16 to payment in a particular part of the industry. You know,
17 has there been a catastrophe, or, in fact, has the industry
18 appeared to be able to adjust pretty well without changing
19 quality and access? And I think he gave an example. It
20 doesn't mean it's always going to be that way, but he did
21 give an example of an earlier change in payment here, and
22 showed, in fact, in the materials that although there were

1 serious concerns in the industry for what would happen to
2 their profitability, in fact, the industry adjusted pretty
3 easily and that did not take place.

4 So that's -- you know, that's historical
5 information. We don't always have that information because
6 sometimes we're considering changes which have never
7 happened before.

8 DR. CROSSON: Okay. So Kathy and then Pat.

9 MS. BUTO: I just wanted to add that I think
10 something that's changed since you first look at this, Jay,
11 is the issue of coming up with the Medicare profit margin
12 analysis, where we're looking now at more variable costs
13 and profit margins versus --

14 DR. CROSSON: Marginal margins.

15 MS. BUTO: Marginal --

16 DR. CROSSON: Whatever we called it, yeah.

17 MS. BUTO: -- yeah. So what strikes me about
18 that is the issue that I think Pat raised earlier about,
19 well, who attends to fixed costs? What is -- what, if any,
20 responsibility do we have for that, if our bottom line is
21 access for beneficiaries?

22 So when we have that larger discussion, I think

1 that's kind of what's changed, is we've gotten more
2 surgical, if you will, in the way we've looked at it for
3 our purposes, to make sure that Medicare is really just
4 attending to Medicare. But in the meantime, have we walked
5 away from some other things that we should be looking at?

6 DR. CROSSON: I think that's absolutely true, and
7 it came up this morning when we were talking about hospital
8 updates, and the fact that, you know, we may very well need
9 to have a discussion at some point about how we approach
10 hospital margins, because, in fact -- and I think this
11 applies to other areas of payment as well -- we talk about
12 the marginal Medicare margin, if you want, as having -- and
13 I think we do that as if -- within and across payment
14 levels, the Medicare burden, if that's the right term, but
15 the Medicare weight is the same.

16 And depending upon -- and let's talk about
17 hospitals for the moment -- depending on what percentage of
18 discharges are Medicare, that marginal margin, if it's
19 small in relationship to the number of patients admitted,
20 has one effect, and if we have a hospital that is extremely
21 dependent on Medicare revenue, somebody has to bear the
22 burden of the capital costs, and it's a different

1 situation.

2 So I do think that this is -- that these are --
3 these issues need to be considered together. I do think we
4 need to do it at a time when we have time together to give
5 due consideration, so that, you know, eventually, and
6 certainly before the next time we do this again, we've kind
7 of -- we may not come to unanimity but we've at least
8 discussed all the issues and come to some sort of sense of
9 where we think we should be doing it, and how much weight
10 we should put on these various factors -- the non-Medicare
11 margin, the marginal margin, et cetera.

12 Because I think -- you know, commissions, over
13 time, will have these discussions. They'll come to a
14 meeting of minds, and then the composition of the
15 commission changes. The issues are still there, and then
16 they come back up again, and people are saying, "Well, why
17 are we doing this? Why do we do it that way?"

18 And as you say, the environment also changes. So
19 it's perfectly reasonable to go back and say, "Well, wait a
20 minute. Why are we doing this again, and how much of this
21 should we be considering and the like, and we will do
22 this."

1 Pat.

2 MS. WANG: So this is a good conversation and I
3 think -- and I look forward to the further exploration of
4 the topic. But, you know, in thinking about the comments
5 that have been made today, which have been very thought-
6 provoking, I think, you know, my general inclination is
7 that it's important to have all the information about
8 margins, all-payer Medicare within that, but that at least
9 I am unlikely to conclude that there is a one-size-fits-all
10 approach to this, because providers are different. You
11 know, the payer mixes in hospitals are different, and what
12 commercial payers pay for there is going to be very big, I
13 think, compared to what they pay for in the home health
14 area.

15 Home health is a virtual service. I mean,
16 there's really no fix. There's no capital. There's no
17 drug costs, you know. And that's why I support the
18 recommendation because I do think that the prior
19 expressions of alarm on all of the changes, and what it
20 would do to the industry really haven't come to pass
21 because the sector has proved itself to be flexible with
22 consolidating, changing the way the service is delivered.

1 It's really -- it's a labor force. And so I support the
2 recommendation and I think it's further reason to support
3 to movement to the PAC PPS.

4 The second thing I just want to note about
5 Medicare Advantage, because people have been mentioning it,
6 and I may have misheard, but I think somebody said that
7 whatever the Medicare fee for service rate is, MA plans
8 can't go above that. That's not true. MA plans can go
9 above it, they can go below it. And so the good news/bad
10 news -- the good news is there's more flexibility. The bad
11 news is that you're subject to the market, like anybody
12 else. So organizations or providers that have more market
13 clout, you're going to be paying more like a commercial
14 payer, and, you know, maybe taking that out of
15 organizations that don't have the market clout. So I think
16 it's important to know that.

17 I think the interest in knowing more about what
18 MA plans do to arrange services, you know, manage services
19 is really important, but I don't think that we should
20 expect miracles there. If we did, then MA costs would not
21 be equivalent to fee for service, now, right? I mean, the
22 content of what MA plans are paying for and how they're

1 paying for it may increase cost, stimulate more efficiency
2 in the delivery system, but when it comes to home health,
3 for example, if a physician wants home health for their
4 patient, there are few MA plans, that I'm aware of, who
5 would say, "No, we have a different medical judgment there.
6 There's no home health approved."

7 And as far as fraud, waste, and abuse is
8 concerned -- yeah, everybody is chasing it. There's a lot
9 of attention.

10 Somebody asked -- Dana, I think, asked the
11 question about substitution and the difficulty of getting
12 at that. The one area that I would suggest maybe could be
13 a little bit on the petri dish to look for that is in the
14 fully integrated products, because, in that case you've got
15 -- you know, you've got all benefits for people who are,
16 you know, also getting cared for at home, because -- or in a
17 nursing home, I guess -- with a Medicaid benefit, but you
18 might be able to see a little bit more closely there, you
19 know, to Kathy's point. You know, a plan might well say,
20 because somebody is at home, "I'm sending a VNS nurse in to
21 see what's going on, because there may be an issue." And
22 it's just one visit, but it might avoid having to get a doc

1 on call. It might avoid a visit to the emergency room.

2 But if there were an interest in exploring that,
3 that might be an area to look for that.

4 DR. CROSSON: Okay. Dana, and then Rita.

5 DR. SAFRAN: Yeah. So, thanks, Pat, for those
6 comments and for circling back to that issue, because, you
7 know, this is my first time through this set of issues but
8 I do find myself longing for some kind of analysis that
9 would give me a holistic picture of post-acute care and the
10 kinds of tradeoffs being made. And so, you know, if the
11 idea of looking at MA to somehow understand how those
12 dynamics play out there, that's one.

13 I find myself thinking about the organizations
14 that have taken on Medicare risk, and the fact that they
15 are sort of the purchasers for the price changes that we're
16 talking about, and wondering, can we model out what
17 different choices they might be making, based on this?

18 And then the last thing I would say is, I was
19 really struck, and actually kind of excited about the fact
20 that for several of these parts of the post-acute care
21 spectrum there are functional outcome measures that are in
22 place and being looked at, you know, in a longitudinal way

1 where we know change, and it just seems exciting to
2 consider expanding that across the full set so that we
3 could start to make some of those substitutions very
4 specifically, and in an empirically based way, because we
5 know certain settings are going to lead to better
6 improvements in functional status for a patient who looks
7 like this.

8 DR. CROSSON: Thank you. Rita.

9 DR. REDBERG: This has been a really good
10 discussion of home health. I wanted to suggest we can talk
11 about maybe fraud and abuse in a broader way. When I was
12 coming to this meeting a colleague shared with me earlier
13 this week, you know, his mother recently had knee
14 replacement and home health came to evaluate her. She was
15 doing well, but they evaluated her as being non-ambulatory
16 and needing three-times-a-day therapy. And she protested
17 and said she was fine, and they said, "No, no, no. This is
18 what we do. Medicare covers it." And she called the
19 Medicare carrier and tried calling the fraud line and they
20 were not interested in hearing about it. They said, "No,
21 we just cover."

22 And as I told years ago, you know, my mother had

1 the same experience with podiatrists and being billed for
2 something that didn't happen, and tried calling the
3 Medicare carrier and, you know, because of the system we
4 have where the carrier is just paying out Medicare money,
5 there's not a lot of incentive to sort of pay attention. I
6 just -- I think it's a systemic problem, and obviously
7 there's a lot of home health that's really needed, but some
8 isn't. And beneficiaries who are really in the best
9 position to know have no way -- no one to listen to. And I
10 wonder if there is, you know, a way that we can sort of
11 make a fraud line that actually listens to the beneficiary
12 when they say, you know, I'm being billed or getting
13 services I don't want and I don't need, and Medicare is
14 paying.

15 DR. CROSSON: That's a good point. I do know
16 that a previous CMS administrator was very keyed in to the
17 home health issue because, in fact -- I'm trying to
18 remember when, but I was, I think, in Los Angeles at a
19 meeting when this individual personally went out with the
20 FBI and had some individuals arrested on the spot for home
21 health, Medicare fraud. So I do think that, at least at
22 periods of time, CMS has been focused in on this, but I'm

1 sorry for what happened to your mother. But I would not
2 have expected anything less from your mother.

3 DR. REDBERG: She gets so upset. Look at these
4 bills. \$4,000, and Medicare paid it.

5 DR. CROSSON: Paul.

6 DR. GINSBURG: I don't want to spend time on
7 this, but since I was the one that said that Medicare
8 Advantage plans don't pay more than Medicare, I just want
9 to say that there are strong regulatory reasons for that.
10 There's a literature which has reported that empirically
11 and qualitatively.

12 And, so, but I think that there's no restriction
13 on paying less when you can get it for less. So that's
14 where I think the opportunity is to learn. If you're
15 paying more for hospital services, let's talk after the
16 meeting.

17 DR. CROSSON: Okay. So Paul and Pat are going to
18 take it outside.

19 [Laughter.]

20 DR. CROSSON: Oh, my God. Where are we?
21 Actually, we're working on this recommendation.

22 So I need to sort of test whether or not we have

1 unanimous support for the recommendation, or if not, do we
2 have a proposal for a different recommendation?

3 DR. HOADLEY: I mean, and the other question
4 we've been raising is whether there's enough people that
5 are willing -- that are considering taking a different
6 position, that want some more information prior to January,
7 as opposed to the --

8 DR. CROSSON: Yeah.

9 DR. HOADLEY: -- the expedited voting.

10 DR. CROSSON: Exactly. So I -- thank you. I'm a
11 little bit confused as to whether the issue is more
12 information or whether the issue is that people would like
13 -- Warner, for one, would like to have a different
14 recommendation with not reducing the payment by 5 percent.
15 So I'm -- Warner, where do you think you are?

16 MR. THOMAS: I think, at a minimum, I would like
17 to see in the chapter more specificity around total margin
18 and more clarity around the 15 percent of agencies that are
19 not included in the analysis that we're reviewing, at a
20 minimum.

21 DR. CROSSON: Jon?

22 DR. CHRISTIANSON: This is just a question.

1 Early on in the discussion, was there some concern about
2 combining the rebasing with the 5 percent, or did I imagine
3 that? We're all okay with that combination of those two
4 things in one? Okay.

5 DR. CROSSON: Okay. I'm really not trying to put
6 you on the spot. I'm trying to -- so we do need to sort of
7 know whether we have unanimity on this recommendation and
8 we take it to expedited voting in January, or we come back
9 and discuss it again. What do people feel? Bruce.

10 MR. PYENSON: I support the recommendation as
11 written.

12 DR. CROSSON: Okay. Is there anybody who doesn't
13 support the recommendation? Gotcha.

14 DR. NERENZ: No, I will support this, but I just
15 thought, you know, for clarity of understanding, since I
16 raised a few questions. I understand clearly what I'd like
17 to have, I can't get, meaning I'd like to have a
18 recommendation that said we'll take 5 percent away from
19 these but not 5 percent away from those. But we can't do
20 that, so I understand hat.

21 DR. CROSSON: Yeah. Well, again, we can't do it
22 right now, you know, because we don't have an analysis. We

1 would like to bring recommendations up twice for voting.

2 You know the routine. Do you want to --

3 DR. MATHEWS: Yeah, if I could just make one
4 point directly in response to David. With respect to the
5 blended payment weight recommendation, for the last two
6 presentations, LTCH and IRF, we did say that the blending
7 of the payment weights does move money in the desired
8 directions and offers cover for across-the-board, you know,
9 update recommendations. Here -- Evan, correct me if I'm
10 wrong -- here and in the SNF sector, that movement is
11 actually of a higher order of magnitude, in terms of moving
12 dollars, you know, away from patients who are getting large
13 amounts of questionably necessary therapy and towards
14 patients who need greater levels of nursing care, complex
15 medical conditions, that kind of thing.

16 And the way those patients sort themselves out,
17 that money travels from for-profit, freestanding types of
18 entities to hospital-based, you know, nonprofit. But
19 again, it's a function of the mix of patients that each
20 type of provider tends to treat. So in home health and
21 SNF, those impacts of a broad, uniform update
22 recommendation, or reduction in this case, are more

1 mitigated by the blended payment weight recommendation than
2 in IRF and LTCH.

3 DR. NERENZ: Thank you, and that did not escape
4 my attention, and that's why I spoke in support of that,
5 when we were on that.

6 DR. CROSSON: Okay. Kathy.

7 MS. BUTO: I support the recommendation. I just
8 want to be clear in my mind, now I'm wondering. We would
9 support doing both, right -- moving to the blended payment
10 and --

11 DR. CROSSON: Yes.

12 MS. BUTO: -- and taking the reduction.

13 DR. CROSSON: Yes.

14 DR. MATHEWS: Yeah, yeah.

15 MS. BUTO: Okay. I just want to be really clear
16 about that because I actually think what could happen is
17 that if Congress needs some savings they'll go for the
18 reduction first and then worry about blended payment. But
19 I want to make sure we're for both.

20 DR. CROSSON: Jack.

21 DR. HOADLEY: I think on that point, what we
22 haven't done, maybe because of how these two independent

1 streams have evolved, is to say more explicitly in each of
2 the four chapters something about that notion that Jim was
3 just talking about. And I think that would be -- that
4 would help on a number of these points, to say, you know,
5 reference the recommendation that's in the, you know,
6 Chapter 7, and say now we're in Chapter 10 and, remember,
7 if we do what -- if you do what's in 7 and you put it
8 together with what we're doing in 10, you get this further
9 impact.

10 DR. MATHEWS: Yes, and again, because of our
11 historical protocol in the way we deal with draft
12 recommendations, with the December meeting mail-out we
13 don't include the draft recs because we don't trust any of
14 you. But in the corresponding rationales for each of the
15 PAC sector-specific recommendations, material you haven't
16 seen yet but you have to take it as a matter of faith that
17 it's going to be there, that blended payment weight rec is
18 referenced in exactly this way.

19 DR. HOADLEY: And have the sort of numbers that
20 were in the table that Carol presented, that would sort of
21 say, and here's the impact in this sector, and obviously,
22 beyond that, you talk about how the two sort of intersect

1 is maybe not numerically done but you can at least talk
2 more qualitatively.

3 DR. MATHEWS: But directionally, yes.

4 DR. HOADLEY: Yeah.

5 DR. CROSSON: I just want to be very clear. Jim
6 was joking.

7 DR. MATHEWS: No, no.

8 DR. CROSSON: No, you weren't?

9 [Laughter.]

10 DR. CROSSON: You were joking. The draft
11 recommendations I don't see for discussion purposes until
12 Monday of this week, and then, over the phone, once the
13 staff has developed the recommendation, and Jim discusses
14 it with me, then I determine, you know, whether or not this
15 is actually what you're going to see as my recommendation
16 or not. But they're not ready to be mailed out at the time
17 that the information is sent to you, including me. So I
18 don't see them either until the Monday of the meeting.

19 Okay. Yes. Well, so, Warner, let me think about
20 this. If we could go forward with this -- I think you're
21 saying that -- and you could help the staff by providing
22 the information that you would like to see in the text,

1 would that be satisfactory?

2 MR. THOMAS: I think that would be satisfactory,
3 and I -- you know, I guess what I get concerned about is,
4 you know, I want to continue to understand the rebasing
5 piece, and maybe I could understand that offline with the
6 staff feedback.

7 DR. CROSSON: Okay. All right. So I think what
8 I'm -- Pat?

9 MS. WANG: On the wording of the recommendation,
10 I have been a little -- I would just urge to take a look so
11 that it's consistent in the SNF section, the recommendation
12 to transition in the PAC PPS was included in the
13 recommendation, and it hasn't been restated in the other
14 sectors.

15 So I just -- I got confused by not seeing it in
16 here. I think the intent is that it's a recommendation for
17 every sector update, but just -- I'm just mentioning it.

18 DR. MATHEWS: Yeah, and so the fact that the
19 blended payment weight recommendation appeared in the same
20 session as we discussed the SNF PPS updated recommendation
21 was a matter of administrative convenience. The way it
22 will appear in the chapter, once it's finalized in the

1 March report, is it will be a separate chapter ahead of all
2 of the PAC silo chapters, and it will indicate clearly
3 that, you know, it applies to IRF, home health, SNF, LTCH,
4 and again, each of those chapters will cross-reference the
5 preamble chapter.

6 DR. HOADLEY: People read, often, chapters in
7 isolation. I think that's particularly important. And
8 even the way it's structured on the website, where you can
9 go in and just see one particular chapter. So I think, you
10 know, you can do some of that with links and references
11 back, but I think making that very clear is vital.

12 DR. CROSSON: Okay. Good discussion. I mean it,
13 actually. I think we have a consensus to go forward with
14 the recommendation. Therefore, we will bring it in January
15 as part of expedited voting.

16 Evan, thank you very much for your presentation.

17 We'll now move to the public discussion, comment
18 period. Do we have any of our guests who wish to make a
19 public comment? At this time please come up to the
20 microphone so I can see who you are.

21 [No response.]

22 DR. CROSSON: I see some people escaping but

1 nobody heading for the microphone. Therefore, we are
2 adjourned until, yes, 8:00 tomorrow morning. Thank you.

3 [Whereupon, at 4:34 p.m., the meeting recessed,
4 to resume at 8:00 a.m., Friday, December 8, 2017.]

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

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 8, 2017
8:05 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
DANA GELB SAFRAN, ScD
WARNER THOMAS, MBA
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

AGENDA	PAGE
Assessing payment adequacy and updating payments: Outpatient dialysis services	
- Nancy Ray, Andrew Johnson.....	3
Assessing payment adequacy and updating payments: Hospice services	
- Kim Neuman.....	44
The Medicare Advantage program: Status report	
- Scott Harrison, Carlos Zarabozo, Andrew Johnson.....	80
Public Comment.....	161

P R O C E E D I N G S

[8:05 a.m.]

1

2

3

4

5

6

7

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

DR. CROSSON: Okay. I think it's time to get going.

MS. RAY: Good morning. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2016, there were more than 390,000 Medicare fee-for-service dialysis beneficiaries treated at roughly 6,700 dialysis facilities. Total Medicare fee-for-service spending was about \$11.4 billion for dialysis services in 2016.

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 2015 and 2016, growth in dialysis treatment stations grew faster than beneficiary growth. Between 2015 and 2016, more

1 facilities opened than closed; there was a net increase of
2 roughly 250 facilities. Few facilities closed in 2015.
3 There was a net increase in for-profit, freestanding
4 facilities as well as facilities located in rural and urban
5 areas. The roughly 40 facilities that closed were more
6 likely to be hospital-based and nonprofit compared to all
7 other facilities. Few patients -- about 0.5 percent --
8 were affected by these closures, and there is no indication
9 that affected patients were unable to obtain care
10 elsewhere.

11 Another indicator of access to care is the growth
12 in the volume of services. We track volume growth by
13 assessing trends in the number of dialysis fee-for-service
14 treatments and dialysis beneficiaries. Between 2015 and
15 2016, the total number of dialysis beneficiaries grew by 1
16 percent while total treatments grew by 3 percent. In
17 addition, there was also an increase in treatments per
18 beneficiary of 2 percent.

19 We also look at volume changes by measuring
20 growth in the volume of dialysis drugs furnished. Dialysis
21 drugs are an important component of dialysis care. Since
22 the Prospective Payment System was implemented in 2011,

1 dialysis drugs have been included in the payment bundle.
2 Consequently, providers' incentive to furnish them -- in
3 particular, the erythropoietin-stimulating agents (ESAs) --
4 has changed. ESAs are the leading dialysis drug class in
5 terms of utilization. Before the start of the dialysis PPS
6 in 2011, there were both clinical reasons and financial
7 reasons for their overuse. As anticipated, after the PPS,
8 ESA use went down significantly. Between 2010 and 2015,
9 use of ESAs declined in aggregate by 51 percent. This
10 outcome was expected and desired and has occurred according
11 to researchers with some positive changes to beneficiaries'
12 health status. Much of the decline occurred during the
13 initial years of the PPS -- 2011 and 2012. Between 2015
14 and 2016, ESA use has continued to decline. In addition,
15 we are seeing a shift in beneficiaries being switched to
16 lower-cost ESAs.

17 Next we look at quality of care by examining
18 changes between 2011, the first year of the PPS, and 2016.
19 Mortality and readmissions are trending down, as well as
20 admissions. Monthly use of the ED has increased between
21 2011 and 2016. The percent of dialysis beneficiaries using
22 home dialysis, which is associated with improved quality of

1 life and patient satisfaction, has modestly increased from
2 a monthly average of 9 percent in 2011 to nearly 11 percent
3 in 2016. This is a good trend. However, the rate of
4 growth since 2014 has slowed. Your mailing materials
5 discuss a shortage of the solutions necessary to perform
6 one type of home dialysis that began in the fall of 2014
7 and has continued since. One indicator that measures how
8 well the dialysis treatment removes waste from the blood --
9 dialysis adequacy -- remains high.

10 Regarding access to capital, indicators suggest
11 it is adequate. An increasing number of facilities are
12 for-profit and freestanding. Private capital appears to be
13 available to the large and smaller-sized multi-facility
14 organizations. Since 2011, the two largest dialysis
15 organizations have had sufficient access to capital to each
16 continue to vertically and horizontally expand.

17 Moving to our analysis of payments and costs, in
18 2016, the Medicare margin is 0.5 percent. The biggest
19 difference across freestanding facilities is the difference
20 between rural and urban facilities. The aggregate Medicare
21 margin for rural facilities, which account for roughly 20
22 percent of facilities, is negative 4.9 percent. The lower

1 Medicare margin for rural facilities is related to their
2 capacity and treatment volume. Rural facilities are on
3 average smaller than urban ones. They have fewer treatment
4 stations and provide fewer treatments. And smaller
5 facilities have substantially higher cost per treatment
6 than larger facilities, particularly overhead and capital
7 costs.

8 The 2016 margin does take into account the
9 revised low-volume payment adjuster and the new adjuster
10 for all rural facilities that CMS implemented in 2016. We
11 think that the revised low-volume adjuster is a step in the
12 right direction although we have discussed approaches to
13 better target the adjustment.

14 For this year's analysis, we also calculated the
15 rate of marginal profit -- that is, the rate at which
16 Medicare payments exceed providers' marginal cost. It is
17 calculated by subtracting out capital costs from each
18 providers' total cost per treatment. In 2016, the marginal
19 profit is 17.2 percent, suggesting facilities with
20 available capacity have an incentive to treat Medicare
21 beneficiaries. This is a positive indicator of patient
22 access.

1 The 2018 projected Medicare margin is 0.4
2 percent, roughly the same as the 2016 margin. Let's review
3 some of the factors that the projection accounts for.

4 The first factor that the projection takes into
5 account is the rebasing of the base payment rate. The
6 Congress rebased the base payment rate to account for the
7 reduced drug utilization -- particularly the use of ESAs --
8 that I showed you on Slide 6.

9 So for 2017 and 2018, this rebasing adjustment
10 decreased the update by 1.25 and 1 percentage point,
11 respectively.

12 This projection also accounts for a small
13 positive regulatory change that CMS made in 2017.

14 And it also accounts for a small estimated
15 reduction in total payments due to the ESRD Quality
16 Incentive Program in both years.

17 Policy changes to occur in 2019 include the
18 statutory update of the base payment rate, which is set at
19 the ESRD market basket reduced by the productivity
20 adjustment. There is also an estimated small reduction in
21 total payments due to the ESRD QIP.

22 Here is a quick summary of the payment adequacy

1 findings. Access to care indicators are generally
2 favorable. Quality is improving for some measures. The
3 17.2 percent marginal profit suggests that facilities with
4 available capacity have an incentive to treat Medicare
5 beneficiaries. The 2018 Medicare margin is projected at
6 0.4 percent.

7 So here is the Chairman's draft recommendation.
8 It reads: The Congress should change the calendar year
9 2017 -- I'm sorry -- 2019 dialysis outpatient base payment
10 rate by 1.3 percent. The intent of the recommendation is
11 to update the base rate by the amount specified in current
12 law, which is the ESRD market basket less the productivity
13 adjustment. We are expressing the draft recommendation as
14 a number; obviously, the market basket can change when the
15 update is finalized by CMS, but for present purposes this
16 is what we are intending.

17 In terms of spending implications, this draft
18 recommendation has no effect on spending relative to the
19 statutory update.

20 No adverse impact on beneficiaries is expected.
21 This recommendation should sufficiently cover providers'
22 cost increases and thus not adversely affect providers'

1 ability to furnish care. Given the large marginal margin,
2 this recommendation is expected to not have an adverse
3 impact on beneficiaries' ability to obtain dialysis care.

4 That concludes the presentation. We look forward
5 to your questions.

6 DR. CROSSON: Thank you, Nancy.

7 We're open for clarifying questions. I see
8 Kathy, David, Paul, Jack, and Rita.

9 MS. BUTO: So, Nancy, I just wondered if you
10 could remind us -- I was trying to find it in the paper but
11 didn't -- how home dialysis is paid for. Is it paid the
12 same rate as in-facility or is there some reduction?

13 MS. RAY: No, it's paid -- for adults over the
14 age of 18, it's the same base rate.

15 MS. BUTO: Okay. And you mentioned the
16 beneficiaries meeting the adequacy of dialysis guidelines
17 is still pretty high. Can you tell us what that percentage
18 is or what the --

19 MS. RAY: It's in the high 90s.

20 MS. BUTO: Okay, so it's very high.

21 MS. RAY: Yes.

22 MS. BUTO: And I guess the question is: Has it

1 maintained at 90-plus percent pretty steadily since --

2 MS. RAY: Yes. Yes, that measure has.

3 MS. BUTO: Thank you.

4 DR. CROSSON: David.

5 DR. NERENZ: Thanks. Just a quick question on
6 the 1.3 percent. I just want to make sure I understand how
7 they match. If we can go back to Slide 11, just a semantic
8 question. On this slide does 1.3 refer to the productivity
9 adjustment or does it refer to the combination of market --

10 MS. RAY: The combination market basket minus
11 productivity.

12 DR. NERENZ: Thank you.

13 DR. CROSSON: Paul.

14 DR. GINSBURG: Nancy, I'm a little baffled about
15 this. It seems as though the Medicare margins are quite
16 small, but yet we see a lot of sophisticated capital coming
17 into the industry. Are the margin data reliable?

18 MS. RAY: Well, that's a good question. The
19 Commission did recommend that CMS audit the ESRD cost
20 reports, and the Congress did provide an authorization for
21 CMS to do so, and that audit is still ongoing.

22 DR. CROSSON: I've got Jack, Rita -- Alice, on

1 this point?

2 DR. COOMBS: On this point.

3 DR. CROSSON: Okay.

4 DR. COOMBS: One of the things to pay close
5 attention to when that comes in -- I don't know if you have
6 access to weigh in on it -- is the labor units within the
7 dialysis companies.

8 DR. CROSSON: Paul. Oh, I'm sorry. Jack.

9 DR. HOADLEY: Yeah, thank you, and thank you for
10 the paper. On the recommendation, I'm trying to make sure
11 I understood. You said you'd state it as a 1.3, but is the
12 recommendation essentially to do the market basket, if you
13 got a new number next month we would revise it?

14 MS. RAY: Right. So when CMS -- I mean, unless -
15 - when CMS implements the payment update, they'll propose
16 that next roughly July.

17 DR. HOADLEY: Okay.

18 MS. RAY: So the market basket will have been
19 implemented probably three or four more times between now
20 and when they drop the draft reg and then when they drop
21 the final reg.

22 DR. HOADLEY: But our recommendation is saying

1 that it should be whatever that market basket is at that
2 point in time.

3 MS. RAY: Exactly.

4 DR. HOADLEY: Yeah, I don't --

5 DR. MATHEWS: Jack, if I could jump in and just
6 make a clarification on this point.

7 DR. HOADLEY: Yeah.

8 DR. MATHEWS: So you'll recall that during the
9 initial implementation of the current 2 percent Medicare
10 sequester, we had a lot of discussion here among the
11 Commissioners about what we meant by saying a "current law
12 update." Is it just the market basket, you know, with all
13 the puts and takes, or is it market basket plus 2 to
14 compensate for the sequester, that kind of thing? And the
15 solution was to express the current law update in the form
16 of a number rather than say "current law." So in this
17 case, we are saying 1.3 percent, and that's probably the
18 point estimate that we will stick with through the January
19 meeting. But the corresponding rationale and implications
20 underneath the boldfaced recommendation will make it clear
21 that our intention is that the update would be consistent
22 with current law.

1 DR. HOADLEY: Thanks. That helps.

2 On Slide 6, where you talk about the drug
3 decline, do you have a breakout of how much of that you
4 think is due to price versus volume?

5 MS. RAY: So this slide holds price constant.

6 DR. HOADLEY: Okay.

7 MS. RAY: So what you're seeing here is the drop
8 in utilization.

9 DR. HOADLEY: Is the utilization.

10 MS. RAY: So what I've done is I've used the 20 -
11 - I've multiplied every drug unit by its corresponding 2017
12 ASP.

13 DR. HOADLEY: Got it. Okay. Thank you. And I
14 know you talked in the paper about the cost initiative
15 program and some of the early results from that. But you
16 also talked about the ESRD SNPs. Is there any effort to
17 evaluate in any way what's happening with the ESRD SNPs to
18 know whether that's a helpful development? I mean, unlike
19 the demonstrations, there's not an automatic need to
20 evaluate.

21 MS. RAY: That's a good question. I'll get back
22 to you on that.

1 DR. HOADLEY: Yeah, I just wonder. I mean, how
2 will we know if that was a good idea?

3 MS. RAY: Yeah.

4 DR. HOADLEY: And I don't even know what the
5 baseline was.

6 DR. CROSSON: I've got Rita, Brian, Dana, Pat.

7 DR. REDBERG: Thanks for the excellent chapter.
8 I'm wondering why all the drugs aren't in the bundle. Why
9 are the Vitamin D and the calcimimetics excluded?

10 MS. RAY: Okay. Vitamin Ds are in the bundle.
11 So phosphate binders and the calcimimetic, up until 2018,
12 are still being paid by Part D. And the history behind
13 that is CMS intended that those two classes be included in
14 the bundle in 2014. Congress deferred the bundling of
15 those drugs until, I guess, it would be 2025. But what
16 happened with the calcimimetic is that a manufacturer
17 introduced an injectable form of the calcimimetic, and so
18 what that means under current law is that both the
19 injectable and the oral will be included in the bundle, and
20 that will begin on January 1, 2018. And those two products
21 for roughly two to three years will be paid using a TDAPA,
22 a transitional drug adjustment payment factor, for two to

1 three years while CMS gathers data so they can then figure
2 out how much to put in the bundle. And then the drugs will
3 be put in the bundle. That's the intent.

4 DR. REDBERG: Thank you. And I had another
5 question. I noticed home dialysis had increased, which
6 seems good for beneficiaries, but was slowed, you noted in
7 the chapter, by a shortage of solutions needed. Is that an
8 ongoing issue?

9 MS. RAY: It seems to be ongoing for one type of
10 peritoneal dialysis. That's my understanding. I mean, we
11 are trying to track this.

12 DR. CROSSON: On this point -- sorry.

13 DR. REDBERG: We've also talked before about the
14 rates that -- eGFR when dialysis was initiated, and I'm
15 just wondering if in the future when we look at it more
16 closely we should look at profit status -- or maybe you
17 already had that -- of facilities and why aren't they
18 initiating. And also I'm thinking about the new
19 facilities, sort of Paul's questions, that are coming on.
20 And are they tending to do earlier or later initiation of
21 dialysis?

22 MS. RAY: We can look at that.

1 DR. REDBERG: Thanks.

2 DR. CROSSON: Kathy, on that point?

3 MS. BUTO: Kind of on the same point. It's
4 really about home dialysis.

5 Nancy, do we have any sense of the differences,
6 if any, in the characteristics of patients on home dialysis
7 versus those who are in facility or one healthier as a
8 group than the other? Do we know? I mean, the ability to
9 dialyze at home, sometimes without any assistance, suggests
10 to me you might have a healthier population dialyzing at
11 home, but I don't really know.

12 MS. RAY: Yeah. I guess, so I don't misspeak,
13 I'd like to come back to you in January about the clinical
14 differences in terms of their characteristics. In terms of
15 their demographic, they do tend to be younger, and they do
16 tend to be white versus minorities.

17 DR. CROSSON: Brian.

18 DR. DeBUSK: The ESAs in outpatient or in
19 dialysis are packaged, whereas the same drugs in other
20 applications, like oncology, aren't. Again, that's my
21 understanding. Do we have a feel for the price
22 differentials in how the manufacturers have responded to

1 the packaging request? I mean, could we calculate a
2 differential between, say, the same ESA in an oncology
3 application versus a dialysis application?

4 MS. RAY: I would have to get back to you on
5 that. I mean, my hunch is I don't think we have that
6 available data to do that.

7 DR. DeBUSK: Because the packaged ESAs wouldn't
8 be subject to ASP reporting, would they?

9 MS. BUTO: Nancy, you could --

10 MS. RAY: Oh, yes. No. I mean, the ESAs that
11 dialysis facilities furnish, that is a part of the ASP.

12 DR. DeBUSK: Okay. So that is incorporated in
13 the ASP.

14 MS. RAY: Yes.

15 DR. DeBUSK: I just wonder if there's a way to
16 back into that, and my question is, Is there a broader
17 policy solution? I know Kathy has mentioned time and time
18 again about packaging drugs into the procedure, and I just
19 wonder if this is an opportunity to measure the efficacy of
20 that approach while looking at the same drug in an oncology
21 application and a dialysis application.

22 MS. BUTO: And I think there was a demonstration

1 or maybe even still is an oncology bundling demonstration.
2 I don't recall whether the drug is actually bundled in, but
3 I think the notion was to bundle it, wasn't it?

4 MS. RAY: So under the oncology care model, if
5 that's what you're referring to, drugs are paid ASP+6.
6 Yeah.

7 DR. GINSBURG: I think what would be fascinating
8 is -- I presume in this bundle for ESRD, the ESRD providers
9 are buying the drugs as best they can.

10 MS. RAY: Particularly the -- I mean, my
11 understanding is particularly the two very large dialysis
12 organizations. Yes.

13 DR. GINSBURG: That's right, that are in the
14 bundle.

15 MS. RAY: Yes.

16 DR. GINSBURG: So, in a sense, it would be very
17 instructive to -- I don't know if you can find out how much
18 they pay, or at least either what they pay or how much is
19 allowed for the bundling, creation of the bundle.

20 DR. MATHEWS: And, Paul, just on this point --
21 and Brian -- just to make sure I understand the question on
22 the table right now -- I think I do -- Brian, your point is

1 that the same ESA can be used for dialysis where it is paid
2 under the bundle, and it can also be used for other
3 indications, such as oncology, where it's paid ASP+6.

4 Nancy, the payment under the bundle does not make
5 an ASP+6 payment underneath the bundle; is that correct?

6 MS. RAY: That is correct.

7 DR. MATHEWS: Okay. And so what you are asking
8 between the two of you is can we determine the price that
9 the dialysis facility or the organization is paying for the
10 ESA and compare that to the ASP+6 rate. Is that what
11 you're getting at?

12 DR. DeBUSK: Absolutely.

13 And I think the question would be what if there's
14 a 20 percent differential.

15 DR. MATHEWS: Understood. I just wanted to
16 clarify what you were asking.

17 MS. RAY: Right. I mean, if you wanted -- okay.
18 So I'm glad you did that, Jim, because I misinterpreted
19 your question. If you want to compare the ASP+6 of an ESA
20 versus providers' cost -- ESA cost per treatment as
21 reported on their cost reports, that we can do.

22 DR. DeBUSK: Okay. So we could actually measure

1 the efficacy of packaging an expensive drug into a
2 procedure.

3 MS. BUTO: Right. But I think that one of the
4 things we're learning is that there was a lot of
5 flexibility in dosing, right?

6 DR. DeBUSK: Mm-hmm.

7 MS. BUTO: And what happened was the volume of
8 drug per treatment has gone down, as I understand it. The
9 volume changes have been significant.

10 DR. DeBUSK: And probably the side effects as
11 well.

12 MS. RAY: Yes, yes. That is correct.

13 MS. BUTO: So that to save money and maintain
14 adequacy, there is a different level of drug that got you
15 to the same result or a better result.

16 DR. DeBUSK: Agreed. I think there's a leading
17 indicator here that we may be able to look at this
18 particular policy.

19 I understand they're used differently, but it
20 would be interesting to see how the manufacturers respond
21 when they're responsible for an entire bundle. It's a
22 larger payment.

1 DR. CROSSON: Jack wants to weigh in here.

2 DR. HOADLEY: Yeah. I mean, you also had
3 evidence that there was some product switching, presumably
4 as a result of the bundle. So given multiple alternatives
5 for ESAs, they were making choice of product. So that's a
6 part of what's going on too, right?

7 MS. RAY: Right. We've seen that within the ESA
8 class and we've also seen that within the vitamin D class
9 that there has been some product switching under the PPS.
10 For the ESA product switching, that's happened
11 more recently with the launch of a third ESA.

12 DR. HOADLEY: And presumably, part of that is a
13 price response that they're getting offers of lower prices,
14 and so it would be interesting at least to see what we
15 could learn about what's going on inside that.

16 DR. CROSSON: Amy, on this?

17 MS. BRICKER: Just for clarification.

18 We're asking the question of cost to the provider
19 versus reimbursement?

20 DR. DeBUSK: We're asking how the same
21 manufacturer would price the same product into two
22 different markets that are in dramatically different

1 reimbursement schemes. ASP+6 is sort of that super-charged
2 -- you know, the more you spend, the more you make, whereas
3 this is a truly capitated model where there's a fixed
4 payment with some adjustors. So it's up to the provider to
5 really buy the best product at the best price.

6 MS. BRICKER: Yes.

7 DR. DeBUSK: And those are two very dramatic
8 scenarios.

9 MS. BRICKER: Yeah. I just wonder if it would be
10 skewed of to the point there's two large dialysis
11 purchasers and how then you would compare the oncology
12 space and the large purchasers there. I think you'd have
13 to kind of sort through and normalize for those large --

14 DR. DeBUSK: For purchasing power. Yeah.

15 MS. BRICKER: Mm-hmm.

16 And also, Brian, I think the other missing piece
17 here is that there is no cost report for the individual
18 physician who is prescribing the ESA, so we don't know the
19 acquisition cost to the non-ESRD situation. We know when
20 Medicare pays, but we don't always know what that
21 differential is between what Medicare pays and what they
22 actually purchase the drug for.

1 DR. DeBUSK: Agreed, agreed.

2 And I think Nancy mentioned something that -- and
3 I had not thought of this until you -- well, I hadn't
4 thought of this, and then you said it, which was that we
5 can look at the ASP. Then we can look at the cost reports
6 from the dialysis centers, and in theory, once we know the
7 rough ratio of what percentage of the ESAs are used in
8 dialysis, we can back into a differential for non-dialysis
9 use versus dialysis use, the pricing for that same drug, I
10 think, couldn't we?

11 MS. BRICKER: But doesn't that get to Paul's
12 point around the margin question? I mean, is this not
13 where maybe the margins are with respect to the provider?

14 DR. CROSSON: Okay. I'm going to suggest we move
15 on. I think this is a good suggestion. Nancy will try to
16 get what information you can by January and put it into the
17 report.

18 On this? I'm sorry?

19 MR. PYENSON: [Speaking off microphone.]

20 DR. CROSSON: Different. Okay. All right.

21 I'm sorry. I got you on the list, but Dana is
22 next.

1 DR. SAFRAN: So thanks for this.

2 My questions have to do with the home dialysis.

3 So it was interesting to see the uptake of about 2
4 percentage points and interesting to hear you say that the
5 payment for Medicare is the same.

6 I'm wondering a couple things. One, do we know
7 whether there's a difference in uptake, urban and rural?
8 And what do we know about differences in cost of delivering
9 the facility setting versus at home? Because I'm
10 wondering, given my understanding of the literature -- I
11 think you said this a little bit as well, that safer and
12 certainly better quality of life, what Medicare might be
13 able to do to encourage the adoption of home dialysis. And
14 that sort of piqued my interest further when I heard that
15 right now, uptake seems to be among those who may be just
16 more aware of their opportunities, so what we can do.

17 MS. RAY: Right. So I will have to get back to
18 you on the urban versus rural split.

19 One factor that does affect the uptake of home
20 dialysis is your exposure to some sort of pre-ESRD program,
21 whether it's -- and educational efforts.

22 In terms of cost of delivery, historically home

1 dialysis has been less costly to furnish. I think -- and
2 Andy should chime in, but the cost reports, using the cost
3 reports to try to get at that is somewhat difficult, I
4 would say. It's challenging.

5 DR. JOHNSON: In particular, peritoneal dialysis
6 is less costly, but home hemodialysis may not be when
7 compared to inside --

8 DR. CROSSON: Okay. Pat.

9 MS. WANG: This goes back to the margin question,
10 and I apologize if I missed it in the materials. What is
11 Medicare as a share of total payer mix, and what is the
12 all-payer margin?

13 MS. RAY: Okay. So Medicare fee-for-service
14 treatments compared to all -- Medicare fee-for-service
15 accounts for roughly 60 percent, 60 percent of all
16 treatments.

17 In terms of the all-payer margin, this is very
18 rough. Based on available information, it exceeds 20
19 percent, the all-payer margin.

20 DR. CROSSON: Pat.

21 MS. WANG: So the margin for 60 percent of the
22 business is what you showed here for Medicare, and the

1 remaining 40 percent is driving a payer margin that is --

2 MS. RAY: Well, let me be clear. The remaining
3 40 percent includes Medicare Advantage, Medicaid, other
4 government programs like the VA, and then commercial.

5 MS. WANG: Yeah. Okay. But that's --

6 DR. GINSBURG: I recall that's a major issue in
7 the implementation of the ACA marketplace, has been
8 movement of the ESRD patients to ACA commercial plans and
9 dramatically higher reimbursements.

10 DR. CROSSON: Bruce.

11 MR. PYENSON: Nancy, I'd like to ask a question
12 about Table 7, Table 7 in the materials. I've got a
13 question. This is the financial results for the ESCOs, and
14 this looks like a rather good result in the first year.
15 And I think, if I recall correctly, compared to first-year
16 results of ACO programs, broader MSSPs and others, this is
17 really very positive. Is that your impression as well?

18 MS. RAY: Yes, that is my impression. For the
19 first year, which included the period, I think, October
20 2015 through the end of 2016, the 13 ESCOs were, I think --
21 were positive. The results were very positive.

22 MR. PYENSON: So does this point to either the

1 evidence of ability to reduce cost or a rapid expansion of
2 this program, perhaps making it mandatory?

3 MS. RAY: So CMS issued a second solicitation for
4 more ESCOs, and so an additional 24 ESCOs have been
5 included under the Round 2 of the program, so that will up
6 them to 37 ESCOS, from 13 to now 37.

7 I think it remains to be seen in subsequent
8 payment years how these ESCOs perform before answering your
9 question.

10 MR. PYENSON: Thank you.

11 DR. CROSSON: Okay. Seeing no further questions,
12 we will move on to the recommendation. Put up the Slide
13 No. 13, if you would.

14 I'd like to hear comments on the recommendations.
15 Kathy.

16 MS. BUTO: I can support the recommendation. I
17 wonder whether, given the information in the paper, we
18 ought to consider adding some language around the disparity
19 in the use of home dialysis, the disparity with African
20 Americans versus -- or minority patients versus other
21 patients, which seems to me to be an access issue. So as
22 long as we're trying to get both at payment and access, I

1 think maybe we do it in the text, but we need to highlight
2 that as an issue for the agency to address.

3 I understand that some of the other disparities
4 in treatment are multi-factoral, but it sounds to me like
5 home dialysis is one area where it's not clear why there's
6 such a disparity.

7 The other thing I wonder about, but I don't have
8 a suggestion on this, is the -- Dana was mentioning
9 essentially is there a way to provide incentives for more
10 home dialysis. It seems to me we're theoretically
11 potentially overpaying home dialysis versus in-facility
12 dialysis, and maybe that's what we intend to do in order to
13 encourage more provision of home dialysis services.

14 But I remember when I was at the agency, we had a
15 major legal issue around the provision of free staff with
16 home dialysis because of the overpayment in the home
17 dialysis setting, and it was very difficult to get away
18 from a charge-based system, which at the time was a very
19 different payment system from facility dialysis, which
20 really overpaid home dialysis, to such an extent they could
21 provide a free staff person.

22 So I think we just have to be aware that there

1 could be distortions. I don't know that it affects the
2 recommendation, but it worries me a little bit. That we
3 don't want to over-incent, if you will, home dialysis if
4 it's not appropriate for all patients. It should be an
5 option that's adequately paid, but I worry about the issue
6 of patient characteristics and potential overpayment.

7 DR. CROSSON: Okay. So, Nancy, that's something
8 you can do for the January write-up.

9 DR. GINSBURG: If I could follow up?

10 DR. CROSSON: Paul.

11 DR. GINSBURG: It seems to me that this is a very
12 important policy issue. That with home dialysis having
13 different costs, being for some types of patients superior
14 as far as it -- and to have these issues ignored by our
15 payment policy, which just blindly pays the same, it seems
16 as though that's something we might want to work on in the
17 future of coming up -- perhaps it's going to be complex
18 because, as Andy mentioned, perhaps -- just depending --
19 there are different types of home dialysis. Not all are
20 lower cost. Some may be higher cost, but it just doesn't
21 feel right to have this all ignored by our payment system.

22 DR. CROSSON: Dana, one second.

1 So I'm getting a little confused as to whether we
2 think -- I think I understand that we'd like to see more
3 explication of this issue, and I agree with that. Are we
4 hearing concerns that we think Medicare should be
5 differentiating payment based upon whether it's home
6 dialysis, it's peritoneal dialysis, because it costs less
7 and therefore should be paying less, or do we think it's
8 preferable for beneficiaries, so we should be paying more?
9 I think I've heard both points here.

10 DR. GINSBURG: It could be either one. It's just
11 a matter of we should find out.

12 DR. CROSSON: Got it.

13 [Laughter.]

14 DR. CROSSON: Dana.

15 DR. SAFRAN: Well, I was going to point to that
16 confusion also and just mention two things that I think we
17 should be thinking about. One is if we think about our
18 support for and the movement toward accountable care and a
19 global budget payment and wanting to incentivize care in
20 the lowest cost setting, I think that I personally land in
21 a place I'm not so opposed to for now, having payment be
22 the same in both settings, even if it costs less to deliver

1 it in the home setting, in order to encourage care to be
2 moved in that direction.

3 But it sounds like, to the point that Kathy
4 underscored for my question, we need to do more to at least
5 educate the whole population about the availability of
6 this, say for much more convenient, et cetera, opportunity.

7 The other thing, which is really not relevant in
8 the Medicare population, but I'll mention it because I
9 think it has some analogy here, is in a commercial
10 insurance world where we know we have dramatic overuse of
11 C-section, but we pay the same for C-section and vaginal
12 delivery. There are advocates in the field who are
13 clinicians who say part of the reason is that it's a
14 workflow issue. It's just easier to schedule C-sections
15 and not worry about labor and so forth, and could you pay
16 more, in fact, for vaginal delivery to sort of incentivize
17 that?

18 So I just think this question of what actually do
19 we think is the safer, more desirable form of care to see
20 happening and factor that into our recommendations about
21 whether there should or shouldn't be payment differentials
22 is something that could benefit from some more explication

1 in the paper.

2 DR. CROSSON: Okay. Kathy and Alice and Jack on
3 this point.

4 MS. BUTO: On this point, so, Jay, to answer your
5 question, I think what Paul and I were both saying is I
6 think we need to know more about the differences in the
7 patient characteristics. I don't think we're ready to make
8 any conclusion. But it doesn't feel correct to just say
9 these should be paid the same without that information. We
10 need to know more about whether there's some risk
11 adjustment or something else that should be going on, or
12 maybe a bonus payment for certain kinds of home dialysis,
13 if appropriate. But we don't have that information, so
14 it's hard to sort of come to a conclusion. But I just
15 think a way of highlighting that in the paper and the fact
16 that we'll be trying to look into it or that we think CMS
17 ought to pay closer attention I think would be helpful.

18 DR. CROSSON: Exactly. So what I'm beginning to
19 see here is that we're going to ask Nancy to put whatever
20 information she has and can put together between now and
21 writing the January report -- which is like tomorrow.

22 [Laughter.]

1 DR. CROSSON: You know, so that we can read that.
2 But then also I think I'm hearing fairly broad interest in
3 us taking a look at this more substantially when we can
4 build it into the work flow.

5 Alice and then Jack.

6 DR. COOMBS: Yeah, so before Nancy goes off to do
7 her homework, I just want to bring to the attention that
8 the whole notion of our interventions for renal failure
9 patients has changed over the years. As you know, we had a
10 higher threshold for transfusions. We had a higher goal
11 for hematocrits. That has changed dramatically, and that
12 is part of the conundrum of this whole thing with ESAs
13 versus transfusion, is that we've found that people with
14 lower 'crits actually do better. So that's a piece of this
15 declining utilization. It's not just some of the policies,
16 but it's also the medical literature proving to be more
17 fruitful in terms of directing the therapy, in terms of
18 evidence-based guidelines.

19 DR. GINSBURG: I think that actually influenced
20 the policy.

21 DR. COOMBS: Yes, yes. Despite us thinking that
22 the policy drives the behavior, it is actually that there's

1 evidence that drives behavior.

2 For the differential, if there were -- I think
3 for what we have right now, peritoneal dialysis is a
4 wonderful means of treating dialysis patients. I think
5 that the knowledge base and the whole convenience of
6 peritoneal dialysis, while it appears to be very
7 attractive, you have a catheter and you have to dwell at
8 night. It's a big deal. It's not -- whereas the dialysis
9 patient goes into the dialysis unit, they get a treat or a
10 snack, and they watch a movie for three hours and then they
11 roll out. There is this whole notion of the actual play
12 that the patient has to interface with the peritoneal --
13 you have to be ultimately sterile because if you get
14 peritoneal infections, it's a big deal. The patient's home
15 in and of itself has to be adequate for peritoneal dialysis
16 to work, and that means there has to be a certain
17 infrastructure there.

18 In terms of the hemodialysis, back in the day we
19 did something -- we reviewed the ambulance reports, and we
20 found that some of the hemodialysis patients were taking
21 the ambulance to the hemodialysis unit, so the cost of
22 hemodialysis is layered on top of the transportation to the

1 dialysis unit. And I think that's something that we didn't
2 really appreciate until we did that ambulance report -- I
3 forget how long ago it was.

4 MS. RAY: That was a couple of years ago, and
5 ambulance spending for ESRD beneficiaries, I didn't put it
6 in your mailing materials. It has trended down in the last
7 couple years, and part of that is because of the policies
8 that have been implemented by CMS and by the statute. But
9 it still remains high.

10 DR. COOMBS: Okay.

11 DR. CROSSON: I saw another hand. Was that Jack?
12 And then Bruce.

13 DR. HOADLEY: Yeah, I guess I'm adding
14 potentially more to your homework assignment for the
15 weekend. But I wonder if the ESCOs or the SNPs have had
16 any experience in -- because they are in that environment
17 where they're getting more of a bundle, and whether they've
18 got any experience in use of hoe dialysis.

19 MS. RAY: Right, so it remains to be seen. When
20 CMS released the results of the ESCO, it's literally on
21 this piece of paper, and they did not release the
22 evaluation by services. So I think that's something that

1 we would very much like to look at.

2 DR. HOADLEY: So this is not the weekend
3 homework. This is the next year's homework.

4 [Laughter.]

5 MS. RAY: Correct.

6 DR. CROSSON: Bruce.

7 MR. PYENSON: I'd like to voice support for
8 Dana's comment on the ability to create bundles that have
9 an effect on shifts. And, in particular, if we think that
10 home dialysis is less expensive and a shift to home
11 dialysis would reduce cost, it seems to me that cutting the
12 reimbursement for these bundles would be a good policy
13 because it would put pressure on the dialysis providers to
14 become more efficient in that way. So it's not clear to me
15 that increasing payment is consistent with good policy in
16 this case.

17 DR. CROSSON: So, Bruce, are you speaking against
18 the recommendation?

19 MR. PYENSON: Well, pending on what Nancy comes
20 back with. It's not clear to me this is good policy to
21 have that increase.

22 DR. CROSSON: Right, so, I mean, here's my

1 thought. We've had like three or four different areas of
2 discussion here where we've asked Nancy to bring more
3 information back in the January report. For the most part,
4 they're helpful, but not from my perspective so far, not
5 directly impacting our recommendation for 2019.

6 My own sense -- and push back, please, if you
7 want to, but my own sense is that it would require, you
8 know, more work than can be done between now and January
9 with respect to the tradeoffs between home dialysis, a
10 subset of peritoneal dialysis, hemodialysis, payment rates,
11 et cetera, to be able to come forth in January with a
12 different recommendation as opposed to us doing that moving
13 forward. So I'm not sure that I think we can get to a
14 different decision by January based upon the information
15 that we're likely to have between now and then. So
16 perfectly free to propose a different recommendation or an
17 alteration to the recommendation, but I think in general we
18 try not to make policy decisions for sure, but even policy-
19 driven payment decisions kind of on the fly. So would you
20 be -- again, not to put you on the spot, but would you be
21 okay with this recommendation for this year?

22 MR. PYENSON: Your explanation makes sense to me.

1 DR. CROSSON: Okay. Thank you. Pat?

2 MS. WANG: I'm not going to object to the
3 recommendation, but I do want to sort of go back to the
4 conversation that we were having at the end of yesterday
5 about how we look at situations where, you know, it's a 0.4
6 percent Medicare margin, but apparently a very high all-
7 payer margin with very healthy access to capital and sort
8 of try to rationalize that we're going here, and yesterday
9 morning, you know, we had this whole discussion about
10 hospitals that had a minus 9 percent Medicare margin and
11 the update is very similar. I just think that we have to
12 rationalize kind of why we look at these situations
13 differently and, you know, this is in law. I don't think
14 that I know enough about our approaches to say we shouldn't
15 do this. But I do want to -- I have a little bit of
16 concern that we're kind of doing this after what we just
17 heard about all-payer margin and the healthy capital
18 markets. It's just something seem a little off.

19 DR. CROSSON: And I agree with that. And as we
20 said yesterday following the discussion at the end of the
21 day, I think periodically we have to go through this,
22 because it's very complicated and it's quite subjective.

1 You know, I think we're committed to, and have been for
2 some time, to providing all the information about margins
3 other than Medicare and also this term of art we've now
4 developed, I think, called the "marginal margin," you know,
5 which is -- and as we said yesterday, we fully recognize
6 that using either of these two approaches may be helpful in
7 coming to our decision, but it also may in some ways
8 prejudice in one direction or the other, which may be
9 different from the needs of the Medicare program itself.

10 So what I think we're committed to when we are
11 able to get together with sufficient time to do this is to
12 go over this again, not just simply from my perspective to
13 say this is the way we used to do it, so we want to do it
14 that way. But to make sure that this Commission going
15 forward understands, you know, the pros and cons of adding
16 some of this information into our decisionmaking process
17 and comes to -- much as we can, comes to an agreement on
18 how we want to think about, how we want to apply it, et
19 cetera, et cetera. So we are committed to doing that.

20 I saw Kathy and Paul.

21 MS. WANG: Can I -- [off microphone]?

22 DR. CROSSON: Yeah, go ahead. I'm sorry.

1 MS. WANG: Yeah, I appreciate that, Jay. That's
2 why, you know, I'm going to go with the recommendation
3 that's up here. And as I said yesterday, I don't think
4 that we're going to come out -- I'm not suggesting that
5 there be like one rigid black-and-white, this is our
6 position on how we assess the all-payer results. But I do
7 think that to the extent that we make different decisions
8 with that information, it should be intentional. That's
9 all I'm asking, that we get the whole picture and that we
10 go in X direction or Y direction with intent.

11 DR. CROSSON: Yeah. Thank you for that. I
12 agree.

13 Okay. Paul and then Kathy.

14 DR. GINSBURG: I wanted to offer something to Pat
15 about why I think we look at the hospital update decisions
16 very differently here, because I think this Commission has
17 a longstanding background of concern with its hospital
18 update recommendations, that they have a profound influence
19 on the level of costs incurred in the system. And the
20 concern is that if Medicare pays hospitals very well, there
21 will be a response of allowing costs to increase in the
22 sense that Medicare perhaps has this function of having --

1 of disciplining hospitals or, to put it differently, just
2 having a role in how expensive or inexpensive our hospital
3 care will be. I think many of these other areas in
4 predominantly for-profit enterprises, we're not so
5 concerned about costs. We're assuming that, you know,
6 given the benefits and given their incentives, they'll try
7 to keep costs down. But I think that's what to me puts
8 hospitals in a very separate place as far as just looking
9 back a long time, long before I was on the Commission, in
10 the Commission's thinking about it, you know, all the cost-
11 shifting analysis done really is about that.

12 DR. CROSSON: Okay. Kathy.

13 MS. BUTO: And I want to come at it from the ESRD
14 perspective. I think what's different about ESRD is that
15 it's largely a creature of Medicare. I think Medicare
16 created the industry in facility dialysis, and I'm not
17 saying that's a justification for an increase, but -- in
18 fact, I was surprised to hear it was 60 percent, 60-40. I
19 do know that that 40 is very fragmented, so some of it is
20 an artifact of the law that actually requires a delay in
21 ESRD eligibility. Some of it is VA, some of it -- so all
22 those other payers don't have the same leverage that

1 Medicare has, and so I think it's quite different from
2 hospitals in that way. So I'd just add that.

3 DR. CROSSON: Okay. Warner, and then -- I don't
4 want to try to adjudicate this issue again, but go ahead,
5 Warner.

6 MR. THOMAS: So I can support the recommendation,
7 but I would disagree with Pat, that it's just hard to sit
8 here when you have a summary sheet that you've provided for
9 us looking at all the disciplines, it just seems like
10 there's some inconsistencies in how we are approaching
11 this. And then they warrant another discussion with us to
12 spend more time thinking long term.

13 I also would say that, you know, what's been done
14 historically versus where we are today, we're in a very
15 different world today than we were even five or ten years
16 ago. And so I'm not so certain that how we thought about
17 policy five or ten years ago is as applicable today where
18 we're just seeing an acceleration of the amount of people
19 that are in Medicare overall, and it's a much larger
20 component of spend in all of these disciplines than it has
21 been historically. So I think that's another thing we need
22 to consider as we think about.

1 DR. CROSSON: Thank you. Okay. Seeing no more
2 discussion, as I said a few minutes ago, I think we've
3 asked Nancy to bring us back more information in a paper.
4 I don't think that information will impact what I see as a
5 consensus for the recommendation. And so I'm going to
6 recommend that we come back with ESRD through an expedited
7 voting process in January. And there will be two
8 opportunities. We will have a brief opportunity for
9 questions in January. And, in addition, as Jim pointed out
10 yesterday, you will be getting the final report for
11 external review, and so there's another opportunity if you
12 have any questions or other comments on the new information
13 that Nancy will be putting into the report. Okay. Thank
14 you, Nancy and Andrew.

15 Now we will move forward to the next
16 presentation.

17 [Pause.]

18 DR. CROSSON: Okay. Kim is going to take us
19 through the analysis and recommendation for updates for
20 hospice services.

21 MS. NEUMAN: Good morning. In 2016, over 1.4
22 million Medicare beneficiaries used hospice services,

1 including about half of beneficiaries who died that year.
2 About 4,400 hospice providers furnished care to those
3 beneficiaries, and Medicare paid hospice providers about
4 \$16.8 billion.

5 The hospice benefit provides palliative and
6 supportive services for terminally ill beneficiaries who
7 choose to enroll. To be eligible, a beneficiary must be --
8 must have a life expectancy of six months or less if the
9 disease runs its normal course. At the start of each
10 hospice benefit period a physician must certify that the
11 beneficiary meets that life expectancy criteria. There is
12 no limit on how long a beneficiary can be in hospice as
13 long as they continue to be meets that criteria. A second
14 requirement of the hospice benefit is that the beneficiary
15 agree to forgo conventional care for the terminal condition
16 and related conditions.

17 Before we go through our indicators of hospice
18 payment adequacy, I'm going to review changes to the
19 hospice payment system that occurred in 2016.

20 The Commission recommended, back in 2009, that
21 the hospice payment system be changed. The Commission
22 found that the payment system was misaligned, with long

1 stays being very profitable. This was because the payment
2 for the most common level of care, routine home care, was a
3 flat payment per day, whereas hospice visits tended to be
4 more frequent toward the beginning and end of a hospice
5 episode. So the Commission recommended changing the per
6 diem payment for routine home care from a flat daily rate
7 to a u-shaped payment throughout the episode, to better
8 match the cost structure.

9 Starting January 2016, CMS changed the payment
10 structure for routine home care and that change was
11 directionally consistent with the Commission's
12 recommendation.

13 There are now two daily rates for routine home
14 care: a higher rate for the first 60 days and a lower
15 rate for days 61 and beyond.

16 During the last seven days of life, hospices also
17 receive additional payments for registered nurse and social
18 worker visits. These visits are paid at an hourly rate and
19 are paid on top of the regular daily rate.

20 CMS projected the new payment structure to be
21 budget neutral in the aggregate but to redistribute
22 revenues across providers. Provider-based, nonprofit, and

1 rural hospices were projected to see revenue increases
2 because these providers tended to have fewer patients with
3 very long stays.

4 So now we will go through our indicators of
5 payment adequacy.

6 First, we have a chart showing the growth in the
7 number of hospice providers. The green line is the total
8 number of hospices. The total number of providers has been
9 growing for many years and increased by 4 percent in 2016.
10 The other three lines in the chart show the number of
11 providers by type of ownership, and you can see from the
12 yellow line that growth in provider supply is accounted for
13 entirely by growth in for-profit providers. The number of
14 nonprofits and government hospices has been on a slight
15 downward trend.

16 The next chart shows growth in hospice use among
17 Medicare decedents. Between 2015 and 2016, the share of
18 Medicare decedents who used hospice increased from 48.6
19 percent to 49.7 percent.

20 Over the years, hospice use has grown most
21 rapidly for the oldest beneficiaries. In 2016, 59 percent
22 of decedents age 85 and older used hospice. As we've seen

1 in past years, minorities and beneficiaries in rural areas
2 continue to have lower hospice use, but use has been
3 increasing as well.

4 So this next chart gives us a more detailed
5 picture of utilization growth. The number of hospice users
6 grew about 3 percent in 2016 to more than 1.4 million
7 beneficiaries. With the growth in the number of hospice
8 users, we also saw growth in the total number of hospice
9 days, reaching over 100 million days in 2016.

10 The bottom of the chart shows hospice length of
11 stay among decedents. Average length of stay among
12 decedents increased slightly in 2016, as we observed a
13 slight increase in length of stay both at the median and
14 the 90th percentile.

15 As you will recall, our prior work has shown that
16 longer stays have been more profitable than shorter stays,
17 and this next slide shows you that length of stay varies by
18 observable patient characteristics like diagnosis and
19 patient location, so that hospices that choose to do so
20 have an opportunity to focus on more profitable patients.
21 And consistent with that, we see for-profit providers
22 having substantially longer stays than nonprofits, about

1 106 days versus 66 days, on average, in 2016.

2 When we look at margins later in the
3 presentation, one factor that's going to contribute to
4 differences in financial performance across providers is
5 going to be length of stay differences.

6 So next we have quality information. In August
7 2017, Hospice Compare released the first public hospice
8 quality data for individual providers. Currently, Hospice
9 Compare includes seven process measures that gauge whether
10 hospices performed certain activities appropriately at
11 patient admission. Examples include documenting treatment
12 preferences, and screening and assessing patients for pain.

13 Most hospices scored very high on six of the
14 seven measures, and while the high scores are encouraging,
15 they also suggest that these measures are or will become
16 topped out. Other quality reporting efforts are underway
17 but data is not yet publicly available.

18 The Hospice CAHPS survey surveys family members
19 of hospice patients that have passed away, to get
20 information about the care provided by the hospice. And
21 Hospice CAHPS data are expected to be released in early
22 2018. CMS has also added quality measures of whether

1 hospices provide visits in the last days or week or life,
2 and that will be forthcoming as well.

3 As we've discussed before, live discharge rates
4 are also a potential indicator of poor quality or program
5 integrity issues. We would expect some live discharges
6 from hospices to occur, because sometimes patients improve
7 and no longer meet the eligibility criteria, or because
8 patients might change their mind and decide to return to
9 conventional care. However, if a provider has a live
10 discharge rate that is substantially higher than its peers,
11 it may signal that the provider is not meeting patient
12 needs or that the hospice is admitting patients that do not
13 meet the eligibility criteria.

14 In 2016, across the entire hospice population,
15 the percentage of discharges that were live discharges was
16 16.9 percent, up slightly from the prior year.

17 Some hospices appear to have outlier live
18 discharge rates. In 2016, 10 percent of hospices had a
19 live discharge rate of 53 percent or more.

20 So next we have access to capital. Hospice is
21 less capital intensive than some other Medicare sectors.
22 Overall access to capital appears adequate. We continue to

1 see growth in the number of for-profit providers, which
2 increased about 7 percent in 2016, suggesting capital is
3 accessible to these providers. Reports from publicly
4 traded companies and private equity analysts also suggest
5 that the hospice sector is viewed favorably by the
6 investment community. We have less information on access
7 to capital for nonprofit freestanding providers, which may
8 be more limited. Provider-based hospices have access to
9 capital through their parent providers.

10 So next we are going to go through information on
11 hospice costs and margins. First we have data on hospice
12 costs by level of care for freestanding providers. There
13 are four levels of hospice care. Routine home care
14 accounts for the vast majority of days, but there are three
15 other levels of care that are available in certain
16 circumstances when the patient needs additional support.

17 Data on cost by level of care are now available
18 because the hospice cost reports have been substantially
19 revised, starting with freestanding providers in 2015.
20 Prior to these changes, we were only able to estimate the
21 cost per day for all levels of care combined, not
22 separately by level of care.

1 Looking at the chart, the first row shows routine
2 home care. For routine home care, freestanding providers
3 had an estimated average cost per day of about \$124,
4 compared to a Medicare payment rate of \$159. In contrast,
5 for the other three levels of care, the estimated cost is
6 higher than the Medicare payment amount.

7 These data suggest a potential need to rebalance
8 the payment rates across the four levels of care, which is
9 something that we could consider further in the future.

10 Next, we have Medicare margins. These margins
11 include payments and costs for all four levels of care and
12 are for all types of providers. Different from other
13 sectors, we have historical margin data through 2015,
14 because 2016 margin data are incomplete. So for 2015, we
15 estimate that the aggregate Medicare margin for hospice
16 providers was 10 percent, up from about 8.2 percent in
17 2014. A couple things to note. We exclude non-
18 reimbursable costs from our margin calculations, which
19 means we exclude bereavement costs and the non-reimbursable
20 portion of volunteer costs. If those costs were included
21 in our margins, it would reduce the estimates by, at most,
22 1.6 percentage points.

1 Next we have margins by category of hospice
2 provider. Before we go through these numbers, one thing
3 to keep in mind is that the payment reforms that occurred
4 in 2016 are not reflected in the 2015 margins, but we will
5 have a slide later with some information on the 2016
6 effects.

7 So, in 2015, freestanding hospices continue to
8 have strong margins, 13.8 percent. Provider-based hospices
9 had lower margins than freestanding hospices.

10 The chart also shows margins by type of
11 ownership. For-profit hospices have substantial margins,
12 16.4 percent. The overall margin for nonprofits is 0.1
13 percent. Looking just at freestanding providers, the
14 nonprofit margin is higher, at 5.0 percent.

15 One other point to note is that like other
16 sectors we have calculated the marginal profit, which is
17 the amount Medicare payments exceed the marginal cost of
18 treating an additional patient. For hospices, the marginal
19 profit is estimated to be 13 percent in 2015.

20 Next we show what's underlying some of the margin
21 differences. On the left, we have the relationship between
22 length of stay and hospice margins. And as you can see,

1 providers with longer stays had higher margins in 2015.

2 In the right chart, we show how margins increased
3 with the percentage of patients in nursing facilities.

4 There may be a number of advantages to the nursing home
5 setting, including access to patients that have conditions
6 associated with longer stays, economies of scale from
7 treating patients in one location, and overlap in services
8 provided by the hospice and the nursing facility.

9 So, as I said, our 2015 margin estimates do not
10 reflect the 2016 payment system changes for routine home
11 care. To estimate the effect of the 2016 payment changes,
12 we compared 2016 actual payments to what we estimate 2016
13 payments would have been if the old payment system had
14 continued. And as you see from the numbers on the chart,
15 the new payment system led to modest changes in payments
16 for provider groups. As expected, the effects varied by
17 providers' length of stay. On average, payments increased
18 about 3 percent for the 20 percent of hospices with the
19 fewest long-stay patients while payments decreased, on
20 average, about 3 percent for the 20 percent of hospices
21 with the most long-stay patients.

22 The effects by category of provider, like type of

1 ownership, provider-based vs. freestanding, and rural and
2 urban, are modest, but in the expected direction given the
3 mix of patients these providers treat.

4 When the Commission commented on the hospice
5 proposed rule for changes to the payment system, the
6 Commission stated that the payment system changes were
7 modest and left room for additional changes. So this is
8 something that we could consider in the future.

9 So next we have our 2018 margin projection. To
10 make this projection, we start with the 2015 margin, and we
11 take into account the market basket updates, including
12 productivity adjustments and additional legislated
13 adjustments in 2016 and 2017, and the 1 percent update
14 mandated in 2018 by the Impact Act. We also take into
15 account the phase-out of the wage index budget neutrality
16 adjustment and other wage index changes, and we take into
17 account the implementation of the new payment system.

18 Taking all those factors into account and
19 assuming cost growth consistent with historic trends, we
20 project a margin in 2017 of 8.7 percent.

21 So to summarize, indicators of access to care are
22 favorable. The supply of providers continues to grow,

1 driven by for-profit hospices. The number of hospice users
2 and average length of stay among decedents has increased.
3 We have limited quality data but those data are generally
4 favorable. Access to capital appears adequate. The 2015
5 aggregate margin is 10.0 percent, and the 2015 marginal
6 profit is 13 percent, and the 2018 projected aggregate
7 margin is 8.7 percent.

8 So this brings us to the Chairman's draft
9 recommendation, and it reads: The Congress should
10 eliminate the fiscal year 2019 update to the hospice
11 payment rates.

12 Given the margin in the industry and other
13 payment adequacy indicators, we anticipate that providers
14 can cover cost increases in 2019 without any increase in
15 their payment rates. So this recommendation is expected
16 to have no adverse impact on beneficiaries nor providers'
17 willingness or ability to care for them.

18 So that concludes the presentation.

19 DR. CHRISTIANSON: Thanks, Kim. Questions for
20 Kim? Brian, Jack, Rita. Okay. A lot of questions. Let's
21 start with Brian and go around.

22 DR. DeBUSK: Thank you for a very well-written

1 chapter.

2 I have two questions. The first, you know, the
3 53 percent live discharge rate is fairly ridiculous. Well,
4 again, miracle workers. But are there certain conditions
5 that are more susceptible -- I mean, it does suggest, a 53
6 percent rate does suggest that there's some gamesmanship
7 and possibly even a program integrity issue.

8 But my question is, are there incoming conditions
9 that are more susceptible? You know, for example, say, you
10 know, a Stage 4 pancreatic cancer, I don't see a lot of
11 opportunity to gain hospice care there. But are there
12 other conditions that are more susceptible to gaining?
13 Could we identify them? Could we focus program integrity
14 efforts in a more concentrated way?

15 And then my second question was, I noticed you
16 mentioned some changes to the wage index. Do you mind
17 elaborating a little bit on what they're doing and the
18 impact of those adjustments?

19 MS. NEUMAN: Sure. So on the first point about
20 live discharge rates, it is true that live discharge varied
21 -- rates varied by diagnosis, and so there are some
22 diagnoses, by nature of, I think, both the fact that some

1 conditions are more unpredictable and also that those
2 conditions are then attractive to focus on. It means that
3 you are going to see some variation in live discharge
4 rates, both across the type of patient and then also across
5 providers, in terms of how they choose to select patients.

6 DR. DeBUSK: Is there evidence that these
7 providers may be target or focused, or try to go after
8 these more nebulous conditions?

9 MS. NEUMAN: It's hard to sort of speak to how
10 they're going about recruiting their patients. What I can
11 say is that we have different providers that have very
12 different mixes of patients.

13 You had a second question, which was on the wage
14 index. So the biggest thing that has occurred, and it's
15 been going on over a seven-year period, is there was this
16 thing called the Wage Index Budget Neutrality Adjustment,
17 and it had to do with switching from out outdated wage
18 index to a more current one. And in the process, they
19 agreed to give the hospices an adjustment. It basically
20 increased their payments about 4 percent. And they kept
21 that in place for a number of years.

22 And so CMS back -- I believe it started in 2010 -

1 - decided to take that extra payment away. And so it's
2 been phasing out, and 2016 was the year where it got
3 completely phased out. So after this year, we won't be
4 talking about the sort of phase-out anymore. It's done.

5 DR. DeBUSK: So they got to use the raw wage
6 index calculation before the budget neutrality requirement
7 was imposed on it.

8 MS. NEUMAN: They got -- how it worked is they
9 switched to a more accurate wage index but that would have
10 led to lower payments, and so the government said, okay,
11 we're going to get you to this more accurate wage index and
12 we're going to compensate you because we know that -- and
13 give you an extra 4 percent. And then, over time, we've
14 taken that extra 4 percent away.

15 DR. CHRISTIANSON: Okay. Let's keep on going up
16 this way, so Jack, you're next. We'll go around.

17 DR. HOADLEY: So I'm looking at Slide 15 on the
18 margins, where you've got some pretty disparate margin
19 comparisons in some of the categories. And then your
20 discussion, a couple of slides later on what it would look
21 like, or what the implications of the 2016 phase-in of the
22 new system. Am I correct to read the numbers that you

1 showed there, which were about payment changes, not about
2 margin changes, to suggest that these margin differences
3 might shrink a little bit, say between freestanding and
4 hospital-based, or for-profit and not-for-profit, but the
5 basic pattern of some pretty wide differences would
6 persist?

7 MS. NEUMAN: Yeah, that's correct.

8 DR. HOADLEY: Okay. I want to come back to that
9 on Round 2.

10 DR. CHRISTIANSON: Okay. Dana, did you have any
11 questions? No? Okay. Warner.

12 MR. THOMAS: Do you have any insight or can you
13 come to any conclusions about the significant acceleration
14 in for-profit hospice versus the flat and/or declining in
15 not-for-profit or governmental?

16 MS. NEUMAN: So the sort of market entry of for-
17 profit providers for a really sustained period of time has
18 always raised the question of whether sort of the
19 profitability available in this industry has been a draw
20 for more and more providers.

21 DR. CHRISTIANSON: Is that it, Warner, or do you
22 want to follow up? No? Okay. Rita.

1 DR. NERENZ: Obviously a draw for some certain
2 types of providers but not all.

3 DR. CHRISTIANSON: Thank you, Rita.

4 [Laughter.]

5 DR. REDBERG: Any time.

6 DR. NERENZ: I just had the thought.

7 DR. REDBERG: Thanks for the great chapter. I'm
8 curious. You mentioned in the mailing materials that
9 there's a substantial increase in payments to the social
10 worker and nurse in the last seven days of life. Is that
11 applied retroactively, or how does that exactly work?

12 MS. NEUMAN: Right. So what happens is after the
13 patient has passed, then they look at the claims and they
14 find the last seven days of life, and retroactively they
15 see what visits were provided by registered nurses or
16 social workers in that period and then they pay the extra
17 amount for those visits. So it is exactly retroactive.

18 DR. REDBERG: What is the rationale for that?

19 MS. NEUMAN: So the idea was that they wanted to
20 provide additional money at the end of life to recognize
21 the higher intensity of needs at that time, and there, at
22 the same time, is concern that some hospice providers may

1 not be providing many visits at the end of life. There's
2 some data that suggests that there is sort of variation in
3 how much services is provided at the end of life.

4 So the idea was that if you paid fee-for-service
5 for the nurse and the social worker visits with a cap, but
6 paid fee-for-service in those sort of last seven days, that
7 you would target the money better toward those providers
8 that were furnishing services.

9 DR. REDBERG: I won't belabor it more, but it's
10 hard to know what are the last seven days of life. So I
11 just wonder how well that's achieving that effect, unless
12 offering more services.

13 DR. MATHEWS: So I could weigh in a little bit
14 here, if you don't mind.

15 DR. REDBERG: Sure.

16 DR. MATHEWS: So our work on hospice goes back
17 for the better part of a decade here, and you've been
18 around for a good half of that period of time. But we have
19 established the fact that while Medicare paid an unchanging
20 per diem rate throughout the course of a hospice episode,
21 that costs incurred by the hospices were higher at the
22 beginning of the episode when the patient was being taken

1 into a hospice care and then at the end when the intensity
2 of interventions in the form of nursing care, social work
3 because more substantial

4 So we made a recommendation back in 2009, 2010,
5 thereabouts, to change the hospice payment system from a
6 linear approach to one where the payment varied, higher at
7 the beginning of the episode and higher at the end and
8 lower in the middle. And CMS has tried to do that in the
9 most recent revisions to the payment system. They pay a
10 higher per diem rate for the first 60 days, a lower rate
11 for the days thereafter, but obviously, you can't predict
12 when the patient is going to pass and, thus, when those
13 higher rates need to be put into effect.

14 So the notion of a retrospective per-visit
15 payment for the last seven days is the agency's attempt to
16 reflect the U-shaped distribution of hospice's costs, and
17 it is not inconsistent with at least the conceptual
18 approach that we identified a while back. Obviously,
19 people can take issue with whether that's the best approach
20 or whether there are alternatives, but it is an attempt to
21 recognize the uneven distribution.

22 DR. REDBERG: Thanks, Jim. That's helpful.

1 And I do remember our discussions about the
2 terminal. Maybe we can at another time -- I just wonder if
3 there is any literature on it because we're all not great
4 at predicting the end of life, and I wonder if there is any
5 literature on actually asking nurses and hospice providers,
6 do they think this is the last seven days, and then going
7 back and looking at it, because the only way that would
8 really work to increase visits is if we're really good at
9 predicting that. And I'm just not that certain we are.

10 My other question, which I think is simpler, is
11 just on Slide 13, and it's kind of related. But do you
12 have any estimates for the number of hours in the routine
13 home care, general inpatient care and inpatient respite
14 care, which are -- you've given the average cost per day,
15 but I'm wondering usually how many hours of care are we
16 talking about in those categories.

17 MS. NEUMAN: So routine home care, how routine
18 home care works is that it's a daily rate, and then they
19 give a certain number of visits a week, depending on the
20 patient's needs. So a patient might get four visits a
21 week, and those visits tend to be maybe an hour, hour and
22 15 minutes, depending on the type of provider. So you

1 might get a couple nurse visits and a couple aide visits a
2 week and roughly an hour-ish, about.

3 I don't have information for you right now on
4 hours of care for general inpatient in terms of how much
5 nurse care or aide care, that kind of thing, but general
6 inpatient is not just those services but then also having
7 the patient in a facility, which means sort of like
8 hospital level-of-care kinds of standards. And so that's
9 both the facility piece and the sort of service piece
10 that's reflected in that line item.

11 Continuous home care, on the bottom, that's when
12 you get -- it's paid at an hourly rate because you're
13 getting at least eight hours of care in the home, and that
14 tends to be somewhere between 16 and 20 hours of care, but
15 again paid on an hourly basis.

16 DR. REDBERG: For just the routine home care, is
17 that paid per hour, or is it just 124 if you've had any
18 visit in that day, no matter how long it was, 10 minutes or
19 2 hours?

20 MS. NEUMAN: So routine home care is a daily rate
21 paid, regardless of what services you receive on a day.
22 There will be some days where you don't get visits, but we

1 pay that rate regardless, and the idea is that it's
2 compensating for visits that occur when you're a patient
3 but also for drugs and someone being able to call and ask
4 questions, durable medical equipment, and the supports that
5 go around these patients as well.

6 DR. REDBERG: Thank you.

7 DR. CROSSON: Questions. Bruce.

8 MR. PYENSON: Thank you very much, Kim.

9 In the ownership category, we split out for-
10 profit and not-for-profit and some other categories.
11 Anecdotally, I have observed that many home health agencies
12 also overlap and provide services for hospice. Some of the
13 services perhaps seem similar, and I'm wondering if it's
14 possible to look at the overlap of ownership between home
15 health agencies and hospices under the same corporate
16 umbrella.

17 The connection there I think is -- of course, re
18 recommended a decrease in home health, is I think the
19 Chairman's recommendation, and here we have another set of
20 -- another silo that's perhaps not such a silo. And we're
21 also -- I think the Commissioner's recommendation is no
22 increase.

1 So rather than viewing these as totally separate
2 entities, I'd be very curious what the corporate overlap
3 is. I don't know if that's possible to look at and whether
4 my anecdotal observations have any merit.

5 MS. NEUMAN: So you're interested in the sort of
6 providers that we have serving the hospice population and
7 to see what share of them also provide home health
8 services? So a provider-level rather than a beneficiary-
9 level analysis?

10 MR. PYENSON: Correct.

11 Now, Kathy just pointed out to me on page 15, 11
12 percent -- I think that's of agencies -- are home health-
13 based.

14 MS. NEUMAN: That means that they fill out a home
15 health-based cost report, so that gives you a sense, but
16 you could still fill out a freestanding hospice cost report
17 but be under the corporate infrastructure of a company that
18 has multiple lines of business including home health. So
19 it would be pretty complicated to figure this out.

20 MR. PYENSON: Okay. Thank you.

21 DR. CROSSON: Amy.

22 MS. BRICKER: Thanks for the chapter. I found

1 this topic exceptionally fascinating and had a number of
2 questions for clarification.

3 When we talk about length of stay and cost, is
4 that the beneficiary level, meaning if I come in and out,
5 enroll, disenroll, enroll, disenroll, are costs and length
6 of stay just per enrollment period or actually tracked at
7 the beneficiary level?

8 MS. NEUMAN: The length-of-stay figures that you
9 see in all of our documents, we calculate a lifetime length
10 of stay, and so we're tracking all the beneficiaries' days
11 while they're a beneficiary in hospice, whether they come
12 in and out multiple times. We just keep counting.

13 On the cost, can you say a little bit more about
14 which costs you're interested in?

15 MS. BRICKER: Just that -- I think you've
16 answered the question. You're looking at it from a
17 lifetime from statistics associated with hospice episode,
18 costs, or length of stay. You're saying you're following
19 the patient if they're coming in and out of hospice and
20 costs associated with them, caring for them.

21 MS. NEUMAN: Right. And the one exception I
22 would say is that a lot of our data is sort of focused on -

1 - the cost data is focused on 2015, and so that data that
2 you see here, like on this chart, this is 2015 costs, not
3 looking at earlier years or later years.

4 MS. BRICKER: Do we know of the entities which
5 are physician-owned?

6 MS. NEUMAN: We don't. I don't know. Is there a
7 way for us to get at that?

8 DR. DeBUSK: [Speaking off microphone.]

9 MS. BRICKER: The Stark applies? Is that what
10 you said? I'm just curious if we could get a -- if any are
11 physician owned and what the attributes of those provider
12 types are, associated with sort of what a standard -- the
13 gold standard is for quality and all the things that we've
14 talked about in the chapter around questionable practices,
15 like live discharges or those that are hitting caps.

16 Okay. Last question. On that point, around
17 those, in the chapter you talk about hitting the caps and
18 more of the for-profit entities hit the caps than not. Is
19 it the similar group that's also then in the 10 percent
20 that have the high live discharge? Is there a correlation
21 there between those two?

22 MS. NEUMAN: So hospices that exceed the

1 aggregate cap have a substantially higher length of stay
2 and live discharge rate than other providers. So I haven't
3 overlapped the groups literally, but statistically, live
4 discharge rates are substantially higher. So, yes, it puts
5 them at the end of that distribution of live discharges.

6 MS. BRICKER: Great. Thank you.

7 DR. CROSSON: David.

8 DR. GRABOWSKI: Great. Thanks, Kim. This was a
9 great chapter.

10 I wanted to ask you about Slide 16, please. I
11 wanted to ask you about, in particular, the high margins
12 for the providers that are offering services in nursing
13 homes. You offer a few explanations here -- potential
14 economies around travel time, the ability to leverage
15 nursing home staff, maybe it's a different diagnosis
16 profile or longer length of stay.

17 I wanted to ask you about another explanation. I
18 know several of the large nursing home chains own their own
19 hospice, and how much of that is going on here and really
20 gets at maybe what Bruce was pushing around, home health?
21 I'm also worried about corporate overlap here, with nursing
22 homes owning their own hospice. I don't know how frequent

1 that is, but I do know that several of the large ones own
2 their own hospice. And how much of that is driving some of
3 what we're seeing here?

4 Thanks.

5 MS. NEUMAN: We haven't been able to isolate that
6 effect. That is a question, and people raised concerns
7 about sort of this overlapping ownership.

8 I would say that we still see this pattern in
9 nonprofit providers. So there could very well be something
10 to the overlapping ownership, but there's also something
11 more going on.

12 DR. GRABOWSKI: And just to follow up on that,
13 there's also this overlap with assisted living, and I don't
14 believe there's any assisted living companies that own
15 their own hospice. So it's certainly something about the
16 care there, but in a 2013 report, I know MedPAC suggested
17 potentially making adjustments and payment across kind of
18 care delivered in nursing homes versus elsewhere, and
19 that's something that we may want to revisit at some point.

20 Thanks.

21 DR. CROSSON: David and then Kathy.

22 DR. NERENZ: Just to follow on that line of

1 questioning and maybe sharpen the point, is there a formal
2 prohibition against double billing? Let's say you've got a
3 patient in a, say, skilled nursing facility in hospice.
4 First of all, can that situation occur, just in terms of
5 program eligibility, and if it does occur, can the two
6 different programs be billed for the same patient, same
7 day?

8 MS. NEUMAN: So a couple of things. When you're
9 looking at that chart, that is largely long-term nursing
10 home patients, not skilled nursing facility.

11 DR. NERENZ: That's why I tried to phrase the
12 question specifically --

13 MS. NEUMAN: Yeah, yeah.

14 DR. NERENZ: -- just because I'm trying to look
15 for this in the Medicare program.

16 MS. NEUMAN: Right. So, technically, a patient
17 can receive hospice and SNF at the same time if they're
18 getting the SNF services for an unrelated condition. So
19 there is some overlap. It doesn't happen often.

20 DR. CROSSON: Kathy.

21 MS. BUTO: I was just going to go back to David's
22 question because I think these are essentially not Medicare

1 nursing home or SNF. It's Medicare, right? So were you
2 trying to get at -- I was trying to understand your
3 question. Were you trying to get at the issue of double
4 billing or inappropriate referrals, I guess, to hospice?

5 DR. GRABOWSKI: Correct. So I don't think this
6 is an issue, as Kim just noted, across the SNF benefit in
7 hospice. It's more around the sort of long stay, and just
8 this idea of this joint ownership issue. So it's really
9 not about the SNF benefit.

10 Medicaid programs do adjust their payment when
11 someone goes into hospice. Most do, anyway. They pay for
12 room and board, but not the services.

13 MS. BUTO: One could argue that it's actually an
14 efficiency or a service that ought to be provided by
15 nursing homes because of the nature of the population. I'm
16 just trying to get at what you were --

17 DR. GRABOWSKI: There's absolutely economies.
18 It's just about getting the payments right, I think.

19 DR. CROSSON: Kim, I actually have a question. I
20 apologize if I missed this in the material, but over the
21 last few years, we've been taking a look at what I call
22 "diagnosis creep," particularly in the area if dementia and

1 other neurologic diseases and its potential impact on
2 length of stay. Is that continuing stabilized or what?

3 MS. NEUMAN: We have seen -- it's pretty similar,
4 the diagnosis profile, from this year to last year. I
5 think if we just -- if we categorize cancer and non-cancer,
6 I think non-cancer climbed up maybe a percentage point.
7 Maybe it's three-quarters now of all our patients are non-
8 cancer, so it's gone up just a tad. So I think it has
9 stabilized some.

10 DR. CROSSON: Okay, thanks.

11 So let's have the recommendation put up on Slide
12 No. 20, and we'll entertain comments on the recommendation.

13 I see Jack.

14 DR. HOADLEY: So it seems like this is one of
15 those areas that we talked some about yesterday where I
16 think, David, you were the one that kept talking about "I
17 wish we could do differential updates across some of the
18 categories," and I think I've raised that same point a
19 couple of years ago.

20 The payment reforms were supposed to help address
21 that, and I think you said during the presentation that --
22 you kept using this term like what CMS did was

1 directionally consistent with our recommendation,
2 suggesting that it was perhaps not fully reflective of what
3 we recommended, and that potentially that was something to
4 look at further.

5 So, I mean, I think the recommendation, as such,
6 given the constraints that we operate under and disinterest
7 in any kind of differential update is a sensible place to
8 be, but it does suggest that we should be looking back at
9 whether there's a way to say something further about the
10 payment structure, if that's the better way, as it probably
11 is, to sort of address this clear discrepancy between the
12 profitability and some of the other characteristics for the
13 different types of providers.

14 DR. CROSSON: Just a comment on that, and it has
15 to do with perhaps this traditional but potentially
16 artificial division in our work, which is we work a number
17 of months in the year on policy issues, and then we work
18 two months of the year specifically on update issues. For
19 better or worse -- and I don't have a judgment on this per
20 se, but the tendency has been over the years to say, well,
21 if we feel like there should be differential payment, let's
22 address that, as in this case, through some policy

1 recommendation, which is separate from our update
2 recommendation. And then when we come to the update
3 recommendations, let's make one update recommendation
4 across the board taking into consideration the fact that we
5 have either recommended or we have seen either CMS or
6 Congress act on former policy recommendations that then
7 shift that update and redistribute.

8 And I think the reason for that predates any
9 thinking that I've done, but I think the reason for that is
10 the acknowledgement that the process of doing differential
11 updates is very complicated. Once you start saying, well,
12 we're going to have this segment and that segment and this
13 segment and that segment, then a lot of the discussion gets
14 into whether the segments are appropriately distributed,
15 whether issues have changed from year to year to year. And
16 the process of doing the updates in this relatively
17 constrained time frame that we have, which is two months --
18 let's do it in December and January -- becomes more
19 complicated.

20 I think, to some extent -- I think we got at it a
21 little bit yesterday, but in some cases, we may want to
22 depart from that a little bit, and I think that's something

1 that over the next year or so, we should discuss.

2 Again, we've done it one way all the time,
3 doesn't mean we have to do it, but there is -- there has
4 been a rationale for doing it this way. And as a
5 consequence, when we get into the December-January piece
6 and we're just looking at the updates, it can be -- as you
7 say, it can be very frustrating, "Well, why can't we do it
8 differentially?"

9 We understand that, and we've tried to approach
10 that through a different mechanism, through the other parts
11 of our work, but that's not always satisfying, and it's not
12 always effective.

13 DR. HOADLEY: We've probably come close on the
14 physicians where we talk about primary care and specialty.

15 One of the challenges here is that sometimes the
16 categories are maybe surrogates for something. I mean, we
17 say for profit, not for profit, or we say urban and rural.
18 Not all urbans are alike. Not all rurals are alike. And
19 we're probably not comfortable saying, "Well, gee, we're
20 going to give this update to urban hospices and this update
21 to rural or for profit and not for profit." We'd like to
22 get down to something that's more driven by the nature of

1 what they do than these sort of more artificial categories.
2 The line between what's for profit and not for profit may
3 be very clear on an IRS basis, but behaviorally, it's not
4 always so clear.

5 DR. CROSSON: And it's exactly why it's complex.
6 Yeah. Kathy.

7 MS. BUTO: I was just going to say I think
8 another way to go at this is to look underneath what's
9 driving the difference. So if there's a higher percentage
10 of live discharges, that may be -- and that's driving
11 profitability, for example, or the kind of diagnoses that
12 are, I guess, shown by the type of facility, we ought to
13 look at that.

14 So I'm wondering -- I'm a little nervous about
15 starting down the road of making a differential update when
16 there's some underlying issues that maybe can get at that,
17 and then I'm also aware of the fact that we're trying to
18 move in the direction of site-neutral payments in other
19 ways in order not to prejudice the site that's providing
20 the service.

21 So I think we have to weigh all these things, but
22 I would really like to see us get underneath some of these

1 differences as we consider things like a differential
2 update.

3 DR. HOADLEY: It seems like the U-shaped payment
4 model was exactly intended in that direction, and so that's
5 why -- and I think you raised appropriately -- the issue of
6 was it done as far as we might have envisioned, could it be
7 done -- was it enough? Do we take another look and see
8 whether there's a different way to tweak that?

9 Again, we've seen this in the PAC where the PAC
10 proposals we had do, in fact, shrink some of the
11 differences that are bothering us when we look at these
12 summary measures.

13 DR. CROSSON: Okay. So I think, once again, here
14 we're seeing a relatively uniform consensus in favor of the
15 recommendation at this time, and so we'll bring this
16 forward through expedited voting in January.

17 Kim, thank you very much. Nice presentation.
18 Nice discussion.

19 So now we'll move on to our final presentation
20 and discussion for the December meeting, and that's on the
21 Medicare Advantage program.

22 [Pause.]

1 DR. CROSSON: Okay. Medicare Advantage program
2 presentation in December and January is somewhat different
3 from the others in the sense that we don't make an update
4 recommendation per se. The Medicare Advantage payment
5 program is set in law in a different way. But we do review
6 the program, and in this particular case we will be making
7 some recommendations of a policy nature as well.

8 So we've got Scott, Carlos, and Andrew again.
9 Andrew has been doing a lot of work. And Scott, it looks
10 like you're going to start out.

11 DR. HARRISON: Good morning. I would like to
12 thank Emma Achola for her work on the chapter.

13 I am going to present our analysis of the
14 Medicare Advantage enrollment, plan availability and bids
15 for 2018. Then Andy will give you an update on risk coding
16 intensity. Finally, Carlos will talk about MA quality, and
17 will have the Chairman's draft recommendations on the
18 quality stars and contract consolidation.

19 We haven't described MA payment policy in a
20 meeting for a meeting for a while, so I think it's time to
21 do it again.

22 Plans submit bids each year for the amount they

1 think it will cost them to provide Parts A and B benefits.
2 There is a separate bid for part D drugs, but the MA plans
3 just get paid for D as if they were standalone Part D
4 plans. Each plan's bid is compared to a bidding target or
5 "benchmark." CMS sets county-level benchmarks based on the
6 county-level fee for service spending. These benchmarks
7 range from 115 percent of fee for service in the lowest fee
8 for service spending counties to 95 percent of fee for
9 service in the highest-spending counties.

10 A plan's benchmark is its enrollee-weighted risk-
11 adjusted average of the county benchmarks. Plans that
12 reach certain quality bonus levels can have their
13 benchmarks raised by up to 10 percent. Carlos will discuss
14 the plan quality bonuses shortly.

15 If a plan bids above its benchmark, Medicare pays
16 the benchmark and the beneficiaries make up the difference
17 with a premium. If a plan bids below its benchmark,
18 Medicare pays the bid plus a rebate, calculated as a
19 percentage of the difference between the bid and the
20 benchmark. The rebate percentage ranges between 50 percent
21 and 70 percent, where plans with higher quality ratings are
22 awarded higher rebate percentages. The rebate must be used

1 by the plan to provide extra benefits to the beneficiaries.
2 These extra benefits can take the form of reduced premiums,
3 reduced Medicare cost sharing, or additional non-Medicare
4 benefits.

5 Now let's talk about enrollment. In 2017, MA
6 enrollment grew 8 percent to 19 million enrollees. The 8
7 percent growth figure is higher than last year's 5 percent
8 growth and higher than the average 7 percent annual growth
9 we have seen over the prior few years. Now, 32 percent of
10 all Medicare beneficiaries are enrolled in Medicare
11 Advantage plans. Since 2007, MA enrollment has more than
12 doubled and plans project continued growth for 2018.

13 If we split enrollment by plan type, enrollment
14 in HMOs grew 5 percent while local PPOs had a big year this
15 year, growing by 800,000 enrollees, or 19 percent.
16 Regional PPOs, however, grew by only 3 percent. All of
17 these figures are significantly higher than the 1 percent
18 estimated growth rate in fee for service enrollment for
19 2017.

20 In 2018 Medicare beneficiaries have a large
21 number of plans from which to choose and MA plans are
22 available to almost all beneficiaries. On this chart you

1 can see trends over the last few years, but to save time
2 let's just walk down the 2018, or right-hand, column.
3 Ninety-nine percent of Medicare beneficiaries have at least
4 one plan available. Forty-one percent have a private fee
5 for service plan available, down again, and a continuation
6 of the expected decrease resulting from pre-PPACA
7 legislative changes.

8 The average number of plans available in each
9 county remained at 10, but when weighted by the number of
10 beneficiaries in each county, the number of average plan
11 choices available to the average beneficiary is 20, which
12 is the highest number during the seven-year period.
13 Finally, the average rebate that plans have available for
14 extra benefits in 2018 has increased to \$95 per member per
15 month, the highest level during this time period.

16 Using plan bids, we estimate that in 2018, MA
17 benchmarks, bids, and payments, including quality bonuses,
18 will average 107 percent, 90 percent, and 101 percent of
19 fee for service spending, respectively.

20 While plan bids average 90 percent of fee for
21 service, that number is kept down because HMOs are bidding
22 88 percent of fee for service, on average. The other plan

1 types bid much higher and local PPOs are bidding at 99
2 percent of fee for service, although that is down from 101
3 percent last year.

4 However, I would like to point out that SNPs, who
5 have enrollees with the highest average risk, bid well
6 below the risk-adjusted fee for service spending. But
7 overall, Medicare is paying more than fee for service. This
8 is due to the benchmarks averaging 107 percent. Quality
9 bonuses, which are included here, raised the benchmarks by
10 4 percent, and the payments by 3 percent.

11 Finally, note that all the numbers on this slide
12 assume that risk differences are properly accounted for,
13 and next Andy might say that not all risk is properly
14 accounted for. We'll see. Not to spoil his findings too
15 much, but if the coding intensity was properly accounted
16 for, payments would average 103 percent of fee for service.

17 And, finally, we find that payments for MA
18 enrollees are roughly equal to payments on behalf of fee
19 for service beneficiaries, if payments due to quality and
20 excess coding are set aside.

21 Now Andy.

22 DR. JOHNSON: Medicare payments to MA plans are

1 unique to each enrollee. Payments are the product of two
2 factors. The first is a base rate that Scott described
3 earlier. The second is a beneficiary's risk score, which
4 is a standardized measure of expected spending, and it
5 adjusts the base rate by increasing payment for
6 beneficiaries who are more sick and therefore expected to
7 have greater health care expenditures, and vice versa.

8 The risk model includes information about each
9 beneficiary's demographic characteristics and certain
10 medical conditions. These conditions are identified by
11 diagnosis codes and grouped into HCCs. Risk scores are the
12 sum of the relative spending amounts associated with each
13 demographic and HCC component. The more HCCs that are
14 indicated for a particular enrollee, the larger the risk
15 score and the larger the associated Medicare payment will
16 be for that enrollee.

17 The components in the risk model are estimated
18 using fee for service data, and therefore reflect the
19 spending and diagnostic coding patterns in fee for service
20 Medicare. Most HCCs are identified through physician and
21 outpatient claims, which in fee for service Medicare tend
22 to be paid based on procedure codes and provide little

1 incentive to document diagnoses for fee for service
2 beneficiaries.

3 In MA, however, payment is tied directly to the
4 number of HCCs identified, so there is a significant
5 financial incentive to documenting all diagnoses. We have
6 consistently found higher rates of diagnostic coding in MA
7 compared to fee for service Medicare, such that enrollees
8 of equivalent health status have higher risk scores when
9 enrolled in MA, and therefore generate greater Medicare
10 spending.

11 The divergence in MA and fee for service risk
12 scores has grown year after year; however, this year we
13 found that fee for service risk scores grew faster than
14 prior years and the fee for service growth rate matched the
15 rate of growth for MA risk scores. Risk scores for MA
16 enrollees continued to be higher than comparable
17 beneficiaries enrolled in fee for service Medicare, but the
18 size of this difference remained roughly the same as it was
19 in the prior year.

20 Our analysis of this issue is somewhat
21 complicated by the transition from an old HCC model to a
22 new model, where a blend of the two models was used for

1 payment in 2014 and 2015. The difference between MA and
2 fee for service was increasing by 1 percentage point per
3 year up to 2015. The first row in this table shows that
4 the difference for the old model increased from 8 to 9 to
5 10 percent, and the last row shows that the difference for
6 the new model increased from 7 to 8 percent.

7 In 2016, only the new model was used for payment
8 to MA plans. The MA risk scores remained 8 percent higher
9 than fee for service. An overall impact of 8 percent is a
10 decrease from 10 percent for 2015. This decrease is due to
11 the transition from the old to the new HCC model and the
12 fact that fee for service risk scores grew faster in 2016
13 than in prior years.

14 Since 2010, CMS has reduced all MA payments to
15 account for coding differences. In 2016, CMS reduced MA
16 risk scores by the mandated minimum amount of 5.41 percent.
17 After accounting for this adjustment, we find that 2016 MA
18 risk scores were inflated by between 2 and 3 percentage
19 points relative to fee for service, due to coding
20 differences.

21 Finally, I will note that in 2016 it was the
22 first year that encounter data was used, in part, for MA

1 risk scores and payment. The impact of encounter data was
2 small and is reflected in the numbers presented here. I
3 will be happy to discuss this topic more with questions.

4 Now I will turn it over to Carlos to discuss MA
5 quality and contract consolidations.

6 MR. ZARABOZO: As part of the MA update, we
7 usually report on year-over-year changes in MA quality. We
8 look at individual measures and the star ratings that are
9 intended to be a summary measure of the overall quality of
10 a contract. The measures are reported at the contract
11 level for star ratings that are determined at the contract
12 level, so the MA contract is our unit of analysis.

13 However, the MA contract as a unit of analysis no
14 longer provides sufficiently accurate information on MA
15 quality, because of a practice we have been tracking over
16 the past several years. In the past five years we have
17 seen a wave of contract consolidations that combine one or
18 more contracts into a single contract, thereby
19 significantly changing the composition of enrollment in a
20 contract. This limits our ability to make year-over-year
21 comparisons at the contract level.

22 There are, at times, good reasons for MA

1 contracts to be consolidated. For example, if one company
2 buys another company and both operate an HMO in the same
3 county, it would be reasonable to combine the two
4 contracts, though there could also be reasons for
5 continuing separate contracts.

6 More often than not, contract consolidations have
7 been undertaken to obtain additional bonus payments. In
8 MA, plans receive bonus payments for contracts with a
9 quality rating of 4 stars or higher on the 5-star scale.
10 The bonus takes the form of an increase in the benchmark.
11 New star ratings are announced in October of each year.

12 There is a timing issue that allows plans to
13 maximize their bonus revenue through consolidations. MA
14 bids are due in June of each year for the coming payment
15 year. Bonus status is determined based on the most
16 recently available star ratings. For the bids submitted in
17 June, the star rating is the rating released the preceding
18 October.

19 Because plans know the bonus status of each
20 contract when bids are submitted, this prior knowledge
21 allows companies to move contracts from non-bonus status to
22 bonus status via contract consolidations.

1 After bids are submitted for the following
2 payment year, CMS posts more up-to-date star ratings on the
3 Medicare Plan Finder web site beginning in October.

4 In the past five years, there have been 140
5 contract consolidations, including 108 contracts moving
6 from non-bonus status to bonus status.

7 4.1 million enrollees have been moved to bonus
8 status—about 20 percent of total MA enrollment. Although
9 the share of enrollment in bonus level plans is reported as
10 being in the 70 percent range, the actual percentage is
11 smaller because lower-rated contracts are being absorbed by
12 higher-rated contracts through consolidation.

13 The highest level of such movement has occurred
14 in the current cycle, with 17 contracts moved to bonus
15 status, affecting 1.4 million enrollees, or about 8 percent
16 of the total MA enrollment.

17 Here is an illustrative example of how contract
18 consolidation works. We begin with three contracts in
19 three different, non-contiguous states, but only one of
20 which has a bonus-level rating, at 4 stars. Currently in
21 the Medicare Advantage program, there is no requirement
22 that the geography that comprises an MA contract must be

1 made up of contiguous areas. In this example, the company
2 uses the consolidation strategy to combine all three
3 contracts under one contract. The surviving contract is
4 the Maine contract, shown as contract #1. After
5 consolidation, contract #1 includes all enrollees in three
6 different states, Maine, Missouri and Hawaii, but the
7 company will set up individual plans in each state so that
8 each state has a separate MA bid.

9 Previously the company submitted three bids
10 because there were three contracts; now they are submitting
11 three bids under one contract. Every bid will have a
12 benchmark based on local county rates with the 4-star bonus
13 included.

14 In addition, during the annual election period
15 going into the year when the three contracts are combined,
16 Medicare Plan Finder will immediately show the Maine star
17 rating of contract #1 as the star rating for beneficiaries
18 looking to enroll in this contract in Missouri or Hawaii.
19 This is true under current policy even though the Missouri
20 and Hawaii contracts have an updated star rating that could
21 have been shown on Medicare Plan Finder.

22 Although this is an illustrative example, the

1 configuration shown here is not unusual. The box in the
2 lower left shows some of the state combinations that we see
3 in this year's round of consolidations. The illustrative
4 example, and the actual cases, highlight why using a
5 weighted average of the stars of combined contracts is an
6 unsatisfactory way of dealing with the issue of
7 consolidation. A weighted average approach would drop the
8 Maine contract to 3 stars and keep Missouri and Hawaii at 3
9 stars even though the Maine plan is operating at a 4-star
10 level of performance.

11 The contract consolidations to boost star ratings
12 give rise to a number of concerns. One of those concerns
13 is the added program expenditures that are incurred when
14 moving enrollees to bonus-status plans.

15 Another concern is the inaccurate information
16 conveyed to Medicare beneficiaries looking at quality
17 indicators in Medicare Plan Finder. A consumed contract
18 immediately acquires the star rating of the surviving
19 contract, even when the surviving contract had operated in
20 a totally different geographic area. Then, in the
21 following year, when quality results are based on results
22 from combined geographic areas, the quality data is not

1 necessarily representative of the performance of the plan
2 in the beneficiary's local area.

3 Finally, the consolidation process allows plans
4 to gain an unfair competitive advantage in local market
5 areas. If two different companies serve one market and
6 only one has a 4-star rating based on its local area
7 performance, it should have the difference shown in
8 Medicare Plan Finder, and it should be able to offer a
9 better benefit package because only that plan should be the
10 contract that has a benchmark that includes bonus payments.

11 When contracts with low star ratings are consumed
12 by higher-performing contracts, and the majority of
13 enrollees are in the lower-performing contract, the
14 combined contract is likely to eventually end up having a
15 lower star rating. One could argue that this would make
16 the consolidations to boost star ratings an issue of
17 concern only in the short term.

18 However, what a company can do in such a case is to re-
19 consolidate. That is, if a consolidated contract ends up
20 having a star rating under 4 stars, what the company can do
21 is have the surviving contract consumed by a different
22 contract.

1 This slide illustrates how that would work. In
2 this illustrative example, at the beginning of 2013, this
3 company has 21 contracts. At the end of 2013, it decides
4 to consolidate two contracts, number H0001 and H0002 under
5 a 4.5-star contract, H0003. The following year it decides
6 to have H0003 consume an additional 17 contracts, contracts
7 H0004 through H0020. Eventually, at the end of
8 2017, because the large contract's star rating has fallen
9 below 4 stars, that large contract is, in turn, consumed by
10 a different smaller contract that has a 4-star rating. So
11 a contract that was the result of a consolidation of 20
12 contracts disappears by consolidation with a much smaller
13 contract that now is the surviving contract for what were
14 originally 21 separate contracts.

15 Although this is an illustrative example, this
16 scenario is what actually transpired in this year's round
17 of consolidations when a 4-star contract with 50,000
18 enrollees consumed a 3.5-star contract with 800,000
19 enrollees. The larger contract that was being consumed had
20 already consumed 20 contracts.

21 To address the problem of artificially boosting
22 star ratings through contract consolidations, we propose a

1 solution whereby the consolidation does not have an effect
2 on star ratings and bonus payments. The ratings would be
3 based on the pre-consolidation configuration of reporting
4 entities.

5 We would also reiterate a long-standing
6 recommendation of the Commission, dating from 2005, which
7 calls for defining geographic units at the local market
8 level. Stars would then be computed at the local market
9 level.

10 The Chairman's draft recommendation number one
11 seeks to address the immediate problem. The draft reads:
12 For Medicare Advantage contract consolidations involving
13 different geographic areas, the Secretary should require
14 contracts to report pre-consolidation quality measures and
15 determine star ratings as though the consolidation had not
16 occurred, until such time as quality is reported at the
17 local geographic level.

18 The spending implication of this draft
19 recommendation is that there should be savings relative to
20 current policy.

21 As for the effect on beneficiaries and plans, for
22 beneficiaries that improve the accuracy of information on

1 plan quality, but results in a lower level of extra
2 benefits in some plans. For plans that would be reductions
3 in bonus payments but it would level the playing field for
4 contracts that compete against contracts that acquired
5 their bonus status solely through a consolidation.

6 The second Chairman's draft recommendation would
7 address the consolidation issues but also improve the
8 reporting of quality in MA.

9 It reads: The Secretary should establish
10 geographic areas for Medicare Advantage quality reporting
11 that are accurate reflections of health care market areas,
12 and calculate star ratings for each contract at that
13 geographic level.

14 The implications for spending are uncertain, and
15 depend on the distribution of star ratings in each year.

16 As for beneficiaries and plans, beneficiaries
17 will have more accurate information on plan quality, and
18 for plans, the draft recommendation would increase the
19 reporting burden for measures that are based on medical
20 records sampling or member surveys.

21 That concludes our presentation. We look forward
22 to your questions and discussions.

1 DR. CROSSON: Okay. Thanks very much.

2 We have a report on the table, and we have two
3 recommendations. Let's take clarifying questions.

4 Brian.

5 DR. DeBUSK: First of all, congratulations on a
6 really well-written chapter, great work on really
7 eliminating the cross-walking process. I think it's
8 fantastic.

9 My first question is on page 6 of the
10 presentation. The 107 percent payment or the inflation of
11 the benchmark, could you walk me through just one time for
12 my own edification the relative contributions of the
13 different factors that get us to 107 percent?

14 For example, the quartile treatments don't add up
15 to 100 percent. There's a little bit of bias introduced by
16 the quartile adjustments. Then there's the quality bonus
17 that would introduce an inflationary, and then there's the
18 double-county bonuses that I think would be inflationary as
19 well, but then there's also the fact that we calculate A-
20 only spending, which would then actually pull the benchmark
21 down a little bit.

22 Could you just walk me through the relative

1 contributions to get to 107 -- oh, and the coding
2 adjustment. Could you just sort of walk me up and then
3 back down to how we arrive at 107 percent?

4 DR. HARRISON: So the 107 here includes four
5 points worth of quality. So, without quality, it would be
6 103.

7 DR. DeBUSK: Okay.

8 DR. HARRISON: So all of that is reflected by the
9 quartiles. So the quartiles right now are at a -- if you
10 just straight looked at the quartiles, you'd be at 103.

11 DR. DeBUSK: So 115 and 107.5, 195 --

12 DR. HARRISON: Right. When you enrollee -- not
13 enrollee. Actually, this one is enrollee. When you
14 enrollee-weight them, you'd get to --

15 DR. DeBUSK: Okay. Because you're applying 95
16 percent to the most expensive and 115 to the lease, so it
17 does not introduce any bias.

18 DR. HARRISON: Right.

19 DR. DeBUSK: Okay. So quality is four.

20 DR. HARRISON: Yeah. And the A/B issue is not in
21 here, and the coding is not in here.

22 DR. DeBUSK: Okay. So where's the other three?

1 DR. HARRISON: It's just that the quartiles
2 themselves, if you were just to play it out, you'd end up
3 at 103 because while it might have been nice for them to
4 end it up at 100, they didn't.

5 DR. DeBUSK: Okay. So the quartiles introduce
6 three.

7 DR. HARRISON: Yes.

8 DR. DeBUSK: And the quality introduces four.

9 DR. HARRISON: Correct.

10 DR. DeBUSK: And that's how we get to seven.

11 DR. HARRISON: Yeah.

12 DR. DeBUSK: Do the double-county bonuses --

13 DR. HARRISON: They're included in the quality.

14 DR. DeBUSK: Okay. So quality plus double-county
15 is four --

16 DR. HARRISON: Right.

17 DR. DeBUSK: -- and quartiles -- sorry. I just -
18 - for one time, I wanted to hear that.

19 My second question is --

20 DR. HARRISON: By the way, the quartiles probably
21 also include -- they also include some cap reduction.

22 DR. DeBUSK: Okay. That's right.

1 DR. HARRISON: Remember there's this benchmark
2 cap?

3 DR. DeBUSK: That's right.

4 DR. HARRISON: Yeah.

5 DR. DeBUSK: Okay. So quartiles plus cap net out
6 to about three. Quality plus double-county bonuses net out
7 to about four.

8 DR. HARRISON: Right.

9 DR. DeBUSK: And the fact that we're using A,
10 incorporating A-only spending isn't factoring --

11 DR. HALL: Isn't in this, these numbers.

12 DR. DeBUSK: Thank you. It's nice for once to
13 have it put to bed. I'll probably forget it by the next
14 meeting. I apologize.

15 DR. HARRISON: That's all right.

16 DR. DeBUSK: On page 8, you make a reference to
17 how the coding intensity in fee-for-service occurred at the
18 same rate as MA did. Is there really any downside to us
19 letting fee-for-service coding continue to improve?
20 Because it seems like we would know more about the
21 beneficiaries if it did, and it would decant off some of
22 these MA overpayments, which I think is about \$8 billion a

1 year. It would decant those off because we would be
2 normalizing the model against a more accurate fee-for-
3 service.

4 Could you speak to any downside? And also, why
5 is the coding beginning to mirror MA? So, first of all,
6 why, and is there any downside to this happening?

7 DR. JOHNSON: I'll start in the reverse order. I
8 don't see any real downside. I think we've said that
9 improving diagnostic coding and fee-for-service would be
10 beneficial for both the beneficiaries and for this issue
11 specifically.

12 As to why fee-for-service has increased in the
13 last year, there's some speculation that there was some
14 effect from the change to ICD-9 -- or ICD-9 to ICD-10,
15 which was late in 2015, and there are some new payment
16 policies in fee-for-service that we're going to look into,
17 see if we can try and disentangle what effect those had,
18 but that might include risk-adjusted benchmark in ACOs,
19 risk stratification in the comprehensive primary care
20 model, and some chronic care management codes, which
21 require you to document that a beneficiary has multiple
22 chronic conditions before you're able to bill for those

1 codes.

2 DR. DeBUSK: Thank you.

3 DR. CROSSON: Jon.

4 DR. CHRISTIANSON: I guess two questions. This
5 is for Carlos.

6 Some of the information in the report talks about
7 organizations, and doing the math, I get about 58 percent
8 of the MA market and four organizations. Are any of the
9 organizations particularly aggressive in terms of this
10 consolidation?

11 MR. ZARABOZO: I'll say yes to that.

12 DR. CHRISTIANSON: Would you say more?

13 [Laughter.]

14 MR. ZARABOZO: I would say, looking at your list,
15 the top two there --

16 DR. CHRISTIANSON: The top two.

17 MR. ZARABOZO: -- historically have been more.

18 DR. CHRISTIANSON: All right. So that's
19 important. So it's not the small players that are trying
20 to sort of advantage themselves.

21 MR. ZARABOZO: Often the small players cannot do
22 this.

1 DR. CHRISTIANSON: What?

2 MR. ZARABOZO: Small players often cannot do this
3 because -- I mean, if you're talking a real small player,
4 they're just operating in a local market area.

5 DR. CHRISTIANSON: Okay.

6 MR. ZARABOZO: And they can't do that.

7 DR. CHRISTIANSON: And the second question is for
8 Scott.

9 The past two days, we've been listening to the
10 update recommendations, and we've been talking about
11 implications for Medicaid. And it seems to always be
12 preceded by for fee-for-service Medicare -- I said
13 Medicaid; I meant Medicare -- for fee-for-service Medicare,
14 which increasingly is not comfortable. I mean, we've got a
15 third of our beneficiaries now in MA Medicare, and yet
16 we're reaching our conclusions based on data for fee-for-
17 service Medicare beneficiaries only.

18 So one thought is it's kind of a conspiracy
19 theory that the three of you are in your offices, have the
20 data for the MA, but you just don't share it with your
21 colleagues. So that could be one possibility.

22 [Laughter.]

1 MR. ZARABOZO: We don't share it with each other.

2 [Laughter.]

3 DR. CHRISTIANSON: I like that even better.

4 So how can we get a more complete picture of
5 what's happening in the Medicare program instead of just
6 referring always to fee-for-service beneficiaries?

7 DR. HARRISON: What would you like to know? I
8 guess I'm not sure what the question --

9 DR. CHRISTIANSON: Well, for fee-for-service
10 beneficiaries, we know that certain fee-for-service
11 beneficiaries get this service, don't get that service, and
12 so forth, but for a third of the beneficiaries, we don't
13 seem to know what's happening with them.

14 DR. HARRISON: Oh, that's good. I can punt this
15 one to Andy on the encounter data.

16 DR. JOHNSON: I thought the question was
17 addressed to you.

18 [Laughter.]

19 DR. JOHNSON: We continue to look at some of the
20 encounter data with the hopes of addressing some of those
21 issues, but to date, we haven't gotten as far as we would
22 have liked. So we're continuing to look at that, and I

1 think -- I don't know. James, do you have any other --
2 Jim?

3 DR. MATHEWS: Yeah. So, if I understand the
4 question -- and I'll repeat it, and you can correct me if
5 I've misinterpreted anything -- you indicate that we look
6 at utilization measures, spending measures for fee-for-
7 service beneficiaries.

8 DR. CHRISTIANSON: Lots of things that are fee-
9 for-service only.

10 DR. MATHEWS: Quality. Yeah, correct. And
11 you're asking why we can't do that for -- inclusive of MA.

12 So I think we last looked at 2014 MA encounter
13 data, and we determined that there were some issues with it
14 that prevented its utility with respect to comparing MA
15 payments to fee-for-service payments at the service level.
16 It potentially has some utilization for being able to care
17 -- compare MA utilization to fee-for-service utilization,
18 and we're still exploring that.

19 But then we also determined that there were some
20 potential issues with the completeness of the MA data with
21 respect to whether or not MA beneficiaries were fully
22 represented in things like IRF pie data or home health

1 OASIS data or MDS data in ways that they should be.

2 So we aren't sure that the state-of-the-art of MA
3 encounter data would fully allow us to give a complete
4 picture of the overall Medicare beneficiary population in a
5 lot of these sectors.

6 DR. CHRISTIANSON: And I wanted to give you the
7 opportunity to say all of that.

8 DR. MATHEWS: Okay.

9 [Laughter.]

10 DR. CHRISTIANSON: But we're not better off than
11 we were many years ago, and we're making decisions based on
12 pretty incomplete data in some cases when you have a third
13 of the Medicare population where we don't see what's
14 happening. That is increasingly disturbing to me as the
15 rate of enrollment in the MA population grows.

16 DR. CROSSON: But you will dismiss the grassy
17 knoll theory?

18 DR. CHRISTIANSON: Not yet.

19 [Laughter.]

20 DR. CROSSON: Okay. Let's move down this way.
21 Pat and then Jack.

22 MS. WANG: I also want to commend you on a really

1 meaty chapter and particularly some of the transparency
2 that was granted to the cross-walking phenomenon. It's
3 amazing.

4 I wanted to ask you a couple of questions. You
5 repeated or reiterated a couple of recommendations that
6 MedPAC has made in the past to tier the coding intensity
7 adjustment, whatever it is, to increase equity among plans.
8 I wanted to ask you about that and also the recommendation
9 on stars, the immediate action recommendation for 2018,
10 whether that requires legislative action or whether CMS can
11 undertake the coding intensity adjustment tiering on its
12 own. Why don't we just start there.

13 DR. JOHNSON: Starting with the coding intensity
14 adjustment --

15 MS. WANG: Yeah.

16 DR. JOHNSON: -- there is room in the law for the
17 Secretary to address coding intensity above what it is
18 currently doing. The law requires a minimum adjustment,
19 which it has been applying.

20 Our recommendation from March 2016 did not
21 formally discuss using tiers, but it was an option that was
22 placed forward for addressing coding intensity that might

1 not be addressed by the two other parts of the
2 recommendation, which were using health risk assessments or
3 removing health risk assessments as a source of diagnoses
4 and using two years of data.

5 That recommendation is still out there. It seems
6 like it is within the Secretary's authority, but that's
7 what we have.

8 MS. WANG: Okay, okay.

9 The other thing -- and maybe this isn't a
10 legislative question so much as -- for the recommendation
11 on stars, that would start with the 2018 stars, bonus year,
12 for a cross-walk to contract to count the star ratings of
13 each individual contract? Can CMS actually do that in
14 2018?

15 MR. ZARABOZO: Well, no. They can't do it for
16 the bonuses payable in 2018 because that was the bidding
17 process in June 2017.

18 Now, all of what we're talking about is
19 secretarial discretion. So they determine how stars are
20 assigned, whether or not people can consolidate, and what
21 you do with the consolidation.

22 The proposed regulation that has just come out on

1 MA says what we'll do is a weighted average of the stars,
2 but in terms of additional activities, as I mentioned, in
3 October all of these contracts, whether consumed or not,
4 got a new start rating because they submitted HEDIS data,
5 for example, in June. They get a star rating, which as I
6 said could have been used in January, as in this local
7 area, this contract is now being consumed, this is how they
8 performed.

9 MS. WANG: Okay. So just to clarify, then, the
10 draft recommendation on page 17 for MA contract
11 consolidations involving different areas, the Secretary
12 should require contracts, blah-blah-blah.

13 MR. ZARABOZO: Right.

14 MS. WANG: I think in the paper, it said starting
15 in 2018. Did I misread that?

16 MR. ZARABOZO: It may have said so in the paper,
17 but 2018 in the sense of -- I mean, you could call it the
18 consolidation cycle of 2018, that is the June 2018 bids for
19 2019.

20 But, no, they cannot affect the 2018 situation.

21 MS. WANG: So the soonest that recommendation
22 would have a practical impact would be 2019 --

1 MR. ZARABOZO: Right, right.

2 MS. WANG: -- is when we'd see that. Okay.
3 Thank you.

4 MR. ZARABOZO: Now, we didn't have a
5 recommendation in May. I mean, this is the first
6 appearance of the recommendation, so --

7 MS. WANG: I wanted to ask something that was
8 related to what Jon raised about encounter data. The paper
9 discusses the likelihood that encounter data would be more
10 accurate in identifying risk scores, just because of the
11 specificity of the information versus RAPS. Is there a
12 reason not to recommend more of a -- the bigger phase-in of
13 use relying encounter data? I know that there's some gaps
14 for the areas that you described or that Jim described for
15 IRF and all the rest. But do those really contribute to
16 HCCs?

17 DR. JOHNSON: We have not found that they
18 contributed significantly to HCCs.

19 The areas that Jim noted were mostly in the PAC
20 sector, which are not used for risk adjustment.

21 MS. WANG: Mm-hmm.

22 DR. JOHNSON: We found that the risk scores for

1 using encounter data were slightly lower than RAPS, and in
2 the paper, we discussed the reasons why that might be more
3 accurate, is through the submission process.

4 MS. WANG: Okay.

5 DR. JOHNSON: An entire encounter has to be gone
6 through a set of edits --

7 MS. WANG: Yeah.

8 DR. JOHNSON: -- and ensure that that encounter
9 happened up front before it's used for risk adjustment,
10 whereas that process is intended to happen after the fact
11 in the RAPS part.

12 MS. WANG: Sure. Was there a reason, given what
13 you just said, that you did not recommend greater reliance
14 or faster phase-in to EDS?

15 DR. JOHNSON: We've heard from some plans that
16 there is difficulty in the processing, and that some time
17 is necessary to ensure that when encounters are submitted,
18 if there is a need for them to be voided and replaced with
19 a new encounter, there's some tracking processes that plans
20 internally need to get up to speed on and might need some
21 more time.

22 For that reason, the 2016 risk scores, which are

1 based on 2015 dates of service, CMS has included an
2 extension to the amount of time they have to submit data,
3 encounter data, for 2015 dates of service, and the idea is
4 just a little bit more time, another year of processing and
5 ensuring that when encounters are submitted, they're
6 submitted once and accurate and then use them for payment.

7 So, at some point, I think we would support
8 moving more towards encounter data for risk adjustment. As
9 to when that is and when is enough time for plans to get
10 processes in places sort of --

11 MS. WANG: Do you feel like based on the
12 conversations that you've been having, because I think that
13 you've been sort of poking at this -- more than poking --
14 digging -- that there is steady movement towards getting
15 those processes into place?

16 DR. JOHNSON: From some small number of
17 anecdotes, I would say yes, and from having reviewed some
18 of the slides in question and answers that have come out
19 from CMS on an EDS, encounter data in RAPS user group, that
20 there are sort of a narrowing of issues, and that there is
21 some learning going on.

22 I don't feel like I have a very close sense of

1 that, but from a 30,000 foot, it does seem like there's
2 progress in the right direction.

3 MS. WANG: Thank you.

4 DR. CROSSON: Okay. So David and Brian wanted to
5 come in on Pat's point -- and Jon too?

6 DR. CHRISTIANSON: No.

7 DR. CROSSON: Okay. Separate, okay.

8 All right. So David and then Brian.

9 DR. NERENZ: I was going to just extend Pat's
10 question about the wording of what we have in front of us,
11 and actually, I find I have two questions about the top
12 part, so if it's appropriate to get into that.

13 As I read, I'm not sure I know what they mean.
14 So, for example, you say, "We require contracts to report
15 pre-consolidation quality measures." Well, it seems like
16 they did. I mean, that doesn't change anything.

17 So I think what that must mean is that after
18 consolidation, you want them to report the quality measures
19 for the units that existed before consolidation. That's
20 what that really means, right?

21 MR. ZARABOZO: That's right. That's what that
22 means. As though the consolidation had not occurred, you

1 will continue to do what you had done in the past, in a
2 sense.

3 DR. NERENZ: Okay. Well, I think I'd like, then,
4 to see that wording cleaned up because it sounds like it's
5 just saying they should do what they've already done.

6 So the second one, determine star ratings as
7 though the consolidation has not occurred, but it doesn't
8 specify how to do that. The consolidation takes multiple
9 things and makes them one thing, but in the end, it is
10 still the contract that has the star rating, so that it
11 implies there's some method.

12 Now, you said weighted average isn't the right
13 way to do it, but this suggests that there is, therefore,
14 some way to do it.

15 MR. ZARABOZO: Yeah. So the example, the
16 illustrative example of combining Maine, Hawaii, and
17 Missouri would say you will have different stars in Maine,
18 Hawaii, and Missouri, is all this says. It's not going to
19 be -- it will list it as a contract, but that contract in
20 Maine will have a different star rating than it will have
21 in Missouri.

22 DR. NERENZ: Okay. Well, I guess I'd ask -- and

1 maybe the text surrounding this will make that entirely
2 clear, but I guess I just want to make sure that that is
3 precisely what we're talking about.

4 MR. ZARABOZO: Yeah. That is the intention.

5 DR. NERENZ: Okay.

6 DR. CROSSON: Brian.

7 DR. DeBUSK: I had a follow-up, too, to Pat's
8 questions about the use of encounter data.

9 I know that you get a lower risk score when you
10 use encounter data versus RAPS, and from what I understand,
11 it's through the encounter data system's filters that dock
12 out certain events. Is the benefit that we're going to
13 enjoy more of a transient benefit, though? Because I would
14 assume that the plans will learn how to load up the correct
15 diagnosis into encounters that are going to pass through
16 those filters. So is the benefit going to be transient, or
17 is there a long-term benefit to moving to encounter data?

18 DR. JOHNSON: I would separate the two issues and
19 say that for the coding intensity issue, encounter versus
20 RAPS, there is some benefit in that having to submit and
21 prove that an encounter happened on a specific date, with
22 all of the information that goes along with that encounter,

1 up front is a more robust process than in RAPS, which is an
2 attestation process. And so the impact on coding intensity
3 might have some limitation going forward.

4 The second benefit is that under the current
5 process of data validation for RAPS data, plans attest that
6 a limited set of information is correct, and then there's
7 supposed to be a RADV audit, which is a risk-adjustment
8 data validation audit that happens later. And so far, a
9 very limited number of audits have happened, and for 2007,
10 there are some results. I think 2011 was the next year,
11 and there are ongoing audits for years, payment years after
12 that, but so far, they would address a limited number of
13 contracts, about 5 percent of all contracts. And in any
14 given year, you may or may not have that data audited
15 versus encounter data gets a little bit more of a robust
16 audit up front.

17 DR. DeBUSK: So there is a sustainable benefit to
18 using it.

19 DR. JOHNSON: Yes.

20 DR. DeBUSK: Thank you.

21 DR. CROSSON: Okay. Let me see. We're still in
22 questions. I had Dana and then Jack and then Bruce and

1 David.

2 DR. SAFRAN: Thanks. Two, I think, fairly quick,
3 simple questions. One is, on page 4 where you show the
4 growth in MA in beneficiary terms, I just wonder whether
5 this growth is disproportionate to overall expansion of
6 Medicare, because I just seem to recall the number "a
7 third" enrollment in MA being a pretty constant, but am I
8 remembering wrong?

9 DR. HARRISON: Well, people may round to a third
10 but we've been going up about a point a year.

11 DR. SAFRAN: Okay.

12 DR. HARRISON: The other thing that we can't do
13 in real time is the share of beneficiaries that have Part B
14 that have MA is a good bit higher than that also.

15 DR. SAFRAN: Okay. Thank you.

16 And then my other question relates to the star
17 program. I like recommendation 2 and kind of moving to the
18 geographic unit, because, you know, that will really make
19 for an informed beneficiary who's actually choosing the
20 plan based on the quality that they're going to experience
21 in the area where they live.

22 My question is, does the stars program already

1 have criteria around sample size requirements to be -- you
2 know, measure by measure, sample size requirements in order
3 for a plan's performance on that measure to count?

4 Because, if not, we would have to, I think, recommend that
5 along with recommendation number 2.

6 MR. ZARABOZO: Yes, and we talked about that, the
7 issues of sample size, and so on the 2010 report about, you
8 know, going to smaller units, essentially. But, of course,
9 this contract consolidation issue, the sample size, as I
10 mentioned in the paper, is 411 across 800,000 people,
11 across 35 different states.

12 So this, you know, going to like state level or
13 whatever local market area level, you would want that
14 sample, the appropriate sample size for that area. And
15 sometimes it may be too small. So we talked about using
16 multiple years.

17 And also the stars, you do not have to have a
18 rating in every single measure to get a star rating.

19 DR. SAFRAN: Yes.

20 DR. CROSSON: Jack.

21 DR. HOADLEY: Thank you, and thank you for a very
22 rich report here. I've got three questions. Two are sort

1 of building off some of the things we've been talking
2 about.

3 On the encounter data use in the risk adjustment,
4 one of the things that you didn't mention here but it was
5 in the paper is that CMS has actually reduced the share
6 that encounter data is included in, the way they blended.
7 Can you say more about -- I mean, is that essentially the
8 same logics that you were talking about in terms of sort of
9 our reluctance to go forward, or are there other specific
10 things CMS has said about that?

11 DR. JOHNSON: I think CMS would put more weight
12 on the issues with the submission process and tracking when
13 an encounter needs to be voided and replaced, to make sure
14 that there is the full and complete set of encounter data
15 for risk adjustment, and that wouldn't affect inpatient,
16 hospital outpatient, and physician claims, or physician
17 encounters.

18 Some of the other issues that Jim addressed
19 earlier were more on the PAC settings.

20 DR. HOADLEY: And I do wonder if you continued to
21 keep a substantial share of the risk adjustment based on
22 encounter data, that, in turn, creates an incentive to do

1 it. So I just wonder if dropping back to as low as I think
2 it's 15 percent, sort of supports that incompleteness in
3 other ways.

4 Second question goes to the contract
5 consolidation, and you alluded, Carlos, in the Q&A, the CMS
6 rule does call for the weighted approach. Is there
7 anything else about what they've said in the rule that
8 seems helpful to this conversation? I mean, I'm with you
9 on the logic that that doesn't get us to the best result,
10 and I think our recommendation approach seems better.

11 MR. ZARABOZO: Yeah. I was going to say, in an
12 area where you -- I mean, if it's one county and it's two
13 companies, then yes, their average certainly make sense.
14 But on the consolidations, that was about it, I think, in
15 the rule.

16 DR. HOADLEY: Yeah. Okay. And my third question
17 I guess goes to some of the accounting things at the
18 beginning of the chapter, and am I right? I think you had
19 this in a note that Medicare or Medicaid plans, the MMPs,
20 are not classified as Medicaid Advantage plans? Is that
21 right?

22 DR. HARRISON: Correct. They're not classified as

1 MA.

2 DR. HOADLEY: It seems like it would be useful --
3 and this isn't a big thing -- to have a text box or
4 something where we sort of both define that a little more
5 clearly, but also just report on the number of plans that
6 are MMPs and cost and pace the different categories that
7 are not MA, and the number of people. I mean, to most of
8 the public they are sort of all part of what people would
9 think of when they think of MA, even if they're not
10 technically classified. And so just being able to say
11 that's another 1 percent or whatever it comes out to, and
12 it could just be a text box, I think. Thank you.

13 DR. CROSSON: Bruce.

14 MR. PYENSON: Thank you. The issues you've
15 raised on stars I think have a profound impact on the extra
16 benefits available or not, and, in particular, zero premium
17 plans. And I think because of the importance to the market
18 of zero premium plans, it would be useful to segment out
19 the enrollment in particular. And I may have missed it in
20 the materials, but it seems zero premium plans are
21 addressed in some places here, but do you have those
22 estimates?

1 DR. HARRISON: So you want enrollment in zero
2 premium plans?

3 MR. PYENSON: Yes.

4 DR. HARRISON: The availability is in the table
5 in your paper.

6 MR. PYENSON: Which table?

7 DR. HARRISON: Table 3 on page 18.

8 MR. PYENSON: Well, that's listed for special
9 needs plans, unless I'm missing that.

10 DR. HARRISON: Got it. Thank you.

11 MR. PYENSON: Oh, you're welcome. But that's
12 availability. Actual enrollment, I think zero premium
13 plans -- non-zero premium plans are not attractive in the
14 market.

15 DR. HARRISON: Uh-huh.

16 MR. PYENSON: So I think rather than the
17 availability, the actual enrollment would be instructive to
18 look at.

19 DR. HARRISON: Okay.

20 MR. PYENSON: Thank you.

21 DR. CROSSON: Okay. David.

22 DR. GRABOWSKI: Great. Thanks for a great

1 chapter. We've been talking about margins for a day and a
2 half so I didn't want to let you guys off the hook. I
3 wanted to ask you about the MA margin section on page 25.
4 And I was particularly struck by how much larger they were
5 for the SNPs, the special needs plans, relative to typical
6 Medicare Advantage plans.

7 You've written a lot in the past about some of
8 the D-SNP plans being coordinated with Medicaid, others
9 not, and I'm curious if you have any insights into what the
10 margins look like for those that are better integrated
11 versus those that aren't. And, in general, do you have any
12 thoughts on why the margins are so much larger for the
13 SNPs, relative to the MA? Thanks.

14 MR. ZARABOZO: On the relatively more integrated,
15 it's also a nonprofit versus profit, and so some of the
16 relatively more integrated, or nonprofits, tend to have
17 lower margins.

18 DR. GRABOWSKI: Negative margins, as you wrote.

19 MR. ZARABOZO: Yes, negative margins, yes. In
20 terms of generally why they are profitable is -- the D-SNPs
21 and I-SNPs are relatively profitable -- the D-SNPs that are
22 not -- you know, the for-profit D-SNPs are also relatively

1 profitable. So I don't know that I have an explanation,
2 but that is the situation.

3 DR. HARRISON: So one theory could be that the
4 SNPs have higher acuity patients, which means they get paid
5 more, and the profit margins on that could be a good bit
6 higher.

7 DR. CROSSON: Jon and then Pat and Warner.

8 DR. CHRISTIANSON: A couple more quick questions.
9 First, for Carlos. So you emphasized in the discussion of
10 the advantages of the contract consolidation the higher
11 payments you get with higher star rating. My understanding
12 -- and I'm not up to date on this -- there used to be
13 enrollment advantages as well with having a high star
14 rating?

15 MR. ZARABOZO: Yes. A 5-star plan can enroll
16 throughout the year.

17 DR. CHRISTIANSON: Yeah. So I think being kind
18 of complete in terms of describing all of the possible
19 advantages that accrue to consolidating in that way might
20 be useful in the chapter.

21 The second thing is, I was wondering if, in terms
22 of trying to assess how the plans are doing under Medicare,

1 have you ever looked at their public filings of their
2 income statements and the profits that they report on those
3 related to Medicare?

4 MR. ZARABOZO: Yes, and we did that when we
5 started reporting on margins in MA, and tried to compare
6 whether or not what we were getting was consistent with
7 what was reported to the SEC, for example, or in state
8 filings, NAIC type filings. The problem there is that
9 sometimes they do not separate out the Medicare line of
10 business. So they may have like government line of
11 business, so it's difficult. But to the extent that we
12 could confirm what we're finding with the SEC filings, they
13 were consistent in the way we looked at margins.

14 DR. CHRISTIANSON: Okay. So it doesn't really --
15 you're saying it doesn't really give you any additional
16 information that you would find useful?

17 MR. ZARABOZO: Right. Right.

18 DR. CHRISTIANSON: Okay.

19 MR. ZARABOZO: Pat.

20 MS. WANG: Thank you. This is a separate topic.
21 On page 21, you showed a very interesting table about
22 movement of the population into the different quartiles at

1 which the benchmarks are set -- 115, 107.5, 195 percent --
2 and what this basically shows, I guess, is that these
3 quartiles were established as part of the ACA. And back
4 then, at least in 2012, the average benchmark to fee for
5 service spending was closer to 100 percent.

6 Because of the change in where counties are
7 falling into these quartiles, the average benchmark,
8 compared to fee for service, is projected in 2018 to be
9 closer to 104 percent. I found the whole issue of the
10 counties falling into different quartiles fascinating, you
11 know, so counties that used to be in the highest fee for
12 service spending quartiles are now in lower fee for service
13 spending quartiles, and ones that were at the bottom have
14 moved to the top.

15 So my question is, it seems to me, at least from
16 the conclusion on the right-hand column, that it's kind of
17 driving some inflation in the Medicare Advantage program,
18 because it's raising benchmarks overall. Is there anything
19 in this movement that you think is, you know, for a good
20 reason, or is this just arbitrary? Is there something in
21 the movement of the counties from quartile to quartile that
22 we should try to preserve, or is this just random?

1 DR. HARRISON: I think at least some of it is
2 random. If you look -- let's see. Do we have that? Yeah.
3 Look at page 25 where we have the little quartiles, and you
4 might notice sort of how narrow the ranges are,
5 particularly in the middle two quartiles, of dollars spent.
6 So --

7 DR. HOADLEY: I'm sorry. What page are you on?

8 DR. HARRISON: Page 25. It's like a stock-ticker
9 chart.

10 DR. HOADLEY: 23? 23.

11 DR. HARRISON: Oh. Mine's 25. Okay. Sorry
12 about that. And, you know, you'll see that it's maybe a
13 \$50 per month spending -- you know, window in the second
14 quartile, and \$70 per month. So random variation can push
15 you over to the borders pretty easily. And we discussed
16 this -- I lose track of time, but 5, 10 years ago we were a
17 little worried about the way the quartiles we're set up.

18 Now I know in this last year we had some big
19 cities move one tick, and the counties that moved back the
20 other direction were much smaller. And, you know, I think
21 there's some randomness now. So, for instance, if the
22 counties were perfectly aligned, I think I got to -- it

1 would be like 104 1/4, is if it -- you know, if the
2 populations of each of the quartiles were the same, that's
3 where you'd end up. So we could move a little more --

4 MS. WANG: There's arbitrariness, though --

5 DR. HARRISON: Yeah.

6 MS. WANG: -- it sounds like. Okay.

7 DR. HARRISON: The penetration rates didn't look
8 that different --

9 MS. WANG: Yeah.

10 DR. HARRISON: -- than, you know, percent of
11 people in the counties in MA. I think this is something
12 interesting, also, and I'd love to dig in a little more,
13 and we'll see. But --

14 MS. WANG: Thank you.

15 DR. CROSSON: Warner.

16 MR. THOMAS: Just in reading the chapter I didn't
17 see, and I might have missed it, information kind of
18 comparing -- because there's a lot of comparison on the
19 payment pieces -- on quality metrics or -- so is there any
20 information kind of looking at quality metrics across the
21 different types of Medicare payment lines?

22 MR. ZARABOZO: Oh, you mean comparing -- what we

1 typically do comparing HMOs to PPOs within MA? Is that
2 what you're -- or MAs --

3 MR. THOMAS: Well, I think, you're comparing
4 payment rates in MA to fee for service consistently. So do
5 we look at quality measures, comparing --

6 MR. ZARABOZO: The problem with looking at
7 quality measures is we don't have comparable measures, so
8 to speak. But, for example, we do look at the caps, the
9 beneficiary survey, and the caps results have been pretty
10 much the same between fee for service and MA. So that's a
11 relatively reliable comparison that's been consistent over
12 several years.

13 MR. THOMAS: Is there any overlap on quality
14 metrics between --

15 MR. ZARABOZO: Well, for example, the readmission
16 measure. There is a readmission measure in MA, and you can
17 compare it to fee for service readmission rates. The
18 problem with readmission measure is that within MA you have
19 other factors at play. For example, they waive the three-
20 day hospital stay. So, again, even though it looks -- it
21 may look like the same measure there, not entirely
22 comparable between the two sectors.

1 MR. THOMAS: Okay. And then on the coding
2 intensity, you know, it would kind of come to this
3 conclusion around, you know, the coding intensity and the
4 incentive around documentation for MA versus fee for
5 service. Is there any assessment or insight into
6 preventative care and proactive approaches in MA versus fee
7 for service, as far as the delivery of care?

8 DR. JOHNSON: Not in this analysis at least.
9 It's something we could look into more and get back to you.

10 MR. THOMAS: I just think these two areas are
11 important to be considered if we're looking at kind of a
12 status report of MA, because I think they're important
13 components to the program overall, and we make a lot of
14 comparisons. So, anyway, I'm going into round 2. I'll make
15 that comment next round.

16 DR. CROSSON: Dana, on questions.

17 DR. SAFRAN: So I have a question that maybe has
18 been answered before I joined the Commission, but I just --
19 and so you can tell me, we can talk about it offline if
20 that's most appropriate. But I'm trying to get my mind
21 around, with this issue that's come up about how counties
22 have flipped and, you know, trying to understand why that

1 would be, where my head went was wondering whether ACO
2 participation in this counties is where you have an ACO
3 that's being very successful at reducing total medical
4 spending, is that. And then where my head went was, okay,
5 so if I'm a provider who is both an ACO and has risk
6 contracts with an MA plan, you know, what are my interests,
7 actually? Because I could be cannibalizing my own payments
8 on the MA side if I'm successful on the ACO side.

9 So I just wanted to -- has this been contemplated
10 and discussed before? If not, could we give that some
11 thought and analysis?

12 DR. HARRISON: We'll talk with our ACO brethren
13 and see if we can do any of that.

14 DR. CROSSON: Paul.

15 DR. GINSBURG: Yeah. I think what you raised,
16 Dana, is an enormous issue, about the fact that, for the
17 most part, ACOs are benchmarked on the ACO's historical
18 experience, and, you know, MA is benchmarked on the county,
19 all-county. So, in a sense, there are very strong
20 incentives for particular providers to go the ACO or the MA
21 routes, and I think people are very well aware of that,
22 when it comes up in discussions about how to do ACO

1 benchmarking better, because I think, you know, the MA
2 benchmarking to the county is the right way to do it. But
3 this is a real problem.

4 DR. CROSSON: Bruce.

5 MR. PYENSON: In thinking about a number of the
6 issues that you've raised here very clearly, the year-to-
7 year fluctuations come up, and that comes up in a lot of
8 places, for example, the year-to-year movement of stars, or
9 consolidations, or the advantages of looking at stars over
10 multiple years, or risk scores over multiple years.

11 And because of that I'm wondering if you have
12 thoughts on what a two-year bid cycle would look like in
13 this context. So to shift the process from this annual
14 cycle and churning and populations moving around to a
15 different system with a lot less of that, perhaps more risk
16 but more stability in some ways.

17 DR. HARRISON: We haven't really thought about
18 that, what the escalator clause would be and things like
19 that, and whether plans would really be locked in for two
20 years.

21 DR. CROSSON: Okay. So thank you for the
22 questions. We've come to the period where we're going to

1 have a comment -- a set of comments. And this is a little
2 different from some of the others because we really have
3 two things on the table simultaneous. One is that this is
4 a status report, and so we've had some suggestions already,
5 snuck into the questions, about, you know, additional
6 information or improvements to the report.

7 So I want to hear two things. Number one, those
8 sorts of comments, like, gee, I wish you could further
9 describe something in the report or add something to the
10 report. That's number one. Number two, we have two
11 recommendations on the table. We'll take those together.
12 They are related -- quite closely related.

13 So in your comments, for those of you who want to
14 make comments, you can think about either or both of those
15 things -- the report itself and then the recommendations.

16 We'll start over here with Brian and we'll go
17 down this way.

18 DR. DeBUSK: I do support both the Chairman's
19 recommendations, as written. I think you have a very
20 clever solution there to deal with cross-walking, and I
21 think it's well thought out.

22 The one thing I hope we can make into the

1 discussion is a little bit more of a discussion around the
2 benefits of fee-for-service continuing to code more like MA
3 or more thoroughly and completely code the patient. It
4 would be nice to see an elaboration of the benefits there,
5 not just the mechanical benefit of decanting off some of
6 these MA overpayments, but also the benefit to the program
7 in general about having better insight and better analytics
8 on the patients.

9 Thank you.

10 DR. CROSSON: Alice.

11 DR. COOMBS: I, too, support the recommendations.

12 One of the things that we talked about the last
13 time we did the Medicare status report is that we looked at
14 the racial distribution, and we were able to parlay it out
15 that there was an over-distribution within the SNP
16 programs. I still haven't been satisfied about the
17 residual large component of MA beneficiaries and what that
18 looks like overall, so if we could just kind of subtract
19 that out.

20 DR. CROSSON: Thank you.

21 Paul?

22 DR. GINSBURG: Yes. I support both

1 recommendations.

2 I'd like us to go further in thinking about
3 policy towards the star ratings. The star ratings has been
4 a very successful program in the sense that the average
5 star rating has increased, so presumably to the degree that
6 the stars are measuring something that is worthwhile, it's
7 improved quality in MA.

8 But this gain has come at enormous cost to the
9 program. As you say, benchmarks are 4 percent higher
10 because of the effect of star ratings, and I believe that
11 we can keep these gains, perhaps extend them, without the
12 huge expenditure of taxpayer and beneficiary funds, by
13 recalibrating the star rewards. So, in a sense, we should
14 -- at this point of time, when a four-star rating has
15 become pretty common, we should not be giving rewards to
16 achieve a four-star rating. We should be giving penalties
17 for getting below a four-star rating. So, in a sense, this
18 keeps the incentives the same, and it really -- it's, you
19 know, let's -- we've had success. Let's live with the
20 success by not paying for the success year after year after
21 year, because we don't have to.

22 When we've used many incentives in the hospital

1 and physician payment systems, we start out with bonuses
2 for providers to do something, and they transition over
3 time to penalties for when the providers don't do that.
4 And I think that way of thinking should come into the star
5 program.

6 I think I've raised this once with the Commission
7 before, but I feel very strongly about this. Don't know if
8 it's suitable for this March report, but if not, I'd very
9 much like it to be taken up for the June reports.

10 DR. CROSSON: So, Paul, two comments. Number
11 one, what you're describing is very consonant with the
12 position that the Commission took in 2004 when we were
13 discussing the need for reduction in MA payment rates, and
14 out of that discussion came the recommendation that while
15 we as a Commission supported that, we also felt that there
16 should be some acknowledgement financially of the higher-
17 quality plans.

18 But having participated in that discussion, I
19 clearly remember that it was much closer to what you're
20 describing than the current situation. So to move back in
21 that direction would be to, in fact, go back to -- at least
22 from my personal point of view, it would be go closer back

1 to what we had originally intended when we originally
2 suggested this notion.

3 I do need to talk to Jim and work with the staff
4 as to when in the course of work we might address that.

5 Okay. Moving further. Pat.

6 MS. WANG: I want to offer some comments on the
7 specific recommendations and some of the other elements of
8 the report, but maybe try to put them into a broader
9 context that sort of thinks about MA as being in need of
10 modernization in many dimensions.

11 So the benchmark movement that we were discussing
12 that you highlighted on pages 21 and 23, I think that all
13 of the questions that have been asked are interesting, but
14 I'm really wondering whether a better solution is just to
15 go to one benchmark for all counties.

16 The quartiles may have had some appeal and some
17 utility when the ACA was passed, but given the fact that
18 everybody is redistributing quartiles, that it's causing
19 inflation in the MA program, and that, as you point out,
20 the dollar spread between quartiles is so small, why not
21 just go to wherever it was, 101 percent or even 100 percent
22 across the board, just get rid of the quartiles? I really

1 think that this is something that -- I'm not seeing the
2 reason not to do that since we have really advanced a lot
3 in time since these were put into place.

4 On coding, I appreciate the repetition of the
5 different sort of recommendations that MedPAC has made over
6 time. Using risk scores for two years previous might
7 address part of your issue around some more stability in
8 the program, and I actually think that's a good idea.

9 The introduction of greater equity into
10 application of the coding intensity adjustment, I think is
11 very important. If anything, I would add that there is a
12 belief that the Secretary has discretion to do something,
13 whether it's the tiering example that was given or
14 something, to address that inequity.

15 I also would like to suggest the importance of
16 encounter data is for risk score accuracy, but it is also
17 to answer questions like Warner raised about what's
18 actually going on in the MA program. You can't do that
19 unless there's full encounter submission, and it sounds
20 like the risk adjustment process kind of nudging the plans
21 in that direction. But perhaps we can say something
22 stronger in the report about really urging CMS to kind of

1 push that along, either by increasing the proportion of EDS
2 that is included in derivation of risk scores or just
3 otherwise -- because to Jon's point, enrollment is ticking
4 up every year, and nobody really knows what's going on in
5 the MA program because we can't do that until we have full
6 encounter data. So I think that that's a very high
7 priority.

8 I also would like to ask -- and I shared with
9 some folks before. You know that I'm very interested in
10 socioeconomic status adjustment. I think whether it's in
11 stars or otherwise in the program, it's not sufficient yet,
12 and it's more folks of dual status and more lower-income
13 folks find MA attractive. I think that within the pot of
14 money, there has to be an appropriate distribution. And
15 SES, in my opinion, is not adequately explored yet.

16 Massachusetts Medicaid program, there was a paper
17 in JAMA that I shared with some folks that recently looked
18 at the introduction of SES factors into risk adjustment for
19 Medicaid and found it to be more predictive of cost than
20 the existing risk-adjustment system, so its' things like
21 housing instability, residents in low-income ZIP Codes,
22 things of that nature, you know, race, ethnicity. I would

1 ask that we consider opening that as a line of inquiry,
2 particularly if the Massachusetts experience seems valid to
3 you.

4 As far as stars is concerned, I hear what Paul
5 and Jay are saying. I would ask us to look at the stars
6 program. I mean, that is certainly a point of view. I
7 think there's a lot wrong with the stars program, though,
8 that has to be addressed at the same time.

9 I think that one of the issues that wasn't really
10 noted -- the cross-walking is. Thank you. That's like a
11 really great investigative report almost that you wrote
12 there. It's possible that one of the things that causes
13 that kind of pressure around stars is that there's a cliff,
14 right?

15 So you can be three and a half stars and get zero
16 quality bonus. If you're not four, you get nothing. So
17 it's like really the stakes for plans to get to four stars
18 may be creating bad behavior, but it's also extremely -- I
19 don't personally think that that is the right way for the
20 stars program to be structured and would prefer to see it
21 scaled with higher amounts as you get higher in the star
22 rating as opposed to this kind of all or nothing,

1 particularly because I think that there is not sufficient
2 recognition for socioeconomic status adjustment in the
3 stars. So until that is improved, I think it makes it very
4 tough to say it's an all-or-nothing thing, especially for
5 the beneficiaries who are on the lower-income scale.

6 The Chairman's recommendations, I agree with
7 David about if you can be a little bit more specific about
8 the first recommendations on stars, that would be good.

9 On the second, for using local payment areas, I
10 also agree, and the conversation that Carlos and Dana were
11 having was interesting because I didn't understand that
12 what you had in mind was that CMS would actually compute
13 new cut points by local area. That would be great, but I
14 would add that if it's not feasible, because that's a lot
15 of work, is that there's still a lot of benefit to using
16 the national cut points, but identifying them at a local
17 level. Do you know what I mean?

18 MR. ZARABOZO: We didn't really say anything
19 about the cut points, so that's a different --

20 MS. WANG: Oh, okay, okay, okay.

21 MR. ZARABOZO: Yeah.

22 MS. WANG: There was another part of the report

1 that was not discussed here, which was trying to -- the
2 desirability of moving a performance year close to the
3 start bonus, which I really agree with. I'm sorry to say,
4 though, that at least from my perspective, the solution in
5 here, which is that plans would prepare two bids, because
6 we wouldn't know what the star rating was, prepare two bids
7 with different benefits, weighting for the result of stars,
8 and potentially have to start preparing and printing two
9 sets of materials to beneficiaries is administratively
10 burdensome, to say the least. So I think it's a great
11 goal, but I think kind of administrative -- operationally
12 different.

13 MR. ZARABOZO: Yeah. The other option is to move
14 the timing of things, to either get the stars more quickly
15 determined or to move the bid timing. There are
16 alternatives to that approach.

17 MS. WANG: Mm-hmm. Okay, okay.

18 That's it.

19 DR. CROSSON: Jack.

20 DR. HOADLEY: So I have a number of comments but
21 first wanted to just sort of associate with some of the
22 comments that Paul and Pat have made.

1 I think what this reflects is some of these parts
2 of the program, the benchmarks, we're pushing towards 10
3 years of using that. The basic star bonus system has been
4 in place for not 10, but a number of years now, and this is
5 actually maybe a good opportunity since it takes us a
6 couple of years -- or if not a couple years, takes us a
7 cycle to work through these things to start to rethink or
8 think about whether to reengage those particular programs.

9 I think the notion of -- I think Paul and Pat had
10 slightly different themes on the stars. I think the notion
11 of pushing harder on the encounter data is also something
12 that makes sense, as Pat mentioned.

13 In terms of the status report aspects, I
14 mentioned one during the first round. The second one I'll
15 mention is probably not for this cycle, but it seems like
16 it might be useful again to look at the extra benefits that
17 plans provide, what variations there are in cost sharing.
18 This might be particularly interesting if CMS goes through
19 with its changes to meaningful difference and some of that
20 to get a sense of what plans are offering that differs both
21 from traditional Medicare and from each other in terms of
22 both extra benefits and cost sharing variations. That's

1 probably a lot more than you could do by January.

2 In terms of the recommendations, I very much like
3 where you're going with these. I think that the work, as
4 several people have said, on the contract consolidation is
5 really important work. I think what we're really seeing is
6 what I consider an outrageous abuse of the existing rules
7 by the plans that have done that, and I think even one of
8 the companies bragged sort of in their statements to
9 shareholders and to the market that this is one of the ways
10 that they're improving their return.

11 But I think it's a harm to the taxpayer because
12 it's costing dollars. It's a harm to beneficiaries in
13 terms of the plan finder comparisons at least and really
14 other aspects as well, and it's also a harm to the
15 competition in markets.

16 A point was made earlier that local plans really
17 can't do this, or smaller plans that are under one contract
18 really can't do this. So I think it's really creating an
19 unlevel playing field in the market, and that's a real
20 problem as well.

21 So I think your solution, proposed solution is
22 good. I agree that some of the wording could be more

1 precise and we make sure that -- I think the ideas you've
2 had are right, and it's just a matter of making sure the
3 words reflect that.

4 I mean, I know we can't do this, but I would love
5 to do this retroactively and go back and recoup bonus
6 dollars from plans. I'm sure that's not really possible,
7 but that's -- if I could be the czar of this, that's what I
8 would try to do.

9 On the second recommendation, I also agree with
10 it. It's something I've believed in a lot time, both here
11 -- and in Part D, there's similar issues. I think the
12 fact, as was raised in the conversation, that the number of
13 enrollees per unit could be small in some cases and have
14 implications for sample size for some of the measures, but
15 it's better, I think -- and I think somebody mentioned
16 this. It's probably better to have some measures that we
17 just can't compute because of sample size and go forward
18 rather than have all of the measures computed on a much too
19 aggregated kind of contract level.

20 I also think that doing it this way aligned much
21 better with the notion that MA is a local product really.
22 I mean, you're talking about -- even if it's a national

1 company, you're talking about a local network of providers,
2 and a company that has a very robust network, doing very
3 good things in one market may not be doing that and may
4 have a much tougher time developing a network in another
5 market, and so performance may, in fact, be quite
6 different. And the notion that we're averaging that out
7 into one score across whatever they've consolidated into is
8 not as helpful. So I think there's a lot of advantages to
9 moving to this kind of a geographic area.

10 I also think -- and I don't know if you had
11 thoughts on this, but the notion that a lot of the
12 contracts go across plan types, so that a PPO and an HMO
13 could both be in the same contract in some instances. Is
14 that not right? Even the local PPOs? I know there's
15 somewhere -- aren't there somewhere where like SNPs and --

16 MR. ZARABOZO: SNPs can, yeah, but not --

17 DR. HOADLEY: So it seems like -- so maybe it's
18 not as big a problem, but, I mean, it seems like even with
19 the SNPs and non-SNPs, sort of lumping them together in one
20 contract with very different kinds of patterns -- I mean, I
21 know on the Part D side, you can lump an enhanced plan and
22 a non-enhanced and basic plan together in one contract, and

1 most do. And again, the formularies can be very different.
2 So if we carry this concept into the Part D world at some
3 point, there's that issue here. I'm glad to hear it's not
4 true across PPO and HMO.

5 And I think that's all of my comments. Thank
6 you.

7 DR. CROSSON: Okay. Comments? I see Dana and
8 then Rita and Kathy. Dana, Rita, Kathy.

9 DR. SAFRAN: Yeah. So just very brief. I am in
10 support of the two recommendations. I like the comments
11 that have been made about the encounter data and the
12 importance of that as well as Brian's points about having
13 the fee-for-service coding information track in parallel
14 and the value of that. I think those are some important
15 points.

16 On the issue that we've talked about relative to
17 stars and that Pat raised around the cliff, it does strike
18 me that while I wasn't here for the MIPS conversation
19 yesterday, one of the things I was excited to see in the
20 paper was the recommendation about moving to absolute
21 performance targets, not relative ones, and I think
22 included there, having a range of targets. But, in any

1 case, that, I think, has emerged as a best practice, and
2 I'm mindful that across different parts of our Medicare
3 programs, we handle quality in very different ways. So it
4 would be nice to start to have some principles and try to
5 line things up, and this would be a good place to start as
6 we're commenting on stars. That cliff is problematic, and
7 that the fact that performance is relative also is
8 problematic, I know, and does lead to challenges, and maybe
9 I would think more of this gaming because you can be
10 improving performance and still fall behind in stars
11 because of how much work other are doing. And so the
12 benchmark moves quite significantly year by year on a lot
13 of these measures. So I just think that some attention to
14 that whole benchmark setting and how the incentive model is
15 set up is a good thing for us to do.

16 Those are my comments.

17 DR. CROSSON: Warner.

18 MR. THOMAS: I do support the recommendations,
19 both of them, with really to caveat David's comment to make
20 sure we have the right specificity there.

21 A couple of comments on the chapters. I would
22 just kind of echo Dana's point around the quality. I think

1 to do an assessment of a program but not have enough robust
2 information about quality -- and I understand, you know,
3 the measures are different and probably that needs to be a
4 major component of that discussion as well, that, you know,
5 the ambulatory measures need to be -- there needs to be
6 similarity there so we can do comparisons. But, you know,
7 I think the programs do operate differently as well.

8 The second thing is I would encourage us to think
9 about whether there should be a discussion on the coding
10 intensity that also includes information about, there are
11 incentives to be much more proactive and much more thorough
12 in doing preventative and wellness care in MA than there is
13 in fee for service Medicare. And I think we jump to the
14 conclusion that the coding intensity is just about coding,
15 and is not about the delivery of care. And I would
16 encourage us to maybe be mindful that that may not be the
17 only reason, it may not be just about coding intensity. It
18 may be the delivery of care is different in MA, and that
19 there's a lot more prevention and a lot more care taken to
20 being proactive versus fee for service Medicare. So I
21 would just encourage us to consider that in that
22 discussion.

1 The third is a concept I've actually talked about
2 previously, with -- specifically with Mark Miller, but I'll
3 bring it up here with the whole group. It's the issue of
4 the auto-enrollment. So today, we essentially auto-enroll
5 people into fee for service Medicare, but in many areas of
6 the country MA is a more cost-effective model. And I would
7 really encourage us to incorporate a component in here that
8 in areas where MA is more cost effective, perhaps there
9 should be the auto-enroll option.

10 And I know that's, you know, different. It
11 doesn't mean people can't change and basically go into
12 traditional Medicare. They would still have the same
13 option, just like they do today. It's just that today we
14 auto-enroll people into fee for service Medicare and then
15 they can opt into MA. Why wouldn't we do the same thing in
16 markets where this is a more effective, a more proactive
17 option, to have people auto-enroll into MA?

18 So I would like to see us consider a discussion
19 around that, especially in markets where it's a more cost-
20 effective option.

21 DR. CROSSON: Rita.

22 DR. REDBERG: I also support the two

1 recommendations and some of the previous discussion on more
2 specificity. I did also want to take the opportunity --
3 and I know we're already trying to do more outcome
4 measures, but, you know, in the whole discussion of quality
5 I am a little concerned that so many of the measures are
6 still process measures that, to me, very imperfectly get at
7 whether we're truly improving health of beneficiaries, and
8 to also mention that we also have been very heavily
9 weighted on things we do but not on things that we
10 shouldn't be doing, and that we should have more low-value
11 care measures in the quality measures, you know, on
12 stopping screening at, you know, age 75 when the harm will
13 exceed the good, you know, or other examples of that
14 nature, because there's very little of that for right now,
15 and I think that the problem is there's a lot of harm
16 occurring in beneficiaries for things that are going to be
17 of no benefit to them.

18 And then, finally, just related, you know,
19 because one of the measures is the blood pressure control.
20 I do have some concern about the new guidelines that were
21 pretty controversial, and especially in the elderly where
22 there's a much greater risk of falls with aggressive blood

1 pressure control. The guidelines contradicted earlier well
2 done, randomized trials that showed aggressive treatment
3 was not beneficial -- more aggressive treatment was not
4 beneficial.

5 So just those concerns about quality, but I
6 support the recommendation.

7 DR. CROSSON: Thank you. David.

8 DR. NERENZ: I support the recommendations and I
9 echo Pat's comments and also a reminder about the wording
10 clarification.

11 On this one, though, just a point about the term
12 "market area." The text may want to go a little farther
13 and talk about what do we mean by that, and I'm thinking
14 that what we really fundamentally want to get after might
15 be something that we call a "quality area" as opposed to a
16 "market are" per se, that there may be regions in which
17 quality is relatively homogeneous within, but sort of
18 varying across, and that it's a little hard to get at that
19 maybe.

20 But I'm thinking, as we go into this, we may find
21 three definitions of geography that somehow don't fit
22 perfectly with each other. So, you know, if we look at

1 things like Dartmouth Atlas and how they define geography,
2 they have a certain way of doing that, and that's not
3 strictly what we're talking about here but there are rules
4 that define these areas.

5 Now we're really talking about problems that
6 start with having stars at the contract level, and we're
7 saying that's not good, and I agree. I don't want to, as a
8 beneficiary, choose plans and see a contract level star
9 rating. Okay, good. So that would suggest that we would
10 want to define stars by plans, not contracts, but the area
11 served by a plan is not necessarily synonymous with what
12 we're talking about up here, unless we say that it is.

13 But then also I'm thinking within a plan,
14 particularly one that has a wide geographic reach, there
15 are probably variations in quality by geography within
16 plans. And all I'm saying is that whatever we say in the
17 text about this term "market area," we just need to be
18 clear, what are we talking about? You know, some of our
19 examples earlier suggested a state could be a market area,
20 meaning -- I meant, the examples of the consolidation. We
21 had Missouri, we had Hawaii. Okay. Well, is a state a
22 market area -- yes or no? Is it smaller than a state?

1 Okay. I'm just asking. We need to be a little more
2 detailed about what do we mean.

3 DR. CROSSON: Kathy, and then Bruce.

4 MS. BUTO: I support the recommendations with a
5 greater specificity that has already been talked about.

6 I really like Pat's idea of looking at what would
7 a modernized -- isn't it time to go back and look at MA?
8 And I think that umbrella would allow us to think about
9 things like Warner's suggestion about auto-enrollment. I
10 think it would also potentially put us on the path to
11 rationalizing better some of the movement we would like to
12 see to more managed settings and a better payment system
13 between fee for service and MA. And I really love Paul's
14 idea of moving away from quality bonuses, with the cliff,
15 as you describe, Pat, to something more like a penalty, but
16 it would have to be after we get some of the SES factors
17 and other important adjustments made.

18 I just think it's time to look at that. I really
19 have to say I really don't like paying for quality. I
20 think that Medicare should establish a level of quality
21 expected, and then those who don't meet that quality
22 standard either should not participate or there ought to be

1 other ways to express the program's interest in improving
2 quality than paying for quality. It just has always been
3 something I think is a problem.

4 So I think it is time to re-look at that, and if
5 we could look at that in the context of the modernization,
6 I think that would be a really useful exercise, and take us
7 back to this issue of how do we begin to rationalize better
8 between fee for service and MA.

9 DR. CROSSON: Bruce.

10 MR. PYENSON: I also support the draft
11 recommendations, both of them. I also like Pat's idea of a
12 comprehensive look. I think we've been fortunate in the
13 choice, this year and last year, of looking at particular
14 issues in Medicare last year -- Medicare Advantage last
15 year -- the risk adjustment, and this year the contract
16 stars issue, of picking things that could be looked at in
17 relative isolation. But many of the things we have been
18 discussing this morning have lots of moving parts and
19 interactions, and I think Pat identified one of them, the
20 unimaginable process of putting in two bids, for example.

21 So I think this is probably not an issue for the
22 June report, even, but perhaps to be scheduled.

1 DR. CROSSON: Okay. And David.

2 DR. GRABOWSKI: Great. Thanks. I support both
3 of the draft recommendations and echo a lot of the comments
4 around the table around the need to improve data so we can
5 make all the comparisons that we want to make, both in
6 counter data and quality data.

7 Jim, I wanted to pick up on a thread you
8 mentioned earlier. There are data right now, assessment
9 data, that are collected in many of the -- for example, the
10 post-acute care settings, such as the minimum data set,
11 where you could merge that with the denominator file and
12 actually tease out who's Medicare Advantage, who's fee for
13 service, and begin to do some of the comparisons.
14 Obviously risk adjustment selection is really important in
15 making those kinds of comparisons, but we should rethink
16 some of the existing data sources that we have and some of
17 the potential comparisons we might make with a bit caveat
18 being risk adjustment. Thanks.

19 DR. MATHEWS: Sure, and we can bring you up to
20 speed on some of the detailed comparisons that we've done
21 in the past. We have done this kind of exercise and we've
22 found, you know, that we do not have MA -- or, I'm sorry,

1 say MDS data for an MA enrollee who the encounter data
2 indicates had a SNF stay. And then we've had MDS data for
3 an encounter -- or an MA beneficiary with no corresponding
4 encounter record showing a SNF stay.

5 So we have sifted through it, and as Andy said,
6 we're continuing to do so. But we can have a more detailed
7 conversation offline if that's helpful.

8 DR. GRABOWSKI: Great. Thank you.

9 DR. CROSSON: Jack and Paul.

10 DR. HOADLEY: Two things. One, you know, I think
11 a revisit of some of those encounter data in one of our
12 sessions would actually be useful to know whether there's
13 been progress. Obviously, if there hasn't been any
14 progress it might be less useful.

15 I also wanted to just pick up on Warner's comment
16 about auto-assignment. I see that as having a lot of
17 problems. You know, it's one thing to think about, sort of
18 conceptually, the notion of putting somebody in the
19 traditional Medicare side or the Medicare Advantage side.
20 Where it starts to get really complicated is you've got to
21 actually put them in a plan, and then you have issues of
22 aligning people with the providers that they're using and

1 risking putting people in a plan that doesn't cover their
2 providers. There's been various attempts, including in the
3 dual demo world, of trying to do, you know, so-called
4 intelligent assignment, to try to put people in a plan that
5 matches, and that's not been very successful to date,
6 partly because of data problems. Maybe someday that will
7 be easier.

8 But I just -- you know, I think it's important to
9 think about those issues when we're sort of considering
10 that kind of a possibility.

11 DR. CROSSON: Paul.

12 DR. GINSBURG: I just wanted to say that I'm
13 really glad Pat brought up the interest in looking into the
14 county quartiles. I know this was in the ACA, I think,
15 when it was enacted. I don't know if MedPAC was involved
16 beforehand in planning of that. But things have really
17 change. I mean, obviously, the quartiles were put in as a
18 way of encouraging that, you know, MA plans be available in
19 more areas, which they weren't. And things have changed a
20 lot, with the MA being such a larger part of the
21 population. And we have experience with it, and it just
22 may be a fruitful topic for us to work on.

1 DR. CROSSON: Okay. Thanks, everybody. This was
2 a good discussion. I heard sort of three strains here.
3 One was the general support for the recommendations,
4 although I think David and others have suggested that maybe
5 we need some work on the wording. I would agree with that.

6 And then we had some feedback to Scott and Andrew
7 and Carlos about potentially improvements to or additions
8 to the report. I think we will make that happen. And then
9 a significant amount of discussion about maybe it's time
10 for us to take a more comprehensive look, at least at some
11 elements of the MA program. I heard certainly the stars
12 program and I heard enthusiasm but I heard enthusiasm in
13 different directions with respect to that. But I think
14 that's something that we therefore should be doing.

15 The issue of the quartiles, the question of
16 whether encounter data uses -- where it ought to be. The
17 question of extra benefits, issue of auto-enrollment. So I
18 think that is -- and this is not uncommon for us, you know,
19 in the update process -- even though this is not really the
20 update process, but it's part of the December/January
21 process, you know, to have the time to reflect on a
22 particular payment area and say whether or not we think, in

1 our policy work, there is a sufficient change in
2 circumstances or change in the marketplace or change in
3 something else that should, you know, have us going back,
4 even to policy issues we've discussed in the past. And I
5 think on the basis of the discussion it's pretty clear that
6 it is a Commission consensus that we should do that.

7 So again, work with Jim and the staff to
8 determine how we do that, whether we take them on all at
9 once, or we do it sequentially, or what, and when we do
10 that. But building it into the work stream going forward I
11 think is clear.

12 Having said that, we need to change the wording
13 of the recommendations, and I think we have maybe a few
14 more additions to the report than we've had in some other
15 areas, I am going to suggest that we not include this as
16 part of expedited voting but we come back and have a second
17 discussion and we actually look at the wording of the
18 recommendations in January.

19 Okay. Seeing no other comments I think we are
20 finished here. Thanks to Scott, Carlos, and Andrew again.
21 You have stimulated the Commission, which is hard to do in
22 the last discussion, of December, particularly.

1 Now we have time for public comment period. If
2 there are any members, of our guests who would like to come
3 up and make a comment about our discussions today, come
4 forward to the microphone so we can see who you are.
5 People are moving around. I see people running away from
6 the microphone, actually.

7 So seeing no one at the microphone, we are
8 adjourned until our January meeting in 2018. Good trips,
9 everybody, and have happy holidays to all of you.

10 [Whereupon, at 11:30 a.m., the meeting was
11 adjourned.]

12

13

14

15

16

17

18

19

20

21

22