

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 5, 2019  
9:18 a.m.

COMMISSIONERS PRESENT:

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AMOL S. NAVATHE, MD, PhD  
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AGENDA	PAGE
Assessing payment adequacy and updating payments: Physician and other health professional services - Brian O'Donnell, Rachel Burton, Ariel Winter.....	4
Assessing payment adequacy and updating payments: Ambulatory surgical center services - Dan Zabinski.....	48
Assessing payment adequacy and updating payments: Hospital inpatient and outpatient services; and mandated report: Expanding the post-acute care transfer policy to hospice - Stephanie Cameron, Jeff Stensland, - Alison Binkowski, Dan Zabinski, Ledia Tabor, - Kim Neuman.....	91
Public Comment.....	158
Assessing payment adequacy and updating payments: Skilled nursing facility services - Carol Carter.....	159
Assessing payment adequacy and updating payments: Home health care services - Evan Christman.....	188
Assessing payment adequacy and updating payments: Inpatient rehabilitation facility services - Jamila Torain, Dana Kelley.....	206
Assessing payment adequacy and updating payments: Long-term care hospital services - Stephanie Cameron, Carolyn San Soucie.....	236
Public Comment.....	258

P R O C E E D I N G S

[9:18 a.m.]

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DR. CROSSON: Okay. We are having the Commissioners assemble at the moment.

I would like to take a moment to welcome our guests to the December MedPAC meeting. Some of you are veterans; some of you may not be. December and January is the time of the year that MedPAC discusses the issue of how much, in this case in fiscal year 2021, the Medicare program should pay the different parts of the health care industry. During today and then tomorrow morning, we will be presenting the update recommendations for nine payment areas, including physicians, hospitals, and others.

It is our tradition at MedPAC to present this data and the draft recommendations to the Commissioners, but not take a vote the first time the information is presented, but to take a vote in the second meeting. That would be the January meeting. So there will be no votes today.

It has also been our policy in recent years that if we find today, this afternoon, and tomorrow substantial Commissioner agreement with the recommendation that is on

1 the table, then we will not have a lengthy discussion of  
2 the issue again in January but will, rather, move to what  
3 we call "expedited voting" with a very short presentation  
4 and voting at that time.

5 At the end of each discussion, these nine  
6 discussions, we will determine whether or not we're going  
7 to have a full re-presentation of the issue in January or  
8 an expedited presentation and voting in January.

9 With that, we will turn to the first presentation  
10 -- which is somewhere -- and that has to do with assessing  
11 payment adequacy and updating payments for physicians and  
12 other health professionals. We've got Brian, Rachel, and  
13 Ariel here, and Brian is going to start.

14 MR. O'DONNELL: Good morning. In this session  
15 we'll review our payment adequacy assessment for physician  
16 and other health professional services and present the  
17 Chairman's draft update recommendation for 2021.

18 We'd like to thank Ledia Tabor and Kevin Hayes  
19 for their assistance with this work.

20 Before we get into the findings, I'll briefly go  
21 over some background on the physician fee schedule and our  
22 framework for assessing payment adequacy for clinician

1 services.

2           In 2018, the Medicare program paid \$70.5 billion  
3 for fee schedule services to about a million clinicians.  
4 The fee schedule includes billing codes for over 7,000  
5 discrete services. Under current law, there is no update  
6 to the fee schedule conversion factor for 2021.

7           But clinicians can receive an adjustment ranging  
8 from minus 7 percent to plus 7 percent for those covered by  
9 the Merit-based Incentive Payment System, or MIPS.  
10 Clinicians covered by MIPS can also receive an extra  
11 payment increase for "exceptional" performance if they meet  
12 certain thresholds.

13           Alternatively, clinicians substantially  
14 participating in an advanced alternative payment model can  
15 receive a lump sum incentive payment equal to 5 percent of  
16 their total professional service billings.

17           This next slide reviews the categories of data we  
18 use to assess the adequacy of Medicare's fee schedule  
19 payments.

20           We use data on beneficiaries' access to care, the  
21 quality of care received, and Medicare payments and  
22 providers' costs.

1           We'll first examine beneficiaries' access to  
2 care. The Commission uses three main measures to determine  
3 whether beneficiaries have sufficient access to care.

4           First, we measure beneficiary-reported access to  
5 care through focus groups conducted in cities across the  
6 country, a Commission-sponsored telephone survey of  
7 beneficiaries and individuals with private insurance, and  
8 the Medicare Current Beneficiary Survey, or MCBS, which is  
9 a large, nationally representative survey of beneficiaries.

10           Using Medicare claims data, we also track changes  
11 in the supply of clinicians billing the fee schedule and  
12 trends in the number of clinician encounters per  
13 beneficiary.

14           Moving on to the results, we found that most  
15 beneficiaries reported no problems obtaining a doctor's  
16 appointment or finding a new physician in 2019.

17           Consistent with previous surveys, beneficiaries'  
18 access to care continues to be similar to or better than  
19 privately insured individuals ages 50 to 64.

20           While overall access remained strong, some access  
21 issues exist. For example, similar to individuals with  
22 private insurance, we found that racial and ethnic

1 minorities reported more difficultly accessing care  
2 compared to non-Hispanic white beneficiaries.

3           Looking across geographic areas, we found minimal  
4 differences in reported access between rural and urban  
5 beneficiaries.

6           We next looked at the supply of clinicians  
7 billing the fee schedule. We found that from 2017 to 2018  
8 the growth in the number of clinicians billing the fee  
9 schedule outpaced beneficiary enrollment growth.

10           However, over the same time period, growth rates  
11 varied by the type and specialty of clinician. In  
12 particular, we saw rapid growth in the number APRNs and  
13 PAs, but the number of primary care physicians billing the  
14 fee schedule declined slightly.

15           And, finally, consistent with past years, nearly  
16 all clinicians who billed the fee schedule did so as  
17 participating providers, meaning they accepted Medicare  
18 rates as payment in full and did not balance bill  
19 beneficiaries.

20           Our next measure of beneficiary access to care is  
21 the number of encounters with clinicians.

22           We found that the number of encounters per

1 beneficiary with clinicians grew by an average of 1 percent  
2 per year from 2013 to 2018.

3 Beneficiary encounters with specialist physicians  
4 accounted for a majority of all encounters. For example,  
5 in 2018, nearly 60 percent of encounters involved a  
6 specialist physician.

7 Similar to our analysis of the number of  
8 clinicians billing the fee schedule, we found that the  
9 growth in the number of encounters per beneficiary varied  
10 by the type and specialty of clinician.

11 For example, from 2013 to 2018, encounters per  
12 beneficiary with primary care physicians decreased by an  
13 average of 2.9 percent per year while encounters with APRNs  
14 and PA increased rapidly.

15 MS. BURTON: Next we'll talk about the quality of  
16 clinician care in fee-for-service Medicare.

17 First, we'll update you on Medicare's approach to  
18 paying clinicians for quality, which consists of MIPS  
19 payment adjustments and 5 percent bonuses for being in an  
20 advanced alternative payment model, or A-APM.

21 We'll also touch on fee-for-service  
22 beneficiaries' ratings of the quality of their care and the



1 rates of ambulatory care-sensitive hospital use we see in  
2 claims data.

3 Under current law, about a million clinicians now  
4 receive some kind of additional payments each year through  
5 MIPS payment adjustments or A-APM bonuses.

6 For the 894,000 clinicians that will get positive  
7 payment adjustments in 2020 under MIPS, CMS has not yet  
8 announced what size these adjustments will be. But in 2019  
9 the highest some clinicians got was 1.88 percent.

10 The size of MIPS adjustments are based on  
11 providers' performance on quality measures, their adoption  
12 of EHRs, whether they engage in quality improvement  
13 activities, and the cost of their care.

14 Another 183,000 clinicians will get 5 percent  
15 incentive payments in 2020 because they are in an A-APM.  
16 This is nearly double the number who got these bonuses the  
17 year before.

18 As a reminder, MedPAC recommended eliminating  
19 MIPS, in part because it relies largely on process measures  
20 that are chosen by clinicians and not meaningful to  
21 patients, and because it imposes a significant reporting  
22 burden on clinicians.

1           We were encouraged by CMS' recent announcement  
2 that it plans to use more outcome measures in MIPS starting  
3 in 2021, but we believe MIPS is still so flawed that it  
4 should be replaced with something along the lines of the  
5 Voluntary Value Program that we described in our March 2018  
6 report.

7           For our own assessments of the quality of care  
8 provided by clinicians, we look at beneficiaries' patient  
9 experience scores and preventable hospital use.

10           These measures generally assess the ambulatory  
11 and hospital care infrastructure in a community, as opposed  
12 to the quality of care delivered by an individual  
13 clinician.

14           To measure patient experience, CMS fields an  
15 annual CAHPS survey among a subset of fee-for-service  
16 beneficiaries. How those beneficiaries rate the quality of  
17 their health care was generally stable between 2014 and  
18 2018, with 85 percent of beneficiaries rating their care  
19 quality a 9 or a 10 out of 10.

20           A more mixed picture emerges when we look at  
21 measures of ambulatory care-sensitive hospitalizations and  
22 ED visits, which are claims-based, risk-standardized rates

1 of hospital use for conditions that may have been avoided  
2 with access to high-quality ambulatory care.

3           Although many beneficiaries don't experience  
4 these potentially preventable events, we see substantial  
5 variation across different geographic markets, with some  
6 areas' rates twice as high as other areas' rates, which  
7 signals opportunities to improve ambulatory care in some  
8 areas.

9           MR. WINTER: We assess Medicare payments and  
10 providers' costs using the following indicators: Medicare  
11 payments per beneficiary, the change in clinicians' input  
12 costs, the ratio of commercial payment rates to Medicare's  
13 payment rates, and physician compensation from all payers.

14           Medicare payments and clinicians' input costs  
15 have been growing. Allowed charges for clinician services,  
16 which include Medicare program payments and beneficiary  
17 cost sharing, grew by 2.3 percent per beneficiary between  
18 2017 and 2018, which was faster than the average annual  
19 growth rate between 2013 and 2017 of 1.1 percent.

20           Growth in allowed charges per beneficiary between  
21 2017 and 2018 varied by type of service, ranging from 1.9  
22 percent for evaluation and management services to 3.5

1 percent for other procedures.

2           There has also been an increase in the Medicare  
3 Economic Index, or MEI, which measures clinicians' input  
4 costs. The MEI increased by 1.7 percent in 2018, and CMS  
5 projects that it will increase by 2.6 percent in 2021.

6           Moving on, we found that in 2018 commercial  
7 payment rates for preferred provider organizations were 135  
8 percent of Medicare fee-for-service rates for clinician  
9 services compared with 134 percent in 2017 and 122 percent  
10 in 2011.

11           The ratio varied by type of service in 2018. For  
12 example, commercial rates were 128 percent of Medicare  
13 rates for E&M office visits for established patients, but  
14 169 percent of Medicare rates for coronary artery bypass  
15 graft surgery.

16           The growth in commercial prices could be a result  
17 of greater consolidation of physician practices as well as  
18 hospital acquisition of physician practices, which gives  
19 physicians more leverage to negotiate higher prices with  
20 commercial plans.

21           And, finally, we look at physician compensation  
22 from all payers. From 2014 to 2018, median physician

1 compensation across all specialties grew by 18.6 percent,  
2 and reached \$302,000 in 2018.

3 But median compensation in 2018 was much lower  
4 for primary care physicians than for physicians in  
5 radiology and nonsurgical, procedural specialties, such as  
6 cardiology and dermatology.

7 Physician compensation from all payers reflects  
8 the structure of Medicare's fee schedule because many  
9 private insurers use RVUs that are similar to Medicare's  
10 RVUs.

11 Therefore, physician compensation probably  
12 reflects the fee schedule's underpricing of ambulatory E&M  
13 visits relative to other services, which contributes to an  
14 income disparity between primary care physicians and  
15 certain specialists.

16 CMS recently decided to substantially increase  
17 the work RVUs for E&M office and outpatient visits  
18 beginning in 2021. This will increase Medicare payments  
19 for specialties that provide many E&M visits, such as  
20 primary care, endocrinology, and rheumatology.

21 Although this is an important first step, CMS  
22 still needs to do more to improve the overall accuracy of

1 the fee schedule.

2           To summarize our payment adequacy analysis,  
3 payments appear to be adequate. Most beneficiaries report  
4 good access to care. Most of them have no trouble getting  
5 appointments. Their access is the same or better than  
6 privately insured individuals. The number of clinicians  
7 billing Medicare is increasing, and the number of clinician  
8 encounters per beneficiary is also growing.

9           Our findings on quality of care are mixed.  
10 Patient satisfaction with care is consistent with prior  
11 years, but there is wide geographic variation in the rates  
12 of ambulatory care-sensitive hospitalizations and ED  
13 visits.

14           In terms of Medicare payments and providers'  
15 costs, Medicare payments per beneficiary are growing. The  
16 MEI continues to increase. The ratio of commercial payment  
17 rates to Medicare rates for clinician services continues to  
18 grow, and physician compensation from all payers has been  
19 rising, although there are still substantial disparities  
20 between primary care and certain specialists.

21           This brings us to the Chairman's draft  
22 recommendation, which reads: For calendar year 2021, the

1 Congress should update the 2020 Medicare payment rates for  
2 physician and other health professional services by the  
3 amount determined under current law.

4 As Brian said earlier, current law calls for no  
5 update, but clinicians who participate in an advanced APM  
6 receive a 5 percent incentive payment, and over 90 percent  
7 of clinicians in MIPS have qualified for positive payment  
8 adjustments to date.

9 In terms of the recommendation's implications,  
10 there would be no change in spending compared with current  
11 law, and this should not affect beneficiaries' access to  
12 care or providers' willingness and ability to furnish care.

13 This concludes our presentation, and we'd be  
14 happy to take any questions.

15 DR. CROSSON: Thank you, Brian, Rachel, Ariel.

16 We're now open for clarifying questions. I saw  
17 Jonathan, Dana, Paul, Bruce, Kathy, Warner.

18 DR. JAFFERY: Thanks, Jay, and thanks for the  
19 great report and a clear presentation. Just a question on  
20 within the reading material, there was some discussion of  
21 the new transitional care management and chronic care  
22 management codes. I wonder if you have any more detail

1 about their use so far. I'm specifically thinking about is  
2 there any correlation with who's using them. Are ACO  
3 providers using them more than non-ACO providers? Is there  
4 any correlation with what happens to patients who are  
5 getting those services? Are we seeing any change in their  
6 utilization patterns? Is there a decrease in ED visits,  
7 hospitalization, particularly ambulatory care-sensitive  
8 admissions, things like that?

9 MR. WINTER: I'll address this a little bit. I  
10 did an analysis, very quick and dirty, looking at use of  
11 CCM and TCM codes by ACOs versus non-ACO providers, and  
12 they were higher for ACO providers. I don't recall the  
13 exact numbers, but we can get that information to you.

14 With regard to their impact on kind of downstream  
15 service use, we have not done work ourselves, but there was  
16 a study published in a journal within the last year -- and  
17 we can get you that information -- which found that there  
18 was a relationship between use of TCM codes and things like  
19 downstream spending and some quality measures. I think  
20 readmissions was one thing they looked at or admission  
21 rates, and we can get that article to you and perhaps talk  
22 about that in the chapter.



1           Is there anything else you wanted to add?

2           MS. BURTON: Yeah, I'll just say that CMS funded  
3 an evaluation of the CCM codes, and we can forward that to  
4 you.

5           DR. JAFFERY: That would be great. For what it's  
6 worth, we have two large provider groups in our ACO, one of  
7 which uses these codes a lot, one which doesn't use them at  
8 all, and we're not seeing a difference. In fact, we may  
9 see the opposite.

10          DR. CROSSON: I'm sorry, Jonathan. You're not  
11 seeing a difference in what?

12          DR. JAFFERY: In admission rates or outcomes,  
13 utilization rates.

14          DR. CROSSON: Okay. Thank you. Dana.

15          DR. SAFRAN: Thanks. I had two questions, one  
16 very similar to Jonathan's, but I was interested in what we  
17 know about the increased use of APRNs and PAs in ACO versus  
18 Medicare Advantage versus traditional fee-for-service  
19 settings. Have we looked at that? Because you talked  
20 about the rise in the use of those other clinician  
21 services, and I was just curious if it's in certain  
22 settings. And then similar to Jonathan's question, what do

1 we see downstream related to use of those providers and  
2 subsequent care?

3 MR. O'DONNELL: Yes. I don't think we have a  
4 whole lot of information there, but I think what we do see  
5 is a very broad-based growth. So we've looked at urban.  
6 We've looked at rural. We've looked at different areas of  
7 the country. APRNs and PA use is growing pretty widely and  
8 quite rapidly across the entire country.

9 DR. SAFRAN: Yes.

10 MR. O'DONNELL: So I think that's the most  
11 fundamental finding that we've seen.

12 Last year, we did look at the literature as to  
13 whether if you are treated by an APRN or a PA, are your  
14 outcomes any better or worse than if you're treated by a  
15 physician, and I think the literature is very -- the  
16 conclusion is that there's not a whole lot of difference in  
17 the findings of the literature. And that is that it's  
18 pretty much the same for the patients that APRNs and PAs  
19 treat. They can't find a whole lot of differences in  
20 outcomes, and a lot of the good research in this area comes  
21 out of the VA. So it might not be entirely applicable to  
22 the entire country, but I think that's the kind of state of

1 play.

2 DR. SAFRAN: Thank you.

3 I had one other question. On Slide 12 where you  
4 talked about allowed charges growing per beneficiary,  
5 growing about 2.3 percent, I was just curious. Since  
6 encounters only grew by about 1 percent, you said earlier  
7 in the presentation, and since there wasn't a payment rate  
8 increase in the previous cycle, I was trying to understand  
9 where that's coming from. Is it based on the coding of  
10 severity of encounters, or what's that about? Thanks.

11 MR. O'DONNELL: Yes. So there's a number of  
12 factors that can affect allowed charges, intensity, and so  
13 the mix of services shifting across settings is going to  
14 have an effect on allowed charges where it would not  
15 encounters and things like that.

16 DR. CROSSON: Thank you, Dana.

17 Paul?

18 DR. PAUL GINSBURG: Sure. I have a question  
19 about the surveys, how the surveys handle the questions  
20 about wait time for appointments.

21 Let's say you have a situation where a patient  
22 saw a physician. The physician says, "Come back and see me

1 in three months." The patient makes an appointment for  
2 three months, hence, and so that patient receives a survey.  
3 They're asked for your wait time for your last physician  
4 visit. I was just wondering since most physician visits  
5 are follow-ups, I was wondering how that's handled.

6 MS. BURTON: The unsatisfying answer is I don't  
7 know, but in the Medicare current beneficiary survey, I can  
8 tell you how it works. They ask the respondent, "Have you  
9 had a doctor's appointment in the past year?" and if yes,  
10 they say, "How long did you have to wait for the  
11 appointment?" And they include did you -- like people who  
12 scheduled the appointment at their prior appointment,  
13 people that called, instances where the doctor's office  
14 called them to schedule it. So you're correct that it  
15 could be including situations like you described, but the  
16 documentation is silent on the particular point you're  
17 talking about.

18 DR. PERLIN: You might, just a little color on  
19 the response rates on the surveys, the currently  
20 commercially insured and the others, the beneficiaries, the  
21 4,000, was that the number returned, or was that the  
22 sampling frame and then some percentage of that responded?

1           MR. O'DONNELL: Right. So the 4,000 respondents  
2 in both the privately insured and Medicare, that's the  
3 number of completed interviews, right? So I think what we  
4 do with our survey is -- it just left the field in October.  
5 So it's very fresh, very recent, and we do it with the  
6 knowledge that we are going to supplement it with findings  
7 from the MCBS because we feel like the MCBS is a more  
8 robust survey in a lot of ways.

9           So when you look at our kind of survey, the  
10 response rate is quite low. It's in the 3.5 percent range,  
11 and then when you look at the MCBS, it's probably up near  
12 the 30 percent.

13          MS. BURTON: It's like 35 or 36 percent.

14          MR. O'DONNELL: So what we do internally is that  
15 the MCBS is lagged by a couple of years, and so we take the  
16 findings from our survey and benchmark it against the MCBS  
17 to see whether our findings hold up. Over time, they've  
18 held up pretty well, despite the substantially lower  
19 response rate.

20          DR. PERLIN: Well, thanks for illuminating that.

21                 With that challenge in the response rates, are  
22 there any patterns or characteristics of the respondents,

1 either geographically or other demography?

2 MR. O'DONNELL: Yeah, there is. And we do a lot  
3 of weighting. So we weight it to census division, age,  
4 race, gender, and I think historically, we've had a hard  
5 time getting enough completed interviews from minorities.  
6 So we do spend a lot of time and effort oversampling those  
7 folks and trying to get enough completed interviews to get  
8 a sufficient population to make a conclusion.

9 DR. CROSSON: Bruce, on this -- on this, Marge?

10 MS. MARJORIE GINSBURG: Yes.

11 Do you seek out folks who are both Medicare and  
12 Medicaid, or do you look for the difference? It's by luck  
13 if you happen to get them, but I'm very curious because we  
14 know that population often has greater challenges with  
15 health care than others.

16 MR. O'DONNELL: So I can speak to our surveys,  
17 and you can mention the MCBS.

18 But for our survey, we don't. We do collect  
19 information on the income of the household. It's not quite  
20 the dual status, but we can get kind of a feel for kind of  
21 the wealth of the household.

22 MS. BURTON: Of course, the MCBS does survey

1 duals. We were able to assess differences in access to  
2 care for duals versus non-duals in our report.

3 MS. MARJORIE GINSBURG: And satisfaction rates?

4 MS. BURTON: Yeah.

5 DR. CROSSON: Okay. Bruce?

6 MR. PYENSON: Thank you very much for the  
7 terrific report. I have got two clarifying questions.

8 One is on the MEI and its strengths and  
9 weaknesses as an index of cost, and the other is on the  
10 extra payments from MACRA and how that figures in.

11 On MEI, my understanding is it's available. It's  
12 out there. It's been established, but it may not reflect  
13 the dramatic changes in the way physicians work in the  
14 delivery of care, in particular, the growth and use of PAs  
15 and nurse practitioners.

16 I wonder if you could comment on the strengths  
17 and weaknesses as you see them.

18 MR. WINTER: So you are correct. The MEI is  
19 based on old data. It comes from 2006 data from the AMA's  
20 Physician Practice Information Survey, and CMS said in the  
21 2014 final rule, they're not aware of any more recent  
22 dataset for calculating changes in clinicians and per cost.

1 And I'm not aware of any more recent comprehensive dataset  
2 that would do so.

3           With regards to your point about reflecting  
4 changes in use of NPs and PAs, they actually did make a  
5 small adjustment in the 2014 final rule where they  
6 increased the cost weight for the physician compensation  
7 category by 2.6 percent to reflect -- to include the cost  
8 of NPs and PAs who bill independently, to reflect the  
9 change in practice patterns where there was an increase in  
10 NPs and PAs billing independently.

11           Also, to make things come out equal, they reduced  
12 the nonphysician compensation cost weigh by 2.6 percent --  
13 2.6 percentage points.

14           But that's really the only recent change I can  
15 think of that they made to the cost weights themselves.

16           They have made changes over time to the price  
17 proxies they used for the different cost weights; for  
18 example, beginning to use BLS data on wages for  
19 professional and related occupations as a proxy for  
20 clinicians, clinician compensation. So they do make those  
21 changes periodically.

22           But in terms of the structure of the cost



1 weights, they have not been changed very much since CMS  
2 adopted the current MEI in 2011.

3 MR. PYENSON: Thank you.

4 On the MACRA payments, it looked like there's  
5 something on the order of 2 percent or more extra payment  
6 in 2019, I think, on behalf of MACRA to physicians, and  
7 presumably, that's going to continue. So how do we  
8 interpret the Chairman's recommendation of a zero update?  
9 Is that zero update but really an extra payment on top of  
10 that?

11 MS. BURTON: Yes, yes. So the MIPS payment  
12 adjustments and the A-APM bonus would stand.

13 DR. CROSSON: Bruce, there are hundreds of  
14 thousands of physicians who are not involved with MIPS as  
15 well.

16 DR. MATHEWS: If I could maybe take a stab at  
17 answering the question a little bit differently, the zero  
18 update pertains to the conversion factor. So what we would  
19 propose here for your consideration is the 2021 conversion  
20 factor would be the same as the 2020 conversion factor. So  
21 any other adjustments to that conversion factor through  
22 MIPS, A-APMs would exist exogenously.

1           MR. PYENSON:  Since we have a recommendation to  
2  repeal MIPS, would it make sense -- would we be able to  
3  come up with a recommendation that takes our -- for the  
4  conversion factor update that takes into account our other  
5  recommendation?

6           DR. CROSSON:  I'm not sure how to think about  
7  that because there's been no action so far on our  
8  recommendation, and I don't know how to anticipate whether  
9  Congress would pick it up at some point.

10           I think our sense is, if we had a sense at the  
11  time -- we still do -- is that as the percentage of  
12  payments available through MIPS becomes larger and larger,  
13  that the support within the physician community for this  
14  particular form of payment update is going to erode as we  
15  get larger and larger differences based on very small  
16  putative changes in quality.  At that point, there may well  
17  be some further stronger consideration about changing  
18  things, but I think we have a little bit ways to go at the  
19  moment.  And I wouldn't know how to incorporate the  
20  potential for that happening into our recommendation.

21           Paul?

22           DR. PAUL GINSBURG:  Bruce, I was going to say

1 it's never a good idea to assume that Congress is going to  
2 implement a recommendation as a basis for another  
3 recommendation.

4 MR. PYENSON: Well, I was going the other way. I  
5 assumed they wouldn't.

6 [Laughter.]

7 DR. PAUL GINSBURG: yeah. But I was going to say  
8 that our alternative to MIPS is budget neutral to MIPS. So  
9 I don't see that it should have any impact on our view  
10 about the conversion factor.

11 DR. CROSSON: Kathy?

12 MS. BUTO: Yeah. Bruce, I thought you were going  
13 in the direction of recommending that the MIPS update  
14 that's authorized under current law would not be -- that we  
15 would recommend it not be given, but maybe that's going too  
16 far.

17 I just wondered about the MEI increase again,  
18 whether you can say anything about what's driving the  
19 increase, first of all.

20 Then, secondly, do we have any idea or data on  
21 the proportion of Medicare versus commercial patients seen  
22 by primary care physicians? In other words, as a measure

1 of access, whether we're seeing kind of a steady state or  
2 whether there's an erosion, given the differential in  
3 payment, erosion of Medicare beneficiaries that are being  
4 seen as a proportion by primary care physicians.

5 MR. WINTER: So with regards to the first  
6 question, I will look into the final rule where there might  
7 be more detail about the components of the MEI increase and  
8 what's driving the increase.

9 I'm not sure I can get you that information for  
10 the 2021 projection, but maybe from a recent year.

11 I would expect that most of it is related to  
12 changes in compensation because the overwhelming majority  
13 of the MEI is physician compensation and nonphysician  
14 compensation. So that's probably what's driving it, but I  
15 will check on that.

16 With regards to your second question, it's  
17 something we can think about and look into, the proportion  
18 of Medicare versus other patients covered by other payers  
19 seen by primary care physicians.

20 One possible source would be the NAMCS data,  
21 which is a survey done by NCHS, where they collect data on  
22 patients, payor -- payors. I'm not sure they collect data

1 on especially the physician, but perhaps we could look at  
2 something like bread-and-butter office visits and look at  
3 the proportion --

4 MS. BUTO: That's what I was --

5 MR. WINTER: -- look at the distribution by  
6 payer.

7 MS. BUTO: Yep.

8 MR. WINTER: But that's going to take some time.  
9 I can't promise we can have that by January.

10 MS. BUTO: And I wouldn't ask you to do that --

11 MR. WINTER: But it's something we can look at  
12 for the future.

13 MS. BUTO: -- for January. Yep.

14 MR. WINTER: Do you guys have any other thoughts?

15 MR. O'DONNELL: Yeah. So one note on that,  
16 Kathy, is that when we looked at our data, the Medicare  
17 data, and we saw these large declines over time and the  
18 number of PCP encounters, what you said was one of the  
19 first things that popped into our mind. Well, are  
20 physicians taking more private-pay patients?

21 But there's been published research from HCCI and  
22 others that found that the large decline that we're seeing

1 in Medicare and the number of PCP encounters or office  
2 visits is also reflected in the private-pay data.

3 It's not dispositive at this point, but I don't  
4 think it's a squeezing the balloon. I think rather it's  
5 the utilization of PCPs is going down across the board.

6 DR. CROSSON: Jonathan, on this point?

7 DR. JAFFERY: Yeah. I guess I would caution us  
8 to over-interpret what may be a decline in those encounters  
9 might mean, and the reason I say that is because with the  
10 advent of ACOs in particular, there's a lot of work that's  
11 been going on at least in some organizations to try and not  
12 have those face-to-face encounters. So there might be a  
13 lot of activities going on that's not getting captured in  
14 the encounter data that may not reflect some of these other  
15 concerns.

16 DR. CROSSON: Okay.

17 MS. BUTO: And that might also affect the way we  
18 analyze primary care shortages.

19 DR. CROSSON: On this?

20 DR. GRABOWSKI: On this point, I wanted to follow  
21 up on the input cost. Is there any sense that it's really  
22 input cost rising to meet reimbursement or payment? As you

1 see commercial payers here driving up payments, is it just  
2 input cost following that?

3 I don't know if you've done any work or others  
4 have tried to match, kind of share a commercial with these  
5 costs. We say this every year. I think Paul said it in  
6 the past. Costs are not fixed, and so the sense that  
7 they're jointly determined with payments.

8 MR. WINTER: Yeah. That's a really good point,  
9 and that's one reason that the MEI uses for the physician  
10 compensation portion of the index. They don't use  
11 physician wages. They use wages for professional-related  
12 occupations, things like lawyers, architects, accountants.  
13 They get that data from BLS. So they're not going to have  
14 that feedback effect at least for physician compensation.

15 I need to look at what proxies they used for  
16 nonphysician compensation, if they used nursing wages or  
17 wages for unrelated occupations, and I can get back to you  
18 on that.

19 The other portion of the index would be rent,  
20 which is about 9 percent of the total, and for that,  
21 they're using general data on commercial rents, I think. I  
22 don't think that's an issue in terms of this feedback

1 effect or loop between -- you know, they might have if they  
2 were using data on rents being paid by physicians. But  
3 I'll get back to you on some of that.

4 DR. CROSSON: Okay. I have Warner, Amol, and  
5 Sue, and then we will proceed to the discussion.

6 Warner?

7 MR. THOMAS: I just want to go back to the access  
8 question in the survey, and Jonathan asked a few questions  
9 here.

10 Your survey is 4,000. It looks like the CMS  
11 survey is 14,000. What confidence do you have that we are  
12 getting an adequate sample, one, and that we're covering a  
13 broad enough set of geographies around access, two? And  
14 then do you see pockets where -- or any certain geographies  
15 where there might be access issues?

16 MR. O'DONNELL: Right. For the Commission-  
17 sponsored telephone survey, I think the way we view it is a  
18 high-level picture. We have 4,000 privately insured, 4,000  
19 Medicare benes. You can only do so many cuts before you  
20 get to numbers that aren't big enough to analyze, and so we  
21 do look at kind of regional variations. And it's weighted  
22 to reflect regions, and we oversample minorities. But I



1 think we're relatively underpowered. If you want to go dig  
2 into county levels or things of that nature into very  
3 granular looks at access, then I think that's why we then  
4 kind of fall back on the claims data and also the MCBS,  
5 which with the larger numbers kind of gives us a little  
6 more power to go looking at those things.

7 MS. BURTON: And when we compare urban and rural,  
8 there's no difference in MCBS.

9 DR. MATHEWS: And just to add one point to this,  
10 Warner, as Brian said, our sample is too small for us to do  
11 very granular analyses of differences in access among  
12 smaller geographic units, but we do make a point in  
13 conjunction with the survey each year. We do go out and do  
14 beneficiary focus groups, provider focus groups, and often  
15 we base where we conduct those sessions on reports of  
16 localized beneficiary access problems. So we'll go to  
17 Phoenix, Indianapolis, wherever there happens to be some  
18 sense that there may be access problems.

19 MR. THOMAS: So you're doing additional testing  
20 in those areas. Okay.

21 DR. CROSSON: I mean, the only thing I would say,  
22 Warner, to your point, is that I think, you know, we will

1 hear, I hear, on occasion, others will hear of examples,  
2 you know, anecdotal examples of where this is a problem,  
3 based on the nature of the community or the history of it,  
4 or things of that nature. So, you know, I personally don't  
5 believe it is, you know, uniform all over the country and  
6 it's fine. It's just not. But this is the best we can do.

7 Okay. Amol.

8 DR. NAVATHE: So related point, actually. I was  
9 curious. You guys didn't note, and it looked like the data  
10 generally supported access, which was good, from across the  
11 three different sources. That being said, you did also, on  
12 page 13, highlight that there were some differences for, I  
13 think, minorities, in particular. And I was curious if we  
14 have -- that seemed to be coming from our -- from the  
15 MedPAC telephone survey.

16 I was curious if that has been triangulated with  
17 other sources, like MCBS or otherwise, particularly trying  
18 to understand what some of those factors that may be  
19 underlying the differences could be. Is it primarily  
20 driven by, you know, same physicians and practices that are  
21 seeing non-minority patients? Is it sort of differential  
22 between the same practices? Is it primarily driven by

1 supply? Potentially there's less physicians and practices  
2 in areas which are serving minorities. I think getting  
3 some deeper understanding of that might be helpful and I  
4 was curious if you guys have any sense of what the  
5 literature might be.

6 MS. BURTON: In MCBS they also found difficulty  
7 with accessing care for racial and ethnic minorities, and  
8 it was driven by the cost of care. They were delaying care  
9 due to cost. They were citing cost as their number one  
10 issue when they said that they had trouble accessing care.

11 DR. NAVATHE: By "they" here you are saying the  
12 beneficiary?

13 MS. BURTON: The beneficiary was stating this.

14 DR. CROSSON: On this point, Marge?

15 MS. MARJORIE GINSBURG: -- the composition of the  
16 surveys. And forgive me if you said this. When these  
17 surveys are done, is it clear that these folks are in  
18 original Medicare or in MA plans? And is that question  
19 asked, and if it's not asked, is there a reason that we  
20 don't?

21 MS. BURTON: MCBS does ask for all the very  
22 detailed information you would want. We know about

1 Medigap. We know about everything you'd want to know.

2 MR. O'DONNELL: Right. And for our commission-  
3 sponsored survey, that is both fee-for-service and MA,  
4 beneficiaries are included. And I think one of the  
5 findings that we take away from our focus groups is that  
6 oftentimes it's difficult to suss out, especially over the  
7 phone, which is our survey, whether a beneficiary is  
8 actually enrolled in MA or fee-for-service, as compared to  
9 the MCBS, which is in-person, and so there can be more of a  
10 kind of feedback loop, so there's more of an ability to  
11 figure that out.

12 MS. BURTON: Yeah. And they also link the survey  
13 data to claims data and they survey the same person for  
14 four years. They come back like every few months to  
15 interview them, so I have a high degree of confidence in  
16 MCBS.

17 DR. CROSSON: You know, oddly enough, it has come  
18 up before, a surprising finding that some Medicare  
19 beneficiaries don't know whether they are in traditional  
20 fee-for-service or Medicare Advantage.

21 Okay. Sue.

22 MS. THOMPSON: Thank you. I'm looking at the

1 footnote back on the MIPS, Table 4 in the reading material.  
2 Am I understanding that if we did eliminate MIPS we would  
3 save Medicare \$500 million? And it's budget neutral sort  
4 of amount of money. I mean, if performance goes up and  
5 there are more providers that perform at a higher level,  
6 their actual, what they receive, is less.

7 MS. BURTON: You are correct that we would see a  
8 \$500 million savings.

9 MS. THOMPSON: A \$500 million savings. Okay.  
10 But more notable, in the discussion around site neutral and  
11 the payment differential between hospital versus clinic  
12 payments, in '18 we are estimating that \$2.2 billion  
13 expenditure to Medicare, as a result of the fact that we do  
14 pay that differential. And this goes back to just  
15 reflecting on pass recommendations by MedPAC. Have we not  
16 had any comment on site neutral and this situation since  
17 2012, and then again in 2014, which was more specific? But  
18 it feels like we've had a lot of conversation, but I'm just  
19 referencing the information in this document.

20 MR. WINTER: Yeah. So on -- what's the most  
21 recent year that we cite for that?

22 MS. THOMPSON: 2014.

1           MR. WINTER: 2014. So that's when we made, 2012  
2 and 2014, when we made our two recommendations regarding  
3 aligning the payment rates between physician offices and  
4 HOPDs. Since then, in pretty much every proposed rule that  
5 has come out from CMS, at least since they began  
6 implementing a variation of our recommendation that applied  
7 to new off-campus departments, in our comment letters on  
8 those rules we have reiterated our recommendation. We have  
9 addressed issues, questions that CMS has raised with  
10 regards to implement it and operationalize it. And as you  
11 know, CMS recently expanded that site-neutral policy, at  
12 least for E&M office visits, to any off-campus HOPD,  
13 whether it was considered new or not. It's approximately -  
14 - I think it's 40 percent. They get 40 percent of the HOPD  
15 rate.

16           Is Dan nodding? Okay, good. Thumbs up. That's  
17 correct.

18           And so when CMS engages in its annual rulemaking  
19 process, we continue to reiterate our recommendation in  
20 this area and support their efforts to expand the site-  
21 neutral policy.

22           MS. THOMPSON: Thank you.

1 DR. CROSSON: Okay. Thank you. So we will move  
2 on to the discussion. Can we put the recommendation up  
3 please? So the order of business, we will have a  
4 discussion about support or lack of support for the  
5 recommendation. I saw Jonathan and Larry -- Jon and Larry,  
6 sorry.

7 DR. PERLIN: Generally in support. You know, I  
8 think it speaks of the need to improve the measurements of  
9 quality more broadly. I think, you know, the issue of MIPS  
10 is that there may not be alternatives for APMs in  
11 particularly vulnerable regions, rural in particular. And  
12 I think that is important considering, in conjunction with  
13 the discussion we had about the survey.

14 You know, from the data we have heard, and I  
15 think it's on page 11 or 12, page 11, that 72 percent of  
16 beneficiaries had no problem obtaining primary care, which  
17 sort of sounds good in face until you turn around and it  
18 says 28 percent had a problem. And that concerns me  
19 because I'd like to know what the characteristics of those  
20 individuals are. I think that is something we can't answer  
21 from the survey, just because of the power of the survey  
22 and the response rate. It would seem that there -- I would

1 suspect that with a 3.5 percent response rate that the  
2 responses have some systematic characteristics that, you  
3 know, make them more difficult to interpret.

4 I also have a little bit of a concern about the  
5 Medicare Current Beneficiary Survey. If, in fact, they are  
6 followed for four years, then there are 14,000 respondents,  
7 that means that only 3,500 are new in a particular year.  
8 And the categories of beneficiaries they most worried about  
9 in terms of access are two. One, the new beneficiaries who  
10 are just kind of learning the ropes in the programs, and  
11 maybe these individuals have a lot of deferred health needs  
12 and may not have come from insurance and may not, you know,  
13 know the sort of mechanisms to access services. And the  
14 second is the older old, are those individuals. When I  
15 think about the characteristics of physician practice in  
16 terms of Medicare beneficiaries, and we had this  
17 conversation before, this is sort of parsing at the  
18 practice into kind of patients that are likely to be  
19 quicker to meet their needs, which read younger, likely  
20 commercially insured, and those with greater complexity,  
21 multiple morbidities, difficult social vulnerabilities,  
22 read Medicaid, and those that are particularly frail



1 elders. I think it is worth getting some insight into  
2 whether those individuals have particular challenges in  
3 getting care.

4 I think that is above and beyond -- let me take  
5 you off the hook here -- I think that is above and beyond  
6 the mandate for MedPAC and staff. However, if I were  
7 running CMS or HHS, as part of annual enrollment I would  
8 have three or four really basic questions about this, and  
9 that way it would change the sampling frame to the entirety  
10 of beneficiaries, and we would really have good information  
11 about this part of access.

12 So there is a methodological comment, but in  
13 general support, and just the concern about the convergence  
14 of MIPS with the issues of access. Thanks.

15 DR. CROSSON: Thank you, Jon. You know, I would  
16 add, it struck me as you were talking that what we are  
17 talking about right now is a payment tool, right -- pay  
18 more, pay less. We spend a lot of time understanding, I  
19 think and believing, that we need to see, and thankfully  
20 CMS has finally listened, we need to see more movement of  
21 more payment to primary care services.

22 Anyway, the other question that I think underlies

1 this, which we are not addressing, is are there enough  
2 doctors? And I think we are going to see, from what I've  
3 been reading, we are going to see, irrespective of the  
4 growth of nurse practitioners and physician assistants, I  
5 think we're going to see activity coming forward the next  
6 few years about the supply of physicians per se, and that  
7 might not be an issue for this Commission but to the extent  
8 that the number of residency slots paid for by the Medicare  
9 program is part of that question, we could find that work  
10 as part of our charge as well.

11 Larry?

12 DR. CASALINO: Yeah. Three pretty quick  
13 comments, two related, one unrelated. One is I think  
14 people tend to assume that NPs and PAs are working in  
15 primary care, and as you know that is increasingly not the  
16 case. So it might be interesting in future reports just to  
17 correct that misconception from anybody who sees it to try  
18 to at least point that out, and if there is some data on  
19 the rate of change from primary care to specialty care of  
20 NPs and PAs and what the current ratios are. I think that  
21 would be interesting.

22 Second point, I should say I am in general in

1 accord with the recommendation and the general slant of  
2 what you guys had to say, but there is some language that I  
3 think maybe could use some reflection, because I suspect it  
4 is has just gone on from year to year. And that is along  
5 the lines of things that say, well, most beneficiaries  
6 report. There are a number of comments like that.

7 Or on page 10 of our written materials, 72  
8 percent of Medicare beneficiaries said that they were able  
9 to find a primary care physician without a problem. And in  
10 the context of the report, it makes it sound like that's  
11 good, no problem. But actually, you know, that means that  
12 more than a quarter of Medicare beneficiaries do have  
13 problem finding a primary care physician, and I suspect  
14 that in that 28 percent that have a problem there are a lot  
15 of minorities, there are a lot of very old people, there  
16 are a lot of people with cognitive problems.

17 And so I would not paint that, actually, as  
18 necessarily a positive thing, whether or not it relates  
19 well to access in commercial insurance. But just maybe  
20 more reflection on the general tone of the report, that  
21 most, and 72 percent -- it is not necessarily that good.

22 And then my last comment is on a different

1 subject and probably won't make me popular with some of the  
2 people in the room here. I think that it needs to be  
3 pointed out that the 5 percent update -- not the 5 percent  
4 update but the 5 percent bonus for physicians in advanced  
5 APMs, as opposed to a 0 percent increase for other  
6 physicians, and very questionable incentives for physicians  
7 in MIPS, as the Commission has pointed out, and Jay just  
8 mentioned, I'm totally in agreement with a push toward  
9 getting more physicians into advanced alternative payment  
10 models.

11           But I think it needs to be said that this does  
12 involve, in my opinion, does involve CMS in picking winners  
13 and losers. I think a better policy would be to give -- to  
14 make better rewards available for advanced APMs, and so  
15 then if you're a physician in an advanced APM you have  
16 potentially a lot more reward but you don't automatically  
17 get 5 percent. You take certain risks and you go through a  
18 lot of hassles that people who run these kinds of  
19 organizations in this room know how difficult it is to get  
20 these rewards.

21           But still, I think it would involve less picking  
22 of winners and losers to say if you want to be an advanced

1 APM you can get a good reward but it's not guaranteed. By  
2 just kind of giving 5 percent to some physicians and 0 to  
3 others, it is, deliberately, I suppose, but again, it is  
4 picking winners and losers, and I think that should be at  
5 least noted.

6 DR. PAUL GINSBURG: Larry, I'm not sure about  
7 that. If you say we'll give you a bonus for being in an  
8 APM, and being in an APM means taking risk, so we're not  
9 guaranteeing anyone that they are going to win.

10 DR. CASALINO: But you're 5 percent ahead to  
11 start with.

12 DR. PAUL GINSBURG: Yeah.

13 DR. CROSSON: To be clear, our standing  
14 recommendation with respect to that part of MACRA is that  
15 the 5 percent should only include physicians who are part  
16 of an A-APM that is successful in saving costs.

17 DR. CASALINO: That's the MedPAC recommendation.  
18 That's not current policy, though.

19 DR. CROSSON: No.

20 DR. CASALINO: No, I think that's a great  
21 recommendation. I do not know that action and I agree with  
22 that.

1           MR. WINTER: And Larry, if I could just respond  
2 to your second comment about the 72 percent of  
3 beneficiaries in our survey, you said that they did not  
4 have a problem. This is a subset. This question applies  
5 to a subset of respondents who are looking for a new  
6 primary care physician, which was only 8 percent of all the  
7 Medicare respondents to our survey. So if you look at --  
8 so of those 8 percent, 72 percent said they had no problem  
9 finding a new primary care physician, 14 percent said they  
10 had a big problem. But 14 percent of those who were  
11 looking had a big problem. So it was 1.1 percent of all  
12 the Medicare beneficiaries in our survey.

13           DR. CASALINO: Oh, that's helpful.

14           MR. WINTER: So it's not that 72 percent of all  
15 beneficiaries had no problem and 28 percent had a small or  
16 big problem. It's 8 percent of the total who were looking  
17 for a new primary care physician, 72 percent had no problem  
18 and 14 percent had a big problem and the others had a small  
19 problem.

20           DR. CASALINO: No, that's helpful, and I should  
21 have seen that. I agree. That makes it seem like much  
22 less of a problem.

1 DR. CROSSON: Okay. Warner, last comment.

2 MR. THOMAS: Thanks. Just generally I support  
3 the recommendation. I would just comment on Jonathan's  
4 comment that I do think this idea of understanding the  
5 access issue in a deeper way would be important, especially  
6 as we see more people aging into Medicare. I think it's  
7 going to put more pressure on physician providers and there  
8 is going to be transition in their payments. As we  
9 indicated, you know, commercial payments are significantly  
10 higher than Medicare, and so I get concerned about an  
11 access issue over time, and I just wonder if we should, you  
12 know, look at our survey tool and also maybe comment on  
13 whether CMS' survey tool is broad enough or deep enough to  
14 really understand, you know, given the 28 percent. So that  
15 may be something we want to comment on and maybe recommend  
16 that there be deeper analysis done here going forward.

17 DR. CROSSON: Okay. Thank you. good discussion.  
18 My sense is -- and I'm going to test this as I will each  
19 time -- that there is no substantive disagreement with the  
20 recommendation. Now, there have been suggestions about  
21 potential wording changes -- I heard that from Larry and  
22 others -- perhaps some additional information, if it is

1 possible, to get that in a timely way that could be added  
2 to the supporting documentation.

3 But having said that, unless there's an objection  
4 I think we will take this up in January through the  
5 expedited voting process. Seeing no objection, that's what  
6 we will do. Brian, Rachel, Ariel, thank you so much.

7 Okay. We're going to move to the second  
8 presentation, which is payment adequacy for ambulatory  
9 surgical centers. Dan is here and, Dan, you have the  
10 microphone.

11 DR. ZABINSKI: Thank you. All right. So in this  
12 presentation, we'll discuss the payment adequacy for  
13 ambulatory surgical centers, or ASCs.

14 In our assessment of payment adequacy for ASCs,  
15 we use the following measures: first, access to care as  
16 measured by capacity and supply of ASCs as well as the  
17 volume of services; second, quality data, using measures  
18 from the ASC Quality Reporting Program, or ASCQR; access to  
19 capital; and aggregate Medicare payments.

20 Finally, we are not able to use margins or other  
21 cost-dependent measures because ASCs do not submit cost  
22 data to CMS.



1           Important facts about ASCs in 2018 include:  
2 first, that Medicare fee-for-service payments to ASCs were  
3 nearly \$4.9 billion; second, the number of fee-for-service  
4 beneficiaries served in ASCs was 3.5 million; and the  
5 number of Medicare-certified ASCs was just over 5,700.  
6 Also, the ASC payment rates will receive an update of 2.6  
7 percent in 2020.

8           Now, many of the surgical services that are  
9 provided in ASCs are also often done in hospital outpatient  
10 departments, or HOPDs, and also the ASC payment system is  
11 tightly linked to the outpatient prospective payment  
12 system. Therefore, we think it's worthwhile to compare  
13 ASCs and HOPDs.

14           Now, there is a clear benefit to having surgical  
15 services provided in ASCs rather than HOPDs because ASCs  
16 have much lower Medicare payment rates than HOPDs, which  
17 can result in lower payments for Medicare and lower cost  
18 sharing for patients.

19           Also, ASCs offer efficiencies over HOPDs such as  
20 shorter waiting times for patients and greater control over  
21 the work environment for physicians.

22           But encouraging greater use of ASCs should also

1 be considered alongside the fact that most ASCs have some  
2 degree of physician ownership. And some studies have  
3 indicated that this physician ownership may encourage  
4 higher volume of surgical procedures.

5           Then, finally, we have found that there is a very  
6 low concentration of ASCs in rural areas and in some  
7 states, especially Vermont, while availability of HOPDs is  
8 more widespread.

9           In our assessment of payment adequacy, we use the  
10 measures we presented on the second slide. And on this  
11 table, the values for the measures of payment adequacy in  
12 the second column indicate growth in the ASC setting in  
13 2018. The number of fee-for-service beneficiaries served  
14 increased, as did the volume of services per fee-for-  
15 service beneficiary, and the number of Medicare-certified  
16 ASCs.

17           Turning to quality, we have data from 2013  
18 through 2017 from the quality measurement program for ASCs,  
19 the ASCQR. Throughout the 2013 to 2017 period, the  
20 measures in the ASCQR showed some improvement.

21           In addition, CMS has decided to discontinue some  
22 measures that were topped out or where the cost of

1 collecting the data was greater than the benefit, and we  
2 supported those changes.

3           However, some measures, such as the share of ASC  
4 staff that have had a flu vaccine, are well below the  
5 maximum of 100 percent, so there is room for improvement.  
6 Also, we believe CMS could improve the measures in the  
7 ASCQR.

8           First, CMS could add more claims-based outcomes  
9 measures because the current set of outcomes measures don't  
10 apply to all specialties that are practiced in ASCs.

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

16           Then, finally, CMS could add measures to both the  
17 ASCQR and the hospital outpatient quality reporting program  
18 so that the two programs are more in sync.

19           The best measure for measuring ASCs' access to  
20 capital is the growth in the number of ASCs because capital  
21 is needed for new facilities. And this graph shows that  
22 the number of ASCs has increased steadily. Positive growth

1 of 2.6 percent in the number of ASCs in 2018 indicates that  
2 access to capital has been adequate.

3 In addition, hospital systems and other health  
4 care companies have been acquiring ASCs, and this trend  
5 continued into 2018. But keep in mind that the number of  
6 ASCs involved in these organizations is less than 15  
7 percent of all ASCs.

8 Also, it's important to understand that Medicare  
9 is a small part of ASCs' total revenue, perhaps 20 percent.  
10 Therefore, Medicare payments may actually have a small  
11 effect on the decisions to create new ASCs.

12 This graph indicates that Medicare spending per  
13 fee-for-service beneficiary in ASCs has been increasing,  
14 with a strong increase of 7.4 percent in 2018.

15 The growth in 2018 was largely driven by a 4.4  
16 percent increase in the average relative payment weight for  
17 the services that are provided in ASCs, with smaller  
18 effects from increases in volume, the payment rate update,  
19 and changes in the payment status for some heavily used  
20 drugs and devices from separately paid status to packaged.

21 On a final point, we cannot determine a margin  
22 for ASCs because ASCs do not submit cost data to CMS.

1           Now, to summarize our ASC findings, indicators of  
2 payment adequacy suggest that access is good. In 2018, all  
3 measures of access to care improved.

4           Quality data also showed improvement, but the  
5 measures used in the program could be strengthened. The  
6 increase in the number of ASCs suggests access to capital  
7 is good, and corporate entities such as hospital systems  
8 have obtained and invested in ASCs.

9           Finally, Medicare payments increased  
10 substantially, but we remain concerned that ASCs do not  
11 submit cost data, even though the Commission has  
12 recommended doing so since 2009.

13           We believe that ASCs should be able to submit  
14 cost data because other small providers such as hospices  
15 and home health agencies furnish cost data.

16           Also, all ASCs in Pennsylvania submit cost and  
17 revenue data each year to a Pennsylvania state agency.

18           For the Commission's consideration, the Chairman  
19 has this draft recommendation:

20           For calendar year 2021, the Congress should  
21 eliminate the update to the conversion factor for  
22 ambulatory surgical centers.

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

5           The implication of this recommendation for the  
6 Medicare program is that it would produce small savings.  
7 The anticipated update for the ASC conversion factor is 2.8  
8 percent for 2021, and anything less than that will produce  
9 savings.

10           We anticipate this recommendation should not  
11 diminish beneficiary access to ASC services or providers'  
12 willingness or ability to furnish them.

13           The Commission has wanted ASCs to collect and  
14 submit cost data since 2009, and the Secretary has the  
15 authority to require it. Therefore, we have a second  
16 recommendation: The Secretary should require ambulatory  
17 surgical centers to report cost data.

18           Collecting these data, as Medicare does for  
19 other providers, would improve the accuracy of the ASC  
20 payment system. The Secretary could limit the burden on  
21 ASCs by requiring a cost report that is limited in scope.

22           Implementing this recommendation would not have

1 a direct effect on program spending, and we also anticipate  
2 no effect on beneficiary access to care. However, ASCs  
3 would incur some added administrative costs.

4 That concludes this presentation, and I  
5 appreciate your time. I would like to open up the session  
6 to discussion about our analyses and the draft  
7 recommendations.

8 DR. PAUL GINSBURG: Thank you very much, Dan.

9 We'll start with clarifying questions. Brian and  
10 then Bruce and Dana.

11 DR. DeBUSK: First of all, great report. Thank  
12 you. I really enjoyed reading it.

13 I do have a couple questions, and I want to start  
14 with Chart 4 of your presentation. In that center box, you  
15 listed a concern: Most ASCs have some physician ownership.  
16 Why is that a concern in and of itself? Isn't that an ASC  
17 benefit?

18 DR. ZABINSKI: Well, the concern is that, you  
19 know, through physician ownership -- there have been  
20 studies that suggest that, you know, because of ASC  
21 physician ownership, the presence of ASCs in a market can  
22 increase the number of ambulatory surgical procedures. One

1 thing they don't answer, though, is whether those  
2 procedures are appropriate or not appropriate. That's just  
3 saying that's what it is. It just raises a question. You  
4 know, I don't want to --

5 DR. DeBUSK: I was looking for the paragraph  
6 where it talked about ASCs preserving physician autonomy,  
7 and I just couldn't find it in the writeup, but okay.

8 DR. ZABINSKI: And then at the same time, though,  
9 having physician ownership, you know, ownership, the  
10 private sector can create efficiencies and all that sort of  
11 thing. So, yeah, there could be benefits to it as well.

12 DR. DeBUSK: And, by the way, I'm saving it all  
13 for Round 2, but on page 16 you do do a really nice  
14 discussion of the financial benefits, so I'm on your side.

15 You spoke to induction. In the reading materials  
16 on page 17, you do talk a little bit about the potential  
17 inductive effects of physician ownership in the ASCs, and I  
18 have seen this. You know, this is my fourth time of  
19 looking at this, and I have seen the same studies cited for  
20 four years in a row. How settled is that science? I mean,  
21 do we know, could you speak to how settled the science is  
22 over the inductive effects of ASCs?



1 DR. ZABINSKI: My viewpoint on that is that I  
2 don't think it's 100 percent settled. As you said, I've  
3 been looking every year for a new study on this, and there  
4 just hasn't been one. And, you know, it seemed to be a  
5 popular topic a few years ago, and then nothing has been  
6 done since then. Whether that indicates the science is  
7 settled or not, I'm not certain. Maybe it does, maybe it  
8 doesn't.

9 DR. PAUL GINSBURG: Kathy has a question.

10 MS. BUTO: I don't know if --

11 DR. PAUL GINSBURG: Mic, Kathy.

12 MS. BUTO: I don't know if this is helpful or  
13 not, but the literature on the induction effect of  
14 physicians owning technology, ultrasounds, et cetera, there  
15 is a lot of literature on physician ownership and induced  
16 utilization. I don't know how recent it is, but I don't  
17 think it's an open question, shall we say. I think the  
18 issue is whether we think on balance the utilization is  
19 appropriate or not, and that's the part I think we're  
20 missing here.

21 DR. DeBUSK: Well, and to your point, I think  
22 when you are looking at, say, imaging equipment owned by a

1 practice, there's always the incentive, obviously, to put  
2 that equipment to work. I wrestle -- again, I'm going to  
3 keep this into Round 2. I wrestle with this in surgery  
4 centers because I don't think anyone drives down the  
5 interstate and sees a billboard for a musculoskeletal ASC  
6 and says, "Oh, wow, I'm going to go get a screw put in my  
7 wrist." So, you know, sorry, it's Round 2, but we'll talk  
8 about the nature of what they do.

9 The other question I have is --

10 DR. PAUL GINSBURG: Actually, Brian, before we  
11 leave that, isn't it the case that virtually all ASCs,  
12 whether they're hospital-owned or physician-owned, have  
13 some significant physician ownership? It's part of the  
14 landscape, whether we like it or not.

15 DR. DeBUSK: Yes. Great point.

16 Also, on page 15 of the writeup, too, you talk a  
17 little bit about low-value care in the ASCs. You know, I'm  
18 channeling my inner Rita here. When I think of low-value  
19 care, I think of, you know, 94-year-olds getting PSA tests.  
20 I think of people getting chemo three days before they  
21 pass.

22 You know, we keep citing like spine injections

1 for back pain, and this is a naive question. I'm not a  
2 doctor. Do the people who are actually scheduling and  
3 receiving these injections feel like they're getting --  
4 that this is low-value care? Could maybe one of the  
5 doctors here speak to that? I've never had an injection,  
6 but I would think if I couldn't move that I wouldn't mind  
7 one.

8 DR. DeSALVO: Well, Brian, you raise a really  
9 important point about perception and evidence-based, and  
10 for a person, their perception may be that in their case  
11 there's improvement. But in that particular situation, for  
12 example, the evidence shows that it doesn't actually  
13 improve outcomes. And so, you know, there's always this  
14 balance: I had my one case, and I was okay, your n of 1,  
15 versus what does the randomized controlled trial evidence  
16 show us? And so that's how we come to low-value care  
17 categories that help us decide what we ought to not be  
18 offering to beneficiaries, especially sometimes where the  
19 harm may outweigh the benefit.

20 DR. DeBUSK: Before, when we were looking at low-  
21 value care, I remember there was a tier of sort of the  
22 obvious things, and then there was that tier of the more --

1 this was the "choosing wisely" campaign. I think they had  
2 two different tiers. Would this be in that more gray area  
3 tier? Or is this one of those black and white issues?

4 DR. DeSALVO: I can't speak specifically to what  
5 are in the tiers of choosing wisely, but I think just as a  
6 general opportunity, thinking about how across medicine,  
7 not just in ambulatory surgery centers, we ought to be  
8 paying a lot more attention to avoiding low-value care --

9 DR. DeBUSK: I totally agree.

10 DR. DeSALVO: -- and waste in the system, and  
11 where the evidence is clear, that's a real opportunity for  
12 us as a Commission and for the program to do a better job  
13 of making sure beneficiaries get what they need but not  
14 what they don't need.

15 DR. DeBUSK: I totally agree. Thank you.

16 DR. NAVATHE: Brian, I can also jump in here as  
17 a clinician. I would say you're right to say that there's  
18 a gray area. Even within the gray area, obviously, there's  
19 heterogeneity. So there's going to be some cases where  
20 interventions are maybe on average not that great, but  
21 there is still a decent proportion of people who derive a  
22 lot of benefit. And there could be a gray area where a

1 small minority of people are deriving benefit. So they're  
2 still in the gray area in the sense that they're not  
3 uniformly always useless or something like that.

4 I think the general clinical evidence around  
5 instrumentation, interventions for back pain, have been on  
6 the side of very few people seem to benefit relative to the  
7 broader population who could receive this intervention.  
8 And so I think the idea to call it out as a general growth  
9 in these procedures is perhaps signaling low-value care is  
10 fairly consistent with the evidence.

11 Now, any individual patient, it would be hard to  
12 obviously adjudicate that. One of the major limitations  
13 that we have is in claims data it's almost impossible to  
14 adjudicate appropriateness. So understanding that  
15 limitation, I think it's not a terrible conclusion to make.  
16 It's just that we can't be totally definitive about it.

17 DR. DeBUSK: Yeah, if you're crossing over into  
18 instrumentation, putting the hardware in, pedicle screws  
19 and all that, I'm on board with that. That's iffy at best.  
20 I was just more curious about just the simple injection.

21 One last thing, because I've chewed up way too  
22 much time, anyway, let me ask, have you looked at any of

1 these numbers? In the writeup, it looked overwhelmingly  
2 like there was -- the ophthalmology and GI was sort of one  
3 class of surgery center, and then there was sort of  
4 everything else. Have we ever tried to look at some of the  
5 numbers and reporting and almost treating them as two  
6 separate worlds, that you have these, you know, highly  
7 focused factories, and then you've got, you know, an  
8 orthopedic surgery center or some of the more multi-  
9 specialty or more -- I guess we'd say non-GI, non -- I  
10 mean, it almost seems like two worlds to me. Have we  
11 looked at any of those numbers split apart, or do we lump  
12 them all together for everything?

13 DR. ZABINSKI: Well, they're lumped together.  
14 It's a question for -- so, no, we haven't looked at them  
15 separately. But a question back at you, you know, what do  
16 you think in terms of -- what do you want to see or think  
17 about the separate worlds?

18 DR. DeBUSK: Those two seem so discretionary.  
19 You know, again, I like to go back to my example. If  
20 someone needs plates and screws in their ankle, you're not  
21 really making a choice there. The doctor schedules the  
22 procedure, and you're having it done. I would see, you

1 know, eyelid procedures and at least sometimes cataract  
2 surgery and certainly a lot of colonoscopies as being more  
3 discretionary. And I was just wondering if we were trying  
4 to tease out, you know, the specialties that do have a lot  
5 of discretionary versus the specialties that really you  
6 don't have a lot of choice in. I'm just curious.

7 DR. ZABINSKI: Again, we haven't split them out  
8 like that.

9 DR. DeBUSK: Okay. Well, thank you.

10 DR. ZABINSKI: It's definitely doable.

11 DR. DeBUSK: Thank you.

12 DR. MATHEWS: Brian, just to clarify, assuming we  
13 were able to divide the population of ASCs into these two  
14 categories, are you looking for differences in spending  
15 growth over time, differences in utilization?

16 DR. DeBUSK: I'm wondering if they're  
17 fundamentally different. I'm wondering if we're really  
18 looking at sort of two populations. There's almost the  
19 cookie-cutter ophthalmology or GI ASC, which is really just  
20 a factory. You're just moving one person after the other.

21 Whereas, when I look at, for example, a  
22 musculoskeletal, like an orthopedic surgery center, it

1 really looks like a miniature HOPD. I mean, I was at a  
2 surgery center, an ASC in Minnesota, and it looked nicer  
3 than most of the hospital outpatient departments I've ever  
4 been in. They were doing a hip, a non-Medicare obviously,  
5 but a hip literally in an ASC. I just wondered. To me, it  
6 just seems like there's two worlds there, and in lumping  
7 the two together, we may be missing particularly some of  
8 the benefit of the latter population.

9 DR. DeSALVO: On this point, if I may -- and I'm  
10 trying to look in choosing wisely what the list is, so I'll  
11 get back to you on that, Brian.

12 One of the limitations is there isn't great  
13 evidence about some of this, and that's one of the reasons  
14 it would be helpful to build out the evidence so that we as  
15 the field can know what is not really making improvements.

16 DR. DeBUSK: I just -- again, I appreciate that.

17 DR. DeSALVO: Yeah. So, I mean, it's something  
18 the medicine has wanted to do, but there has been lack of  
19 funding in this kind of work.

20 DR. DeBUSK: I promise this will all be Round 2,  
21 but thank you for that.

22 I look on page 16, and I see 46 percent discount



1 path to physician autonomy. Those are facts. I mean, I  
2 can't really argue that.

3 Then I look on these other page and, well, the  
4 science isn't quite settled, and it may do this and it may  
5 do that. I just see a lot of hard benefits and a lot of  
6 soft potentially -- anyway, that's Round 2, but thank you.

7 DR. CROSSON: Bruce?

8 MR. PYENSON: Thanks, Dan, for a great chapter.

9 In a couple of questions to line up ASCs with the  
10 way we think about other organizations, one of the  
11 datapoints that we collect for physicians and hospitals and  
12 others is the portion that participate in Medicare or don't  
13 participate in Medicare. I'm wondering if that's possible  
14 for ASCs.

15 Another piece of data that we perhaps have  
16 struggled with for nursing homes, for SNFs, and for  
17 hospices is to identify chains versus standalone. I  
18 understand that may not even be easy to find on a Medicare  
19 cost report. So the absence of cost reports shouldn't be -  
20 -

21 [Laughter.]

22 MS. BUTO: It makes it really daunting.

1 MR. PYENSON: Maybe it makes it no less hard, but  
2 I wonder if you could comment on those.

3 DR. ZABINSKI: On the first one, I think -- well,  
4 here's what I know. We do know all the ASCs that are  
5 Medicare certified and we also know which ones have at  
6 least one Medicare claim, and I think maybe that will get  
7 to answering your question. You can see the difference in  
8 that. It's not a big difference. A few hundred don't have  
9 a Medicare claim.

10 MR. PYENSON: So there's relatively few that  
11 don't accept Medicare?

12 DR. ZABINSKI: As far as I can tell, yes.

13 Then on the second one, I am not sure even how to  
14 begin to address that one.

15 DR. DeBUSK: Can I mention on that specifically  
16 on that point, I do think that -- a bunch of them accept  
17 Medicare. I do think the physicians are very clever,  
18 though, when there is physician ownership in that if it's a  
19 -- for example, I know in a distal radius procedure, if it  
20 involves an implant, at least up until a couple years ago,  
21 they would move that into the HOPD over to the hospital  
22 setting because in the ASC, they couldn't get the full

1 reimbursement for the plates and screws that would go in  
2 your wrist. So I do think it's at the case level, there's  
3 some selection, but I think they all take Medicare.

4 DR. CROSSON: Okay. Dana?

5 DR. SAFRAN: Thanks.

6 Just two questions. So, one, I suspect, won't be  
7 answerable, but I'll try. I'm curious what we know about  
8 relative outcomes for a given procedure in an ASC and a  
9 hospital OPD, understanding there's going to be case mix  
10 differences, as Brian just pointed to, in the patients who  
11 are getting a procedure in these two different settings and  
12 also understanding -- you've told us the measures being  
13 used in the program differ. So that's why I'm guessing  
14 there isn't going to be a good answer, but I wonder if  
15 there's any literature on this at all.

16 DR. ZABINSKI: As far as the literature, I'm not  
17 sure. What I do know is that the quality measures between  
18 the two settings, there's some overlap. You can make some  
19 comparisons there.

20 DR. SAFRAN: So what do we know?

21 DR. ZABINSKI: I'm not sure. It's something we  
22 can do, but off the top knowing, I don't know.

1 DR. SAFRAN: Okay. It seems important to include  
2 in the report.

3 DR. ZABINSKI: Okay.

4 DR. SAFRAN: And I realize my second question is  
5 more of a comment, so I'll hold it.

6 DR. CROSSON: Karen, on this point?

7 DR. DeSALVO: No.

8 DR. CROSSON: Okay. Well, then you're next.

9 DR. DeSALVO: Lucky me.

10 Well, related to Dana's question about some of  
11 the decision points and what happens on the front lines, is  
12 there any literature about some of the other consequences  
13 of ambulatory surgery centers, such as, for example, what  
14 we experience in the front lines? Some of the surgical  
15 specialties move their practice to those and move out of  
16 getting hospital credentials, and so there's not been  
17 specialists or general surgeons sometimes on call at  
18 hospitals. Has there been any look at those kinds of  
19 impacts on access to beneficiary care in the hospital  
20 setting when specialists move their procedures into the  
21 ASCs?

22 DR. ZABINSKI: I'm not aware of any study on

1 that. That's a really interesting question.

2 DR. DeSALVO: It's a real-world issue.

3 DR. ZABINSKI: Yeah.

4 DR. DeSALVO: Yes.

5 DR. ZABINSKI: Okay. But, no, I'm not sure about  
6 the literature.

7 DR. DeSALVO: Okay. Thank you.

8 DR. PERLIN: On this point, I think a really key  
9 statistic is transfers to ERs, transfer to hospitals as a  
10 proxy for the solidity of the systems for patient  
11 productions.

12 DR. DeSALVO: Yeah. Am I the last question, so I  
13 can move into comment?

14 [Laughter.]

15 DR. PAUL GINSBURG: Actually, I want to say  
16 something.

17 DR. CROSSON: Paul has a comment.

18 DR. DeSALVO: Rats. Okay.

19 DR. CROSSON: Paul has a comment on a comment.

20 DR. DeSALVO: Just to follow up, which is, yes,  
21 especially maybe five o'clock on Friday, if somebody is not  
22 coming out of anesthesia well, at least anecdotally the

1 kind of thing that emergency medicine physicians receive a  
2 lot of, but there's also the payment issue, which I think  
3 CMS is looking at and you talk about in the paper of how  
4 the splits happen if there's a complication in the facility  
5 and the person has to get transferred to the hospital. So  
6 there are a lot of downstream implications, but it's the  
7 call issue for beneficiary access that has me concerned,  
8 especially when you get to some of the suburban areas where  
9 the doctors have more of a choice. But you're far enough  
10 away from actually a trauma center as a beneficiary if you  
11 needed a neurosurgeon or an ophthalmologist or someone in  
12 the middle of the night, that they may not have hospital  
13 privileges anymore because they're doing their cases  
14 elsewhere.

15 DR. CROSSON: Paul?

16 DR. PAUL GINSBURG: Yeah. I was just going to  
17 say this is a very pervasive issue in the medical care  
18 system that because of the ability, the preference of the  
19 physicians to do their surgery in ASCs, that some  
20 specialties just do not have a relationship with a  
21 hospital, for better or for worse, and I'm sure there are  
22 many implications of that. I don't think we can really

1 handle this in our update recommendation, though.

2 DR. CROSSON: Okay. Seeing no more questions,  
3 we'll move on to the discussion. I put up the first  
4 recommendation, anyway. You've got the two recommendations  
5 on pages 10 and 11. We can't put them both up at the same  
6 time, but we will take them together for discussion  
7 purposes.

8 Brian?

9 DR. DeBUSK: Thank you.

10 First of all, let me start with the second  
11 recommendation that they should do cost reports. I  
12 absolutely agree. I mean, this again, is the fourth time  
13 I've seen this. There is something visceral about not  
14 getting a cost report from these people. At the rate  
15 they're growing, yes, yes, and yes, we should get a cost  
16 report.

17 Now, the one thing -- and this is more of a  
18 personal experience for me -- I do swallow my pride on  
19 something, though, which is they don't send us cost reports  
20 right now. Let's say they did send us cost reports. Let's  
21 say their Medicare margin is 10 or 15 percent. What are we  
22 going to do about it? Are we going to ratchet it down to a

1 nice negative 9 or 10 percent like we do in the inpatient  
2 world and maybe stymy the growth of these and deny  
3 ourselves an access to a 46 percent price discount?

4 I mean, when I buy a cup of coffee in the  
5 morning, I don't really care if the person selling me the  
6 coffee has got a 10 percent positive margin or a 10 percent  
7 negative margin. I just want an inexpensive cup of coffee,  
8 and we're denying ourselves access to a 46 percent cut  
9 price savings.

10 Now, I get it. There's some selection issues  
11 here. Maybe there is some induction. Maybe there is --  
12 and, again, I get that, but it doesn't change the fact that  
13 you're looking at a 46 percent price cut. We're going to  
14 spend the next two days looking at updates and haggling  
15 over, well, is it a half a percent, or is it a 1 percent?  
16 I mean, we're dealing with numbers comfortably less than 1,  
17 and these guys are offering us a 46 percent price cut. I  
18 mean, it's a move-the-needle kind of cut.

19 The other issues, I do think so many of the  
20 policies that we do indirectly drive physicians in the  
21 hospitals and drive them into consolidated practices. This  
22 is one of the precious few things we have to preserve



1 physician autonomy, and, I mean, even this discussion about  
2 physicians coming out of the call pattern, there are worse  
3 things than if a physician sets up an ASC, moves their  
4 volume into the ASC, and doesn't bring enough cases to the  
5 hospital to have to take call.

6 I mean, I get it. There's a call crisis, but  
7 they should have that choice. We shouldn't say, "You're a  
8 doc. If you want to practice in this ZIP Code, you have to  
9 go take call in this hospital." I mean, it's indentured  
10 servitude.

11 So I do think physicians should have a choice,  
12 and I hope we can focus on this area because I do think  
13 it's a path to physician autonomy. Again, as much as I  
14 detest the fact that they don't send us cost reports, I  
15 don't know that that should translate into a zero update  
16 for a sector that's handing us a 46 percent price decrease.

17 Thank you.

18 DR. CROSSON: Paul, do you want to comment?

19 DR. PAUL GINSBURG: Yeah. Brian, you know, this  
20 process is predicated on making update recommendations that  
21 preserve access, that don't pay too much, but preserve  
22 access to beneficiaries, et cetera, et cetera.

1           You are assuming that if we had cost reports, we  
2 would ignore that perhaps to our process, and we would cut  
3 access because we don't want anyone to have high returns.  
4 I don't buy that.

5           DR. DeBUSK: If someone could then walk me  
6 through, if you had the cost report sitting right in front  
7 of you right now, what would you do with that?

8           DR. CROSSON: Well, let me respond a little bit,  
9 I think, just in general. In terms of what this Commission  
10 is about, at least from my perspective, we have three  
11 principal charges here. One is to make sure that the  
12 Medicare program is solvent over time and that the Federal  
13 Treasury and beneficiaries are not overpaying for the  
14 services that they receive.

15           Another one is to make sure that the  
16 beneficiaries are protected, and protecting access for  
17 beneficiaries in this particular circumstance would be how  
18 I would think about that.

19           Then the third one, which I think is also  
20 relevant here, is to the best of our ability to provide  
21 equity, among the providers and other entities that receive  
22 payment from the Medicare program. So that one group, one

1 entity, one institution, set of institutions, set of  
2 providers is not -- are receiving extraordinarily high  
3 payments while others are not.

4           So, in many of the things that we decide,  
5 particularly in the update recommendations, our job is to  
6 balance those things. The problem we have here is that we  
7 don't know how to balance the equities because we don't  
8 know what the profit margins are. So I think our default  
9 position has been -- this is arguable here, but our default  
10 position has been because we believe for the reasons that  
11 Dan stated that this is something that this part of the  
12 industry could do, that it will be very difficult for us in  
13 the absence of any data to make anything other than no  
14 update recommendation. That's been our stance, and I  
15 understand it can be disagreed with.

16           On this point, Kathy?

17           MS. BUTO: Yes. I wanted to respond to what  
18 would you do with cost report data.

19           First of all, it isn't just ASCs. So you've got  
20 OPDs, ASCs, and physician's offices all providing. There's  
21 an overlap in the services that are provided. So you'd  
22 want to actually look at what are the cost issues for an

1 ASC. Are there some site-neutral opportunities that ought  
2 to be looked at? But you can't do that without cost report  
3 data.

4 The other thing is ASCs may be a big saving over  
5 OPDs. They're not a big saving over physician office  
6 procedures, and --

7 DR. DeBUSK: Well, on that point, don't the  
8 physician -- when there is a physician office procedure  
9 that's done to a significant degree that overlaps with an  
10 ASC, I think the ASC payment defaults to the lesser of the  
11 APC or the facility component.

12 MS. BUTO: I cannot remember all the details of  
13 the overlap, but if a procedure is done more than -- I  
14 think it's 50 percent of the time in a physician's office.  
15 It can't be paid as an ASC procedure. There are things  
16 like that.

17 But all I'm saying, Brian, is there is reason to  
18 get the data so you can actually do the analysis of what's  
19 an appropriate payment in each of the settings for  
20 overlapping services at a bare minimum, but it really  
21 shines a light on what a fair payment should be.

22 I wouldn't only look at profit. I mean, profit

1 is not what I would focus on. I'd actually want to know  
2 what costs are, and then you can decide on profit. But  
3 it's really important to understand the components of cost  
4 might be quite different for an ASC than an OPD, and you  
5 wouldn't want to not recognize that. So there are lots of  
6 reasons for getting the cost report.

7 DR. CROSSON: Jon?

8 DR. PERLIN: Thank you for a robust report and  
9 discussion.

10 I think we may be categorically underestimating  
11 the complexity of some of the patients in ASCs today,  
12 advanced orthopedic procedures. There's just been a role  
13 that will allow angioplasty of stenting, not just  
14 diagnostic catheterization. So many of these environments  
15 are very sophisticated and have very complex patients.

16 With that in mind, I think we need to think about  
17 what is the exchangeability of service, either to lower  
18 acuity environments like a physician office or higher  
19 acuity environments like hospitals. With that in mind, I  
20 think it behooves us to find out more about the  
21 characteristics of patients and the mechanisms of selection  
22 for ASC versus those other environments of care.

1           It's in that regard that it strikes me that, if I  
2 remember correctly -- and, Dan, you'll have to keep me  
3 honest on this -- I thought when we looked at the rates of  
4 surgical procedures between fee and MA that actually,  
5 contrary perhaps to intuition, MA had higher rates of  
6 surgical procedures but higher frequency of use of ASCs.  
7 So that may have something to reveal patient  
8 characteristics. It also could reveal something about the  
9 management of the patients. I am just making a point that  
10 in the absence of data, I would not want to impair the  
11 incentives for patients to be in the lowest acuity, most  
12 appropriate setting hospital.

13           Thanks.

14           DR. CROSSON: On that point?

15           DR. NAVATHE: So I would just like to echo that  
16 point and just add one other piece, which is from -- if we  
17 could be very targeted about it, I think we would actually  
18 look at it at a procedural level and say where do we have  
19 tremendous overlap between HOPD and ASC, and in those  
20 cases, we would actually want to incentivize more movement  
21 to ASC where appropriate, and where do we have a lot of  
22 overlap between ASC and physician office, and there we

1 would want to not incentivize ASC to the extent that we  
2 don't need to do that.

3           So one question is we have the rates of the  
4 procedures. We know to what extent we have HCPCS codes  
5 that are showing up in physician offices or not, et cetera.  
6 So one future analysis that could help is just to break  
7 out, stratify essentially the analysis to look at by the  
8 overlap between these two buckets. It will give us a great  
9 sense, in some sense, of what a more targeted scheme would  
10 look like in terms of the savings from ASC, which should be  
11 helpful, because that would kind of deconstruct or  
12 elucidate a little bit more of what the cost saving really  
13 look like, looking at both margins of where it's improving  
14 value and where it's potentially decreasing value.

15           DR. DeBUSK: Specifically on that point, because  
16 when Jon said it I started to say something but you pushed  
17 me over the limit. No, this is great. If you guys are  
18 walking toward saying acuity-adjusted system that reaches  
19 from the physician office to the ASC to the HOPD to the  
20 inpatient care, where you're really looking at a procedure  
21 and an acuity adjustment and placing the patient in the  
22 right venue, I mean, I could get really excited about that,

1 because I think that's ultimately the right direction.

2 That's the PAC PPS for acute care.

3 DR. NAVATHE: Right, which we may not get to in  
4 this next step, but I think we can at least make a step in  
5 that direction through the analytics to support it.

6 DR. CROSSON: On this point or just in line?  
7 Okay.

8 MR. PYENSON: I think in addition to a procedural  
9 analysis, the day of surgery is an important component, and  
10 what I've seen in the data is that lots of things can  
11 happen on the day of surgery, especially in a hospital  
12 outpatient setting, that don't seem to happen nearly as  
13 much in an ASC or a physician office. So that's more to  
14 the episode-based. And one thing perhaps to look at, in  
15 particular, is the proportion of people getting  
16 colonoscopies who also get an upper GI endoscopy on the  
17 same day, and why that might be happening. So I think  
18 there are things like that on an episode basis.

19 DR. CROSSON: Okay. Dana, David, and Sue, and  
20 then I think we're going to be at an end. Dana?

21 DR. SAFRAN: Yeah. I'm in support of both  
22 recommendations, and I know the first one is more



1 controversial so here is why I land there. I'm really  
2 struck that we do not know whether ASCs have been a good  
3 development or not, that we're really unclear about how  
4 much unnecessary additional procedures we're getting, but  
5 it's hard to imagine that we're not getting a lot. And we  
6 don't know the difference in quality across the settings.  
7 And so while the idea -- the premise of having patients  
8 receive a procedure in the lowest acuity setting possible  
9 is absolutely the right premise, and the idea of, you know,  
10 paying accordingly is absolutely the right idea, paying a  
11 lower price for something you don't need isn't a bargain.  
12 And that's my worry.

13           And so, you know, if it's true that, you know,  
14 this first recommendation put a damper on the growth of  
15 ASCs for some period of time and sent some procedures back  
16 to the hospital, I'm not sure we know that that's a bad  
17 thing, based on the data that we have available to us. So  
18 that's why I'm in support of both of these things but also  
19 really getting our science squared away.

20           DR. CROSSON: Yeah, I guess I appreciate that  
21 point. I just want to be clear. I don't think our  
22 intention here, in making that recommendation, or in any

1 other payment update, is to increase or decrease the  
2 availability of particular provider groups. I mean, that's  
3 not what we're trying to do here. I think the reason for  
4 this recommendation is, as some have said and I've said  
5 before, is that there is no basis for us to make a  
6 recommendation other than this in the absence of cost data.

7           Now, you know, I'll stretch a little bit,  
8 because, intuitively, one might imagine that if part of the  
9 industry was in financial trouble and was looking to MedPAC  
10 to provide a more robust recommendation, that producing  
11 costs would be one avenue toward that. On the other hand,  
12 potentially, if an industry had very robust margins and  
13 paid attention to MedPAC at all, and was concerned that  
14 MedPAC would view that askance, one might not be interested  
15 in providing that data.

16           So I don't know that those are motivations, and  
17 I'm not attributing them, but I'm just saying our position  
18 has been, and I believe should remain, with your agreement,  
19 that in the absence of that it's very difficult for this  
20 Commission to make a recommendation for increased payments.

21           DR. SAFRAN: I understood that, and I understand  
22 that with recommendation one that our premise is that, you

1 know, it won't change access. I was merely saying that,  
2 you know, some could hypothesize unintended consequence  
3 might be -- what might it look like? And that if I let my  
4 mind go there, that unintended consequence is not one I'm  
5 concerned about, given the lack of evidence that we have  
6 for whether this has been a good, bad, or neutral  
7 development for Medicare.

8 DR. CROSSON: Good clarification. I'm sorry. On  
9 this, Amol?

10 DR. NAVATHE: Yeah, on this point. I think, so  
11 evidence of absence is different than absence of evidence.  
12 I think we should be careful how we interpret the data  
13 here. Demand inducement, volume inducement, whatever term  
14 we want to talk about here, I think we have to remember  
15 that regardless of setting, the physicians are always going  
16 to have the incentive to do procedures, because that's how  
17 these proceduralists get paid. The evidence that we have  
18 from bundled payments, other places that if demand  
19 inducement exists, it's pretty small in the margin, because  
20 there is a marginal incentive to do procedures. So the  
21 marginal incentive on top of that marginal incentive is  
22 probably relatively small.

1           That being said, clarifying that point and  
2 understanding that, I also think -- I agree with Jay very  
3 strongly, which is, in some sense, that we don't need to  
4 have demand inducement to believe that an update or lack of  
5 update is the right policy. And so I think I would almost  
6 just set that aside for the moment and say what evidence do  
7 we have that we need an update, and I think that's probably  
8 the better frame to look at it. I do think, as Jon  
9 highlighted and I had said earlier, that it would help to  
10 look at some other analyses to help support the sort of  
11 cost efficiency, or payment efficiency, I guess, not really  
12 cost but payment efficiency of ASCs. That would help this  
13 point, but I don't think we need to litigate or adjudicate  
14 the demand inducement point to make a recommendation.  
15 That's just the point I wanted to make.

16           DR. CROSSON: Okay. David and then Sue.

17           DR. GRABOWSKI: Great. I promise to be brief.  
18 So I'm supportive of both of the draft recommendations. I  
19 wanted to come back to this issue of the cost reports, and  
20 I think a good rule of thumb, if you won't show us your  
21 cost reports we won't show you an update. And I think we  
22 want to be really firm on that point, Jay.

1           So I completely agree, and I liked where you were  
2 going, Jay, to suggest if someone is not showing you  
3 something, there is usually a reason for it. And I want to  
4 go back to the report on page 26. They show the all-payer  
5 margin, the average all-payer margin for Pennsylvania, it's  
6 24 percent. I know that's one state and that's an all-  
7 payer margin. But I think these margins are high. That's  
8 the highest number I think we'll look at over this meeting  
9 cycle, maybe the highest number we see, period. You're  
10 saying no?

11           [Laughter.]

12           DR. GRABOWSKI: More to come here. I don't know.  
13 Maybe there's something lurking. But it's a big number.  
14 Let's put it that way. Jim is going to correct me later.

15           So I just want to say I'm supportive here of both  
16 increasing transparency here with the cost reports, and I  
17 like, Kathy, what you were suggesting, not just margins  
18 here but costs, everything, here. We need to see it all.  
19 And I very much agree with the zero update.

20           DR. CROSSON: Last word, Sue.

21           MS. THOMPSON: I will try to be very quick. In  
22 general, I am supportive of both recommendations. I am

1 very supportive of getting access to their cost report  
2 data.

3           But just, you know, in conclusion, listening to  
4 the conversation, having read the chapter, it just reminds  
5 me, this is my fifth time going through these update  
6 discussions. We think in silos in these updates, but yet  
7 the conversation bleeds over into the impact on every other  
8 part of our health care systems. And in this case, I think  
9 the impact we're seeing on the community hospital, the  
10 availability of the call physicians to meet the needs of  
11 our beneficiaries, and the overall health of our hospitals.  
12 I mean, we're going to get to the hospital margins here  
13 pretty quick, and those are not so healthy in Medicare  
14 work. And there is a reason. There is a reason for that.  
15 We don't see a lot of ASCs wanting to do behavioral health  
16 work. We don't see a lot of ASCs wanting to take on OB.  
17 They're taking on the high-margin, procedural work that  
18 has, in the past, been the margin for our hospitals, and  
19 there's an impact there. And I just think it's really  
20 important we get our hands on some data, better understand  
21 their outcomes, and probably most importantly, understand,  
22 in many cases, just do these procedures bring value to our

1 Medicare beneficiaries? In some cases they sure do, but in  
2 all cases, I'm not sure we know.

3 DR. CROSSON: Okay.

4 DR. CASALINO: Jay, may I ask a process question?

5 DR. CROSSON: Yes, Larry.

6 DR. CASALINO: So there were some pretty strong  
7 recommendations in the slides and also in the written  
8 materials we got about the way quality is measured for  
9 ASCs. In general, the Commission does not include  
10 recommendations like that?

11 DR. CROSSON: It's a judgment issue, Larry, as to  
12 whether cases that are made in the next should rise to the  
13 level of a recommendation or not. In general, we have a  
14 sense that our strongest findings, in general, appear as  
15 bold-faced recommendations and therefore require a vote.

16 There are other things, and this is a good  
17 example, where I think we feel strongly about something,  
18 strongly enough to describe it in the text and the like,  
19 but not necessarily bring it forward as a bold-faced  
20 recommendation.

21 DR. CASALINO: And these are the kinds of  
22 recommendations that would appear in a chapter?

1 DR. CROSSON: What you have read?

2 DR. CASALINO: So the three questions on Slide 6,  
3 three recommendations about strengthening the quality  
4 reporting for ASCs.

5 DR. CROSSON: Yes.

6 DR. CASALINO: They would appear in the chapter?

7 DR. CROSSON: Yeah. The chapter -- there will be  
8 a chapter, not dissimilar to what you've read here, with  
9 the additions that have been added today, that will be part  
10 of the March report accompanying this recommendation.

11 DR. CASALINO: Okay. And just a one-sentence  
12 editorial comment. It does seem to me that there has been  
13 this kind of exceptionalism for ASCs about cost reporting,  
14 which we have been discussing. But you could also make the  
15 argument there is exceptionalism on not using their claims-  
16 based outcome measures, for example, where there are some  
17 very obvious ones that could be used for ASCs. So I just  
18 want to flag that this is not, in my mind, a trivial issue.  
19 It's actually quite an important issue, the way that  
20 quality is measured for ASCs.

21 DR. CROSSON: I think that is fair enough, and I  
22 think, Dan, I think we can perhaps raise the profile of



1 this in the written report.

2 Paul, oh, sorry. Pat.

3 MS. WANG: I did have my hand up. I agree with  
4 the recommendations. It strikes me, listening to the  
5 comments made today, that there is so much substance and  
6 content in the types of comments that people have made  
7 about the fact that ASCs are an integral part of the health  
8 care delivery system. They have ripple effects. I mean,  
9 you know, the patient in front of them, that's fine, the  
10 growth, the investment, all of that, but the ripple effects  
11 into the rest of the system, whether it's OPDs, you know,  
12 what is a better setting, whether it's impact on hospitals,  
13 whether there is some cherry-picking of patients, for  
14 example.

15 It's not the purpose of this update exercise, but  
16 it does strike me that if there is an opportunity when we  
17 are evaluating, in some of the content work of MedPAC, the  
18 availability of ambulatory care services, sort of movement  
19 in or out of the community, that we try to figure out a way  
20 to incorporate this, because, yes, it's a black box because  
21 we don't really know anything about the cost. We know very  
22 little bit about quality. But it's a phenomenon and it's

1 growing, and to sort of leave it on the side and only  
2 really analyze or discuss things that we have perfect data  
3 for seems like we're missing something. So it's just a  
4 general comment.

5 DR. CROSSON: That's a good point, and perhaps as  
6 a general answer here, which is that sometimes there is, in  
7 the nature of our work and the requirements that Congress  
8 has laid out for us, a somewhat artificial distinction  
9 between the update process and recommendations about  
10 policy. That's just the way it is, and the fact that we've  
11 divided issues between the March report and the June  
12 report.

13 But it has also been the case, and I think this  
14 is a good example, that as we go through these update  
15 recommendations we often find a fundamental policy issue  
16 that needs to be addressed and is then brought forward in  
17 the workflow subsequently. That's a good point.

18 So here comes the test now. Do we have a general  
19 consensus in support of the recommendations, which would  
20 kind of say, if this is fair, other than some of the  
21 details that have been brought forward, which Dan will add  
22 to the report, is there a belief on the part of any of the

1 Commissioners that we should bring this back for general  
2 discussion in January, or include it in the expedited  
3 decision process?

4           Seeing no objections, we will bring it forward in  
5 the expedited decision process.

6           Dan, thank you so much.

7           [Pause.]

8           DR. CROSSON: Okay. We will proceed with the  
9 final discussion for this morning's session. This has two  
10 parts. The primary part is the question of updates for  
11 hospital inpatient and outpatient services, as well as an  
12 interim report on the mandated report about expanding post-  
13 acute care transfer policy to hospice. And we have Alison,  
14 Stephanie, Jeff, and Dan here, with, I guess, Ledia and Kim  
15 in the background, ready to jump in when needed. This  
16 probably is a record, but who is going to start. Alison?

17           MS. BINKOWSKI: Good morning. This session will  
18 assess the adequacy of Medicare fee-for-service payments  
19 for hospital inpatient and outpatient services, as well as  
20 present preliminary results from a mandated report on  
21 expanding the post-acute care transfer policy to hospice.  
22 The presentation will conclude with the Chairman's draft

1 recommendation for 2021 updates to base payment rates in  
2 the inpatient and outpatient prospective payment systems.

3 As Jay alluded to, numerous MedPAC staff have  
4 made significant contributions to this work. In addition  
5 to those staff listed on the slide, we would also like to  
6 thank Carolyn San Soucie and Sam Bickel-Barlow.

7 Before jumping into our assessment of the  
8 adequacy of Medicare payments to hospitals, we wanted to  
9 first provide some context.

10 In 2018, about 4,700 short-term acute care  
11 hospitals participated in the Medicare program. These  
12 hospitals received approximately \$201 billion in Medicare  
13 fee-for-service payments, which was a 3.6 percent increase  
14 from 2017. These payments included those for inpatient  
15 stays, outpatient services, and supplemental payments.

16 Collectively, Medicare fee-for-service  
17 beneficiaries had 9.5 million inpatient stays and received  
18 171 million outpatient services.

19 Turning to MedPAC's hospital payment adequacy  
20 framework, we assess the adequacy of Medicare fee-for-  
21 service payments to hospitals by looking at four categories  
22 of payment adequacy indicators: first, beneficiaries'

1 access to care, including the capacity and supply of  
2 hospitals; second, the quality of hospital care, including  
3 mortality and readmission rates; third, hospitals' access  
4 to capital, including their all-payer profitability; and  
5 fourth, Medicare payments and hospitals' costs, including  
6 actual and projected overall Medicare margins.

7           Based on these indicators, we will present the  
8 Chairman's draft update recommendation for base payment  
9 rates in the inpatient and outpatient prospective payment  
10 systems.

11           As we note in the chapter, given the growth in  
12 the use of Medicare fee-for-service payment rates to  
13 hospitals as a benchmark, any update to these rates will  
14 affect not only Medicare fee-for-service payments, but also  
15 payments in other parts of the Medicare program and by  
16 other payers.

17           Starting with the first category of payment  
18 adequacy indicators, beneficiaries' access to hospital  
19 care, one key indicator we assess is hospital occupancy  
20 rates. In 2018, we found that excess inpatient capacity  
21 persisted, with aggregate occupancy rates of 63.3 percent,  
22 continuing the trend of small increases seen in prior

1 years.

2           Excess inpatient capacity continued to be larger  
3 at rural hospitals, which had aggregate occupancy rates of  
4 only 41.1 percent. One potential reason for the slight  
5 increase in inpatient occupancy rates is that, given excess  
6 inpatient capacity over multiple years, some hospitals have  
7 sought to reduce their inpatient capacity and replace it  
8 with outpatient capacity.

9           A second indicator of Medicare fee-for-service  
10 beneficiaries' access to hospital care is the volume of  
11 hospital services per capita. In 2018, there was a 1.6  
12 percent decrease in inpatient stays per capita; a 0.7  
13 percent increase in outpatient services per capita; and a  
14 0.3 percent decrease in fee-for-service beneficiaries, as  
15 the share of Medicare beneficiaries enrolled in Medicare  
16 Advantage continued to increase.

17           Collectively, these changes suggest that the 3.6  
18 percent increase in Medicare fee-for-service hospital  
19 payments in 2018 were not driven by increases in the volume  
20 of hospital services, but rather from increases in prices,  
21 the intensity of services, and supplemental payments.

22           A third indicator of beneficiaries' access to

1 hospital care is the number of hospital closures and  
2 openings. After a relatively low in fiscal year 2017, the  
3 number of hospital closures increased, with 23 short-term  
4 acute care hospitals ceasing inpatient services in 2018 and  
5 another 47 in 2019, for a total of 70 over these two years.  
6 Some of these hospitals closed completely while others  
7 converted to outpatient or other facilities. In addition,  
8 some are working to reopen.

9           Among those hospitals that ceased inpatient  
10 services in 2018 and 2019, most struggled with low  
11 occupancy, were small, and within 15 miles of another  
12 hospital, suggesting most had a minimal effect on  
13 beneficiaries' access to inpatient care. However, since  
14 2015, two hospitals that closed were over 35 miles from the  
15 next nearest hospital. This suggests that targeted  
16 policies may be needed to help ensure access, such as the  
17 Commission's previous recommendation to allow isolated  
18 rural hospitals with low inpatient volume to convert to  
19 stand-alone emergency departments.

20           The final indicator of Medicare fee-for-service  
21 beneficiaries' access to hospital services we assess is  
22 hospitals' marginal profit. Hospitals' marginal profit

1 from seeing an additional Medicare fee-for-service  
2 beneficiary continued to be positive in 2018, over 8  
3 percent, on average.

4           This continued positive marginal profit implies  
5 that hospitals with excess capacity continue to have an  
6 incentive to serve more Medicare fee-for-service  
7 beneficiaries.

8           Shifting gears to the second category of hospital  
9 payment adequacy indicators, the quality of hospital care,  
10 we found key quality indicators improved modestly or  
11 remained stable. Specifically, between 2016 and 2018,  
12 risk-adjusted mortality and readmission rates declined  
13 modestly, and patient experience remained high.

14           Hospital quality is improving at a slower pace  
15 than in the earlier years of the hospital quality incentive  
16 programs, which could reflect, in part, that the easier  
17 quality improvements have been made and signal a need to  
18 redesign the hospital incentive programs.

19           As a reminder, in March 2019, the Commission  
20 recommended that the Congress replace Medicare's current  
21 hospital quality programs with a single, outcome-focused,  
22 quality-based payment program for hospitals -- that is the



1 hospital value incentive program -- based on our principles  
2 for quality measurement.

3           Turning to the third category of hospital payment  
4 adequacy indicators, hospitals' access to capital, we found  
5 indicators remained strong in 2018. The key indicator of  
6 hospitals' access to capital is all-payer profitability, as  
7 it largely determines hospitals' access to capital for  
8 expansions and acquisitions.

9           Hospitals' total all payer margin remained  
10 strong, rising to 6.8 percent, near the all-time high of  
11 7.1 percent. In addition, for-profit hospitals had an all-  
12 time high all-payer margin of 11.3 percent. As shown on  
13 the right-hand side of the slide, other indicators of  
14 hospitals' access to capital also remained strong,  
15 including \$23 billion in bonds in 2018.

16           The fourth and final category of hospital payment  
17 adequacy indicators involve examining trends in Medicare  
18 payments under the inpatient and outpatient prospective  
19 payment systems and these hospitals' costs.

20           Starting with inpatient services, we found IPPS  
21 payments per stay grew faster than costs per stay in 2018.  
22 Specifically, as you can see on the left hand of the slide,

1 IPPS payments per inpatient stay grew 2.9 percent, driven  
2 by a 1.1 percent increase in IPPS base rates, and a 1.8  
3 percent increase in reported case-mix.

4           Meanwhile, as shown in middle of the slide, if  
5 hospitals' input costs per stay had grown at the same rate  
6 as the market basket of input prices, e.g., if there were  
7 no productivity gains, and if all of the 1.8 percent growth  
8 in reported case mix reflected a true increase in resource  
9 costs per stay, then hospitals' costs per stay would have  
10 grown at 4.2 percent. However, as shown on the right-hand  
11 side, IPPS hospitals' costs per stay only grew 2.5 percent,  
12 suggesting a combination of more extensive coding of  
13 diagnoses and/or improvements in productivity.

14           Turning to payments for outpatient services, OPSS  
15 payments grew 7.2 percent in 2018. This growth was driven  
16 by three factors: first, continued increases in Part B  
17 drug prices and the introduction of new, expensive drugs;  
18 second, the shift of services from physician offices to  
19 hospital outpatient departments, as hospitals continue to  
20 acquire more physician practices; and third, the shift of  
21 some complex services from inpatient to outpatient  
22 settings.

1           As the Commission has previously noted, the shift  
2 of services from physician offices to HOPDs has led to  
3 increased spending without evidence of improved quality,  
4 leading to the Commission's repeated recommendation to  
5 reduce or eliminate differences in payment rates between  
6 outpatient departments and physician offices.

7           MS. CAMERON: Building on Alison's prior  
8 discussion of trends in Medicare payments and hospitals'  
9 costs, we now turn to the overall Medicare margin.

10           As a reminder, we assess the adequacy of Medicare  
11 fee-for-service payments for hospitals as a whole including  
12 payments for all patient care services as well as  
13 uncompensated care and graduate medical education, and we  
14 compare these payments to the allowable cost of providing  
15 services.

16           Using the most recently available data, we find  
17 that the overall Medicare margin at IPPS hospitals reversed  
18 several years of decline, increasing from negative 9.9  
19 percent in 2017 to negative 9.3 percent in 2018.

20           This increase in the overall Medicare margin in  
21 2018 was likely due to three factors: CMS' overestimate of  
22 input price inflation; more extensive coding of diagnoses

1 and improvements in efficiency; and increased revenue from  
2 Part B drugs

3           The average overall Medicare margin among IPPS  
4 hospitals increased from negative 9.9 percent in 2017 to  
5 negative 9.3 percent in 2018, and most hospital groups'  
6 margins also increased. However, as we've seen in prior  
7 years, there was substantial variation across the hospital  
8 groups.

9           For example, rural hospitals' overall Medicare  
10 margins increased from negative 8.2 percent to negative 6.6  
11 percent, a higher margin and larger increase than urban  
12 hospitals.

13           As in prior years, for-profit hospitals had the  
14 highest overall Medicare margins increasing from negative  
15 2.6 percent in 2017 to negative 0.9 percent in 2018, well  
16 above the overall Medicare margin for nonprofit hospitals.

17           To better assess the adequacy of Medicare  
18 payments for efficient hospitals, we identified a set of  
19 hospitals that perform relatively well on both quality of  
20 care and cost measures.

21           Consistent with prior years, we found these  
22 hospitals' had better performance and higher margins than

1 other hospitals. In particular, these relatively efficient  
2 hospitals had: mortality rates that were 10 percent lower  
3 than the national median, and readmission rates 7 percent  
4 lower than the national median; all while keeping costs per  
5 inpatient stay 9 percent lower than the national median.

6 Lower costs allow these hospitals to generate  
7 better Medicare margins, with a median margin across all  
8 relatively efficient providers around negative 2 percent,  
9 compared with negative 8 percent among other hospitals.

10 As the last piece of our assessment of the  
11 adequacy of Medicare's payments to hospitals and to help  
12 inform the Chairman's draft recommended update to hospital  
13 payments rates in 2021, we review key policy changes  
14 subsequent to the most recent year of available data,  
15 which, again, was 2018.

16 A key change starting in 2020 is the expiration  
17 of statutory decreases to the annual update to IPPS  
18 operating and OPPS rates, which will lead to substantially  
19 higher payment rate updates in 2020 and 2021 than in prior  
20 years -- specifically, a 2.6 percent annual update in 2020  
21 and an estimated 2.8 percent annual update in 2021. These  
22 represent the highest payment updates since 2011.

1           Combining these policy changes with historical  
2 cost growth, we project overall Medicare margins for 2020.  
3 We estimate that the overall Medicare margin for IPPS  
4 hospitals will increase from negative 9.3 percent in 2018  
5 to about negative 8 percent in 2020.

6           We expect IPPS hospitals' margins to increase in  
7 2020 primarily due to three factors: higher payment rate  
8 growth than in past years, due to substantially higher  
9 payment rate updates and likely more extensive coding; cost  
10 growth similar to past years; and continued growth in  
11 revenue from Part B drugs

12           In summary, we found that each of the four  
13 categories of hospital payment adequacy indicators were  
14 generally positive.

15           With regards to beneficiaries' access to care,  
16 hospitals continue to have excess capacity and positive  
17 marginal profits, though there was an increase in closures.

18           With regards to quality of care, risk-adjusted  
19 mortality and readmission rates improved modestly and  
20 patient experience remained stable.

21           Indicators of hospitals' access to capital  
22 remained strong including all-payer profit margins near

1 all-time highs

2           And, finally, Medicare payments and hospital  
3 costs indicators were more mixed: Medicare margins  
4 improved; however, they remained negative, even for  
5 efficient providers

6           Before we turn to the Chairman's draft  
7 recommendation to update the hospital payment rates, we  
8 wanted to update you on preliminary results of a mandated  
9 report.

10           The Bipartisan Budget Act of 2018 mandates that  
11 MedPAC evaluate the expansion of the post-acute-care  
12 transfer policy to hospice and its effect on beneficiaries'  
13 access to hospice services and on hospital payments.

14           As a reminder, under the post-acute-care transfer  
15 policy, IPPS hospitals receive per diem payments for  
16 certain conditions instead of the full amount when a  
17 Medicare fee-for-service beneficiary has a short inpatient  
18 stay and is subsequently transferred to a post-acute-care  
19 setting.

20           Starting in 2019, hospice was added to the  
21 existing list of post-acute-care settings to which the  
22 transfer policy applies.

1 Preliminary results from the first six months  
2 indicate that the policy change produced small savings  
3 without any significant changes in Medicare fee-for-service  
4 beneficiaries' timely access to hospice care.

5 Our final evaluation will be included in the  
6 MedPAC's March 2021 report.

7 Now returning to the discussion of hospital  
8 payment adequacy, the Chairman's draft recommendation seeks  
9 to balance several imperatives. These include: maintaining  
10 payments high enough to maintain access to care;  
11 maintaining pressure on providers to constrain costs to  
12 improve long-term program sustainability; minimizing  
13 differences in payment rates across sites of care  
14 consistent with our site-neutral work; rewarding high  
15 performing hospitals; and moving Medicare payments toward  
16 the cost of efficiently providing high quality care.

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

20 With that, the Chairman's draft recommendation  
21 reads: The Congress should: For 2021, update the 2020  
22 Medicare base payment rates for acute-care hospitals by 2



1 percent; and provide an amount equal to 0.8 percent of the  
2 2021 inpatient and outpatient payments to hospitals through  
3 the Commission's recommended hospital value incentive  
4 program (HVIP), which also increases hospital payments by  
5 eliminating penalties under current hospital quality  
6 programs.

7           We expect that the net increase of this 2 percent  
8 update and the Commission's previous recommendation to move  
9 to the Hospital Value Incentive Program would increase  
10 payment rates by 3.3 percent, equal to the Commission's  
11 2020 recommendation.

12           Because this recommendation would eliminate  
13 penalties under the current quality programs, we expect  
14 spending to increase in 2021 relative to current law. We  
15 do not expect these changes to affect beneficiaries' access  
16 to care or providers' willingness to treat Medicare  
17 beneficiaries. However, beneficiaries may benefit from  
18 hospitals' enhanced incentives to improve quality of care.

19           And, with that, I turn it back to Jay.

20           DR. CROSSON: Okay. Thank you, everybody. And  
21 we'll proceed to clarifying questions. I see Jon, Brian,  
22 Bruce.

1 DR. PERLIN: Well, thanks for a great team effort  
2 on an extraordinarily complex area. On page 8, this is  
3 truly a clarifying question. Can you remind us, of those  
4 three programs that would be eliminated in lieu of  
5 initiating an HVIP program, which are regulatory, which are  
6 statutory? And, you know, I'm just wondering about the  
7 timeline to dismantle and reconstruct.

8 MS. CAMERON: So at this point, the three  
9 programs that would be replaced by the HVIP are all  
10 statutory. At least two of them came through the ACA, and  
11 so there would need to be legislation to turn those  
12 programs over and create the HVIP.

13 DR. DeBUSK: As Jon mentioned, thanks for a great  
14 report. It's an impressive read.

15 I want to go to page 7 of the presentation. You  
16 talk about the 8 percent marginal profit. I want to get  
17 comfortable, so this isn't a challenge. This is a "make me  
18 comfortable with this fixed cost" issue, fixed versus  
19 variable.

20 If Medicare's paying 90 cents on the dollar of  
21 cost and that still contributes 8 percent toward the  
22 hospital's fixed costs, that means 82 percent of their cost

1 is variable, which means 18 percent of their cost is fixed.  
2 I would ask the staff, I would ask Warner, I would ask Jon,  
3 as operators, is 18 percent -- is it really only 18 percent  
4 of your cost? When I walk through a hospital, I can't tell  
5 that it's 18. So to the staff, sort of an open-ended  
6 question.

7           The other question that I have -- and then I'll  
8 be done, so this is an easier round, but I would appreciate  
9 input from the operators. The other question I had is:  
10 Assuming it is 18 percent, I would assume it's on a  
11 spectrum. Not every single hospital is exactly 18 percent.  
12 So, you know, some may be 12, some may be 24. If it's on a  
13 spectrum, on the leading edge of that, shouldn't there be a  
14 couple of hospitals that don't want Medicare payments  
15 anymore, I mean, especially if you're high occupancy, maybe  
16 higher fixed costs? And so my question is: Have we seen  
17 any evidence, is there a single hospital that has run the  
18 numbers and said, hey, you know, we're on that leading edge  
19 of the histogram, we're above 18 percent, and we don't want  
20 these payments anymore?

21           DR. PERLIN: I'd just make an economic point. On  
22 the long haul, costs are variable, but to your point on

1 this, you know, there have been companies, predominantly in  
2 Texas, that are exclusively geared toward commercial  
3 patients.

4 DR. DeBUSK: So there are operators that [off  
5 microphone].

6 DR. PERLIN: [off microphone] had some  
7 challenges, probably less related to that than the overall  
8 management issues, but there are models of that that have  
9 occurred.

10 DR. CROSSON: Okay. Bruce?

11 DR. MATHEWS: Just --

12 DR. CROSSON: Sorry, did I miss something? Jeff,  
13 did you want to comment?

14 DR. STENSLAND: I'd just say the main point is  
15 when we do this and we look at it over a year to come up  
16 with what we think is variable or not variable and it  
17 looked like about 20 percent when we do it econometrically  
18 or cost-based, certainly if you have small hospitals, like  
19 a critical access hospital, much more of it is going to be  
20 fixed than if you have a large hospital over a period of a  
21 year. So you kind of have to look at how big is the  
22 facility and what time period are you looking over. As Jon

1 said, over the long term everything is variable.

2 But maybe the main point for this discussion is,  
3 I think, if we're saying 20 percent is fixed, a lot of  
4 other people -- and I intuitively think it's bigger than 20  
5 percent. If more than 20 percent is fixed, then that 8  
6 percent number just gets bigger, and now we have 8 percent  
7 plus. So the main point is the marginal profit is  
8 positive, and that means you have an incentive to see more  
9 Medicare beneficiaries. If it's 20 percent or if it's 30  
10 percent or if it's 40 percent, that same positive incentive  
11 is there.

12 DR. PAUL GINSBURG: If I can add something, this  
13 marginal profit is the marginal Medicare patients, not  
14 whether you stop serving Medicare patients entirely. It's  
15 whether you're eager to have another Medicare patient that  
16 year.

17 DR. CROSSON: In an empty bed --

18 DR. CASALINO: On this point, Jay -- or go ahead,  
19 Warner.

20 MR. THOMAS: Just on this point, I think the -- I  
21 would estimate that in our organizations the fixed cost is  
22 higher than 20 percent. I think maybe a better way to look

1 at that, instead of being marginal profit, it is actually  
2 contribution to fixed costs because it's really not profit.  
3 You know, it's really a contribution margin, if you're an  
4 accountant by background, so contribution margin. So it's  
5 really a contribution to fixed cost, not profit per se.  
6 Just a little comment there.

7 DR. CROSSON: Okay. Larry, did you want to come  
8 into this as well?

9 DR. CASALINO: Well, just on this point, just  
10 responding to Brian. From fairly extensive direct  
11 experience, the fact that Medicare and commercial insurers  
12 pay so differently and also that within Medicare and within  
13 commercial insurers, different services are variably  
14 profitable, some of the smartest people in the United  
15 States, their job is pretty much full time to figure out  
16 how can we get more commercial patients and fewer -- this  
17 is for hospitals that are near capacity -- and fewer  
18 Medicare patients; and even within Medicare and within  
19 commercial, how can we get a certain kind of patients and  
20 not others? Because that's the way they get the most  
21 profit, obviously.

22 [Comments off microphone.]

1 MR. THOMAS: Yeah, exactly.

2 [Laughter.]

3 DR. CROSSON: Okay. I think we're going to hear  
4 this all day. I'm not sure.

5 All right. Where are we?

6 DR. PAUL GINSBURG: We're ready for another one.

7 DR. CROSSON: Warner and then Bruce.

8 MR. THOMAS: Just going to fixed costs again, as  
9 I look at the calculations, if I understand, it doesn't  
10 look like there's any labor cost included. Is that  
11 accurate? In the rationale behind this?

12 DR. STENSLAND: And that's why it's a plus,  
13 because they're saying -- we're assuming what if your labor  
14 costs are all variable, and when we do that, it looks the  
15 amount of change that we see that's fixed is about what  
16 occurs when we look at hospitals that actually saw a change  
17 in volume. So you could say there's going to be some of  
18 this labor cost is going to be fixed, so it's going to be a  
19 little bit bigger than 8 percent contribution margin or  
20 marginal profit. But we certainly -- some of the  
21 literature says all the labor is fixed, and we certainly  
22 don't think that's the case. Certainly hospitals are more

1 sophisticated, and to think they're going to have the nurse  
2 staffing the same no matter how many patients are on the  
3 floor, that's not in the realm of reasonableness.

4 MR. THOMAS: And just on the efficient provider  
5 analysis, that, as I saw, is negative 2 percent. Is there  
6 a thinking or do you guys have a thought like where that  
7 ought to be? I mean, I guess you -- and I don't know how  
8 that's trended over time as well. I know that the overall  
9 Medicare margin has trended down, came back a little bit  
10 this year, but has the efficient provider, you know, kind  
11 of trended similarly?

12 DR. STENSLAND: There's usually this kind of  
13 common gap of about 7 percent between what the average is  
14 and what these relatively efficient ones are, and there's  
15 nothing great and magical about this efficient provider,  
16 and, you know, this efficient provider was created in a  
17 particular way for our particular question of saying if  
18 people tried to -- really had some pressure to reduce their  
19 costs and still maintain relatively good quality, what  
20 would their Medicare margin be? Could they break even on  
21 Medicare? And the answer is not quite.

22 You can also look at it on the hospitals under



1 financial pressure. It's a similar concept there at  
2 negative 1. Or even look at for-profit hospitals, which  
3 also has some other incentives to keep their costs down,  
4 they're at about negative 1.

5 So all of those data points say they're not quite  
6 breaking even, but whether that's where you want to be,  
7 that's definitely a question for all you folks.

8 DR. CROSSON: Bruce.

9 MR. PYENSON: Just to pick up on Brian's point,  
10 you know, on Slide 3, one of the indicators of adequacy we  
11 have is beneficiaries' access to care, and we do see some  
12 physicians not participating in Medicare. And, of course,  
13 you know, there's certainly hospitals that specialize in  
14 commercial patients just like there's other kinds of  
15 facilities that specialize in Medicaid patients, like  
16 certain kinds of dental clinics or FQHCs or perhaps others.

17 But I would ask the question from an adequacy  
18 standpoint: Since we're not seeing any hospitals decide  
19 not to switch from taking Medicare patients to not taking  
20 Medicare patients, what would be our tolerance, when would  
21 we say, oh, it seems like we've gone over? And I think  
22 that relates somewhat to Brian's probability curve perhaps

1 of what fixed costs are.

2           So I'm wondering what should be -- how would we  
3 think about that. If we saw one hospital in the United  
4 States say, "We're not going to take Medicare anymore,"  
5 would that change our view of access? Or if we saw 10, how  
6 do you think about that?

7           DR. STENSLAND: Well, I think that's a judgment  
8 call. So what we do is we put up the data, and then you  
9 evaluate. You make your judgment call.

10           [Laughter.]

11           DR. CROSSON: I mean, I'll just make a comment.  
12 My own sense is, particularly in the last few years now, we  
13 have been reasonably more sensitive to the situation with  
14 acute care hospitals than perhaps in the past, and the  
15 reason for that is -- one reason, anyway, is that we'd like  
16 to avoid this circumstance that you describe because of --  
17 remember our mission to protect beneficiaries, in this  
18 case, beneficiaries' access, which leads us, as we did last  
19 year, to a recommendation to actually increase Medicare  
20 costs with respect to acute care hospitals.

21           I'll make the point, which we've made in the  
22 past, that that said, if you take the totality of the

1 recommendations we have before us today and tomorrow, it  
2 results in a substantial net savings for the Medicare  
3 program, but in this case, we're making a recommendation to  
4 increase payments to hospitals.

5 MR. PYENSON: I know we've been concerned with  
6 this issue for several years, but we're not seeing that  
7 materialize, apparently, in our evidence. Maybe our  
8 concern is more than it should be.

9 I think Brian suggested perhaps a financial  
10 reason for that, given our conservative analysis of  
11 variable costs.

12 I would keep in mind if we do see some hospitals  
13 that stop serving Medicare, maybe there's other reasons for  
14 that. Maybe they have bad management or maybe it's a  
15 business decision for other reasons. So I'm just pushing  
16 on that.

17 DR. CROSSON: It's a valid point, and I think  
18 you're arguing both sides of the same question. It's a  
19 valid consideration.

20 But as Jeff pointed out -- and this is where the  
21 subjectivity comes in -- in many cases, this is why we have  
22 a Commission -- to take all these values, sometimes

1 conflicting values, and try to sort them through in a  
2 reasonable way, which is how we've come up with this.

3 Jim, did you want to make a comment?

4 DR. MATHEWS: Yeah. Just one additional point,  
5 and this goes to the question Warner raised about the  
6 financial performance of the efficient provider under  
7 Medicare.

8 The Chairman's recommendation is constructed with  
9 an across-the-board 2 percent update for all hospitals but  
10 with the differential between the current law and 2 percent  
11 as well as the foregone penalties from the current penalty-  
12 only programs funneled to higher quality providers.

13 It is our expectation that those dollars would  
14 differentially or disproportionately benefit the relatively  
15 efficient hospitals that we've identified.

16 We don't have a target margin for them, but our  
17 authorizing statute does require MedPAC to evaluate the  
18 adequacy of Medicare payments with respect to the efficient  
19 delivery of care, if I have that language burned into my  
20 brain sufficiently.

21 Arguably, once could interpret that as saying can  
22 the efficient provider break even under Medicare. So right

1 now, it's minus 2. We expect our recommendation to improve  
2 that financial performance, but at that point, the element  
3 of judgment among the Commissioners does help us calibrate  
4 what we want to do here.

5 DR. CROSSON: Marge and then Warner.

6 MS. MARJORIE GINSBURG: So the 2 percent -- one  
7 of the principles that I understand for the Commission is  
8 that our recommendations be budget-neutral. So if we're  
9 proposing a 2 percent increases, is this one of those  
10 exceptions where it won't be budget-neutral?

11 And the second part, is there any interest in  
12 rewarding the efficient hospitals with more than what we  
13 would be paying the less efficient and using it as kind of  
14 a sledgehammer, if you will, to encourage efficiency?

15 DR. CROSSON: Right. So, no, our recommendations  
16 are frequently not budget-neutral. As a matter of fact,  
17 most of them are not budget-neutral. Some are suggestions  
18 that Medicare pay less, and some are suggestions, but  
19 rarely, in this particular case, though, that Medicare pay  
20 some more.

21 In fact, as Jim described, the second part of the  
22 recommendation, which is similar to what we had last year,

1 is in fact directed perhaps a little obliquely, more than  
2 we would like, but it is directed towards what you said,  
3 which is to try to provide relatively more payment to those  
4 hospitals which are high quality and therefore, in many  
5 cases, efficient.

6 I saw Warner and then Pat. Warner, Pat, and  
7 Larry.

8 MR. THOMAS: Yeah. I just come back to the -- in  
9 getting back to maybe some of these charts, have we thought  
10 about trending the input, especially things like labor and  
11 drugs which are really big components of the cost  
12 structure? Do we have a sense of -- you know, when we look  
13 at an increase, like how much of it may be taken up with --  
14 I mean, we have such a tight labor market now in the  
15 country. How much do we think would be -- you know, if we  
16 propose what we're proposing here, do we know how much may  
17 be taken up just in labor and drug cost escalation, given  
18 kind of where we know some of those numbers are today?

19 So it would strike me that it may actually take  
20 the whole increase plus just looking at those two factors.  
21 So any thoughts?

22 MS. CAMERON: So we haven't looked at the

1 trending of labor costs over time, but I think to your  
2 point -- and last year, we added a new table, which we've  
3 put in the mailing materials again this year, looking at  
4 kind of how the change in cost in patient stay has occurred  
5 and where those cost centers are focused. We really didn't  
6 find any big anomalies this year.

7           Last year, as you'll recall, device costs, for  
8 example, had a fairly large increase in cost relative to  
9 the rest of the cost centers we were looking at, but we  
10 didn't find that this year.

11           Historically, we have found drugs have -- the  
12 cost of drugs has increased in a per-case basis, relatively  
13 quickly. There's been a large cost growth there, but  
14 again, this year we did not find that.

15           DR. CROSSON: On this point?

16           MR. PYENSON: Stephanie, on Slide 12, this  
17 relates to the question of the contribution of drugs. This  
18 is dealing with Medicare margin. That margin increase,  
19 increased revenue from Part B drugs -- and I think the text  
20 identified the hospitals are actually doing better because  
21 drug costs are going up. I wonder if I got that right or  
22 if you could elaborate on that.

1 DR. ZABINSKI: Well, it's a case of the drugs are  
2 paid -- for example, on the outpatient side, where I'm  
3 familiar with things, ASP plus 6, in general, in some  
4 cases, ASP minus 22.5. It's still profitable in case, in  
5 particular, for the 340B hospitals. I think that's what  
6 really driving that point.

7 MR. PYENSON: So are you saying hospitals do  
8 better when drug prices go higher?

9 DR. STENSLAND: I would break that down into do  
10 you do better when prices go higher if it's, A, outpatient  
11 drug or is it inpatient drug. Is it a 340B hospital or a  
12 non-340B hospital? So if it's an inpatient drug and you're  
13 not a 340B hospital -- of even if you are -- that increase  
14 in price is going to increase your costs, but it's not  
15 necessarily going to directly affect your DRG payment other  
16 than through the update.

17 On the other hand, if this is a 340B drug, so  
18 this is a Part B drug, where the price goes up, and you get  
19 that higher price from CMS, the higher price at least that  
20 you used to in the earlier days, you get the full higher  
21 price --

22 DR. CROSSON: Payment.



1 DR. STENSLAND: Payer payment, yeah. But the  
2 cost you have to pay actually goes down because what they  
3 do is they give you a discount, and then they give you  
4 another discount, an inflationary discount as the price  
5 increases.

6 So the price of the drug, the counter-intuitive  
7 thing is for the 340B drugs. The faster the industry  
8 increases the price of those things, the lower the price is  
9 that a 340B hospital has to pay to acquire them because of  
10 this dual discount.

11 DR. ZABINSKI: I'll just qualify it can happen.  
12 I mean, it's not a guarantee, but it can and often does.

13 MR. PYENSON: But I take it based on Slide 12  
14 that on average or across the entire sector that the higher  
15 prices are leading to higher margin. Am I reading that  
16 right?

17 DR. ZABINSKI: Yes. Unless Jeff wants to  
18 disagree with that, but yes.

19 DR. STENSLAND: There's a lot of complicated puts  
20 and takes here that we could go through, but the general  
21 answer is yes.

22 [Laughter.]

1 DR. ZABINSKI: I think a key here to understand  
2 that in the outpatient side, the 340B hospitals account for  
3 more than half of the drug revenue. The whole dynamic  
4 that's going on in that particular sector is really  
5 important here. It's a sector where increasing drug prices  
6 can be beneficial to the bottom line. It's really  
7 important.

8 DR. CROSSON: Pat?

9 MS. WANG: Isn't the phenomenon that you're  
10 describing also connected to hospital acquisition of  
11 physician practices and access to 340B pricing that didn't  
12 exist before? It's not purely prices are going up.  
13 They're getting more opportunity, I guess, to get whatever  
14 the delta is in the price differential that you describe.  
15 It's together, right?

16 DR. STENSLAND: Yeah. I think I would say three  
17 things. You have a growing pie of these drugs. You have a  
18 bigger share of the pie going to the hospital, as the  
19 hospital acquires oncologists or something else, and then  
20 you have the price growing. And as the price is growing,  
21 the discounts get bigger.

22 So the 340B hospitals are making a profit on

1 these drugs, and the bigger the pie grows and the bigger  
2 their share of the pie and the bigger the discount they're  
3 achieving all add up to bigger profits.

4 MS. BUTO: Lastly, Jeff, is the 22 percent  
5 reduction -- wasn't that recently litigated, and didn't the  
6 government lose?

7 DR. ZABINSKI: Yeah. Well, it was litigated. My  
8 understanding is that it's under -- well, the government  
9 lost, but then it's been appealed. So it still stands as a  
10 policy.

11 DR. STENSLAND: The important thing to remember,  
12 though, is the way the CMS did it is they said, "Okay.  
13 We're going to pay these 340B hospitals less, but then  
14 we're going to take that money and increase the rates to  
15 all outpatient services." So, on average, the hospital  
16 industry didn't lose money from that. It was mostly really  
17 a transfer of dollars from 340B hospitals to for-profit  
18 hospitals and other places that aren't 340B.

19 MS. BUTO: Trying to change that incentive, I  
20 guess, is what I'm saying at the same time, but it remains  
21 to be seen whether that's going to actually stick.

22 DR. CROSSON: Larry? Did I miss --

1 DR. PAUL GINSBURG: No.

2 DR. CROSSON: Oh, I'm sorry. Pat, I thought we  
3 had you.

4 MS. WANG: I just wanted to make sure I  
5 understand the update recommendation. Since the changes to  
6 HVIP -- so the recommendation is 2 percent the delta from  
7 current law update, .8 percent, is going to be -- the  
8 recommendation is to target it in a certain way, but you  
9 pay it. Given the time lags and the uncertainty that the  
10 Commission's HVIP proposals would actually be adopted and  
11 assuming that they don't happen in the next fiscal year, is  
12 your recommendation for the update 2 percent or 2.8  
13 percent?

14 DR. STENSLAND: Clearly, you guys could discuss  
15 it and come up with what you want, and we could say  
16 something in the text. But right now, it's written as if  
17 it's a package deal where we're saying all these things  
18 would happen together.

19 MS. WANG: Because there are two ways of looking  
20 at that. One is it's 2 percent, and then there's an extra  
21 quality bonus that is not necessary to assure the access  
22 quality, et cetera, or it's 2.8 percent, a portion of which

1 is going to be funneled and directed to provide incentives  
2 for certain quality improvements.

3 DR. CROSSON: Which is the position that we came  
4 to after two or three years of trying to figure out or  
5 trying to decide to move away from what we had traditional  
6 done, which is one update for all hospitals, based on the  
7 predicate that there were some hospitals who are more in  
8 need of the money than others.

9 As you may remember, we went through a number, a  
10 few iterations, anyway, of how we might do that, and last  
11 year, we arrived at this particular way to do that.

12 The problem is if we don't come forward with that  
13 or a similar recommendation, then we're back to the  
14 starting point, which is to say we're just going to have  
15 one update for all hospitals. So the decision here is to  
16 reiterate what we did last year, and you're absolutely  
17 right. This may not fly, but it's based on a long set of  
18 discussions we've had here at the Commission that this is  
19 something we should try to do.

20 Karen, on this?

21 DR. DeSALVO: On this point, I just had a  
22 question. The way Pat was interpreting this also that

1 there's an update, but then that's predicated on some other  
2 changes we've recommended, going back to the prior  
3 conversation about physician update, we did not include a  
4 predicate based upon our recommendation of eliminating MIPS  
5 in that.

6 DR. CROSSON: That's correct.

7 DR. DeSALVO: I just wondered, to help me  
8 understand the distinction.

9 DR. MATHEWS: For my benefit, can you repeat the  
10 question?

11 DR. DeSALVO: Yeah. One, to understand the  
12 distinction of predicating this update on a recommendation  
13 that we've made to Congress that has not been acted upon  
14 yet compared with the physician update where we did not  
15 include the change in the value-based payment  
16 recommendation of eliminating MIPS.

17 DR. PAUL GINSBURG: I think it's based on our  
18 renewal of the recommendation in a sense. Clearly, if  
19 Congress doesn't take a past recommendation, that current  
20 law is unchanged, but in the sense that this is a 2 percent  
21 update plus a recommendation to implement, to authorize the  
22 HVIP, which would bring it up to 2.8 or 3.3.

1 DR. DeSALVO: I understand. I'm just trying to  
2 understand the distinction between the uncoupling of one  
3 and the coupling of the other.

4 MS. BUTO: I can add one thought, and I don't  
5 know that this is the reason why there is a distinction,  
6 but the MIPS recommendation is something that would  
7 actually require some infrastructure to change to make that  
8 work the way we've organized it. And it's got several  
9 moving parts. I have a hard time seeing that happen in one  
10 legislative cycle.

11 I think HVIP if possible, if Congress were to  
12 enact it between now and next August when the  
13 administration would put out the proposed rule, I think,  
14 for hospitals. So that's just my thinking about it. I  
15 think it just takes longer to do the MIPS change, and we  
16 couldn't incorporate or assume that it were enacted as part  
17 of our physician --

18 DR. CROSSON: I think you're absolutely right,  
19 but to be truthful, rather than this being a conscious  
20 decision, I think it was an unconscious decision based on  
21 that subjectivity.

22 DR. DeSALVO: Can we look at that again based on

1 the prior round's conversation? I do have a question.

2 DR. SAFRAN: Could we look at it again? Now that  
3 we've called attention to it, let's convince ourselves that  
4 if we're uncoupling it one place and coupling at the other,  
5 that it's for a very good reason, not just because we  
6 didn't realize that we were doing it that way.

7 DR. CROSSON: So do you want to go back and look  
8 at the physician update recommendation? Is that what  
9 you're saying? I'm not sure what you're saying.

10 DR. SAFRAN: What I hear folks saying, what I  
11 hear Kathy saying is that the reason to uncouple it in the  
12 physician case is it would be impossible -- you didn't use  
13 that word -- to couple it because the MIPS change requires  
14 much more than the HVIP change. That's my understanding.

15 DR. CROSSON: And I think we understood at the  
16 time we made the MIPS recommendations that given all the  
17 equities that had taken place to get the bill passed and  
18 the like that it was going to take some number of years.  
19 We wished it didn't. It was going to take some number of  
20 years for folks to come to the realization that this  
21 doesn't work and needs to be replaced.

22 I don't know how long that is, but it's a



1 significant length of time.

2           But I'm trying to be frank, to be clear, and,  
3 Jim, correct me on this. I don't think we had a conscious  
4 discussion let's not consider it here and let's consider it  
5 here, but if we had, it would have been along the lines  
6 that Kathy described.

7           DR. MATHEWS: Actually, let me try and jump in  
8 here and clarify, which is always a dicey proposition  
9 whenever I start talking.

10           When we made the MIPS recommendation, it was  
11 based on the assessment by the Commission at the time that  
12 MIPS was fundamentally flawed in terms of being able to  
13 measure and either reward or penalize individual physicians  
14 on the basis of their quality performance. So we made a  
15 standalone recommendation that said MIPS should be  
16 eliminated and replaced with our, I think, VVP, if I have  
17 the acronym correct here, and we made that recommendation  
18 independent of the update.

19           With respect to hospitals, last year, we had a  
20 two-part recommendation, but -- and I'm trying to figure  
21 out how to say this. Even had we not tied the two pieces  
22 together, the update and the HVIP, we would have

1 independently recommended a change in the way hospitals'  
2 performance on quality measures was assessed and rewarded  
3 or penalized. We could have booked that in the same way we  
4 did the MIPS recommendation, but since we did that and  
5 since we are also evaluating the adequacy of Medicare  
6 payments to hospitals at the same time and, to be candid,  
7 an across-the-board recommendation sufficient to increase  
8 the efficient provider into the black was financially  
9 unsustainable, we made a decision to route certain  
10 additional dollars through the HVIP that happened to be  
11 recommended at the same time.

12           So there's a bucket. Let's put some of these  
13 dollars into that bucket, and that's kind of what we are  
14 doing here, if this makes any sense at all.

15           DR. CROSSON: So, Dana, let me get back to you,  
16 because, remember that what we say, in general, with  
17 respect to the expedited voting process is we do that if we  
18 have no objections. So if you wish, we can reverse the  
19 decision and bring this physician payment update back in  
20 January for a full discussion.

21           DR. DeSALVO: And I just -- oh, I will let you  
22 answer. I'm sorry.

1 DR. SAFRAN: What Jim just said helped me  
2 understand. You know, in this case, we are recommending an  
3 update and so we're trying to route some of that update in  
4 a certain way, and I think that's a distinction. So I'm  
5 not looking to reverse our decision on an expedited review,  
6 at least not on my account, on the physician payment  
7 update. I do think it's useful for this Commission to  
8 understand, better than it seems like some of us,  
9 definitely myself, do right now, what would be required to  
10 make the policy change that we've recommended with respect  
11 to MIPS.

12 DR. CROSSON: I think that's fair enough, and I  
13 didn't put you on the spot.

14 [Laughter.]

15 DR. CROSSON: Jon, did you want to get in?

16 DR. PERLIN: I'll wait.

17 DR. MATHEWS: I have one additional  
18 clarification. I'm sorry. So I believe Kathy's assessment  
19 is correct, that HVIP is probably more within reach, you  
20 know, administratively, regulatorily, if that's the right  
21 word, that a complete replacement for MIPS, given the fact  
22 that at least some of the measures that we've posited for

1 the HVIP are measures that are currently in place for the  
2 readmissions reduction program, hospital VBP. Hospitals  
3 are, indeed, accustomed to being assessed on an individual  
4 basis, and if it's one bucket of measures this year and,  
5 you know, 75 percent of those measures the second year,  
6 along with a couple of new ones, it's not a radical shift  
7 in what's happening.

8 DR. CROSSON: You okay?

9 DR. DeSALVO: Yeah. I'll be okay with this. I  
10 feel like the physician update is predicated on reality and  
11 what we think is going to be happening, and so we made a  
12 decision that there is going to be some increase anyway of  
13 physicians that are part of value-based care, and that's  
14 why zero was factored into it. I think in this case it's  
15 predicated on the expectation that hospitals will move more  
16 towards value, and I completely endorse that concept. So  
17 I'm okay. I just wanted to understand so that I could  
18 explain it.

19 DR. CROSSON: No, you helped us all understand.

20 DR. DeSALVO: Okay. Can I ask a question? Am I  
21 in the queue?

22 DR. CROSSON: Where are we?

1 DR. DeSALVO: Separate topic. No?

2 DR. CROSSON: Did Larry already go?

3 DR. DeSALVO: So is this a question or are you  
4 trying to push the second round? Okay. Go ahead.

5 DR. CASALINO: I've actually forgotten, we're  
6 still in the first round.

7 [Laughter.]

8 DR. CROSSON: I'm having a little trouble myself.

9 DR. CASALINO: Let me see if I can fit this into  
10 the first round. I think I can, actually. So probably any  
11 of us could do that with anything, and I won't name names.

12 But I guess one thing, have you thought about, in  
13 the discussion of relatively efficient hospitals, it's  
14 important, I think, but it could lead to some problems.  
15 One of the biggest problems with dealing with the hospital  
16 sector, I think, is that there are usually haves and have-  
17 nots, and it's not clear that we want the have-nots to  
18 disappear, and it is not even clear that for a lot of have-  
19 nots that it's their fault that they are have-nots, that  
20 they're poorly managed or whatever. So I'm not saying  
21 anything that isn't already now.

22 But when we talk about relatively efficient --

1 when you guys, if I interpreted what you wrote correctly,  
2 talking about relatively efficient hospitals, didn't so  
3 much take that into account. So for the proposed hospital  
4 value-based purchasing, whatever, you know, it's supposed  
5 to be done in strata, right. But as far as I can  
6 understand, and this is, I guess my question, I don't think  
7 you were evaluating relatively efficient hospitals in  
8 strata.

9           So on page 44 of the written materials you say,  
10 well, the relatively efficient hospitals tend to be large  
11 nonprofits, because they do well on quality measures, and  
12 then there are some other categories, and looking at the  
13 appendix, too, of something in 2016, which only extremely  
14 motivated the vehicle. Brian probably already did it.

15           But what would you think about there being more  
16 attention to, first of all, highlighting more in the  
17 chapter, not just saying referring to the bench, but what  
18 are the characteristics of relatively efficient? So we  
19 found that the relatively inefficient, say, tend to have a  
20 poor payer mix, for example, and on top of that, even a  
21 worse socioeconomic mix. That would be significant.

22           And so I wonder if it makes sense, in thinking

1 about relatively efficient hospitals, first of all, making  
2 their characteristics more up front in the chapter, but  
3 secondly, thinking about that in strata and not just  
4 overall.

5 DR. STENSLAND: We could add something in there  
6 to show that there is this diversity of hospitals, maybe  
7 the DSH shares of the relatively efficient versus not  
8 relatively efficient. Maybe that might add a little  
9 comfort in there.

10 I think our method of looking at the relatively  
11 efficient is not a perfect method, and our objective wasn't  
12 to get all the relatively efficient in there. It was to  
13 let's at least get a subset of these things that look  
14 relatively efficient. And so there are certain screens we  
15 go through.

16 And one screen we have in there is, well, what if  
17 you really are kind of cherry-picking your patients, maybe  
18 because they're the easy patients or maybe there are  
19 socioeconomic things. We don't have so much data on who  
20 the easy patients are, but we did throw out everybody that  
21 had really low Medicaid shares. So, in essence, there is a  
22 lot of physician-owned hospitals that would get thrown out,

1 because you just don't treat a lot of Medicaid patients.

2           The other thing we do is when we standardize our  
3 costs we include in there to what share you have more DSH  
4 patients, so that should affect your cost to some degree.  
5 So it's in there to some degree, and I think we can go  
6 through then and maybe explain the outcomes of that, that  
7 might help people be a little more comfortable.

8           DR. CASALINO: I think that would be good, and I  
9 don't want to generate another month of work that might not  
10 be that valuable, but it would be interesting to know  
11 within each stratum what are the characteristics of the  
12 efficient hospitals and the less-efficient ones.

13           DR. CROSSON: Okay. Karen, do you have the last  
14 question?

15           DR. DeSALVO: It's about the hospital closures,  
16 and I'll try to be brief, and you all can be brief in your  
17 responses. Given the importance of that as maybe a leading  
18 indicator, of are we appropriately paying, getting access,  
19 I just want to understand a couple of things. Great  
20 treatment in the paper, but do we know about payer mix, and  
21 related to that, do we know whether uncompensated care is a  
22 driver for some of the closures? So the back way I might



1 want to know about that is do we know the states where  
2 those 70 hospitals closed, even pulling out the bad actor  
3 hospitals, to get a feeling for whether this is a Medicare  
4 issue or whether this relates to a broader payer mix  
5 challenge that may be beyond our control?

6 MS. BINKOWSKI: I think, as you noted, there are  
7 many factors that contributed to these increase in  
8 closures, and I'd say most, if not all of them, are beyond  
9 the scope of Medicare. There is, you know, excess  
10 inpatient capacity in many markets and kind of decrease in  
11 inpatient volume for multiple reasons. It is not Medicare  
12 specific. We did look at the results by geography and by  
13 whether states had expanded Medicaid or not, and found a  
14 disproportionate share of the closures were in states that  
15 had not expanded Medicaid. There is more. I could go on,  
16 but that's the short answer to your question.

17 DR. DeSALVO: Thank you very much. And very  
18 quick follow-up, if a rural hospital converts to  
19 outpatient, is that considered a closure, or is that still  
20 treated as an open hospital?

21 MS. BINKOWSKI: So, yeah, for the purposes of the  
22 paper, a closure was a cessation of inpatient services to

1 Medicare beneficiaries. As we do note, many of the  
2 facilities did convert to outpatient facilities, and some  
3 also specialized into other types of inpatient facilities,  
4 like long-term care psychiatric. So I'd say roughly half  
5 of the closures still have some services remaining at the  
6 site.

7 DR. DeSALVO: That's really helpful. Thank you.

8 DR. CROSSON: Okay. So we've actually had a  
9 fairly substantial discussion already, so I'm thinking  
10 we're moving from round 1.5 to round 2. So if you could  
11 put up Slide 20, Stephanie. And so we'll have a discussion  
12 on support or lack of support for the recommendation,  
13 starting with Jon.

14 DR. PERLIN: Thanks. I'm generally supportive.  
15 I just have that nagging question, what's our fallback if,  
16 on the off chance Congress doesn't enact, you know, within  
17 the next six months. Just kind of busy in the political  
18 season so I'm a little skeptical there. With that in mind,  
19 if there were a caveat that said, you know, in the absence  
20 of that full date, then I think that's rational.

21 I would also -- I'm a little less sanguine that  
22 everything is completely buttoned down in the measurement

1 space for hospitals. For example, our recommendations, as  
2 I recall them, for the HVIP, was readmission, mortality,  
3 spending, and spending experience. And, you know, the  
4 readmission is fraught. I mentioned the Health Affairs  
5 article of July that demonstrated that change actually  
6 occurred before the measure went into place. And  
7 notwithstanding that, you know, the current, the updated  
8 star ratings, for example, that used the readmission-drawn  
9 data from 3Q15 to 2Q18. So you're talking about four years  
10 in arrears. So that's -- that are obsolete, to some  
11 degree.

12           The other is that because for that and for some  
13 of the safety measures, these are relatively low-frequency  
14 events, we aggregate a bunch of quarters to try to predict  
15 what's going to happen in a particular quarter, or  
16 aggregate a bunch of years to try to predict what's going  
17 to happen in a particular year.

18           And so I think we have a responsibility to  
19 recommend these elements, which, in and of themselves, are  
20 not objectionable, that we have the appropriate methodology  
21 in place so that it's actually predictive and we can make  
22 accurate assessments about quality and value. And, you

1 know, certain things are just, I think, incontrovertible  
2 that they are important, like mortality. So that's my  
3 recommended modification there.

4 I would, second, identify with the implication of  
5 Larry's comments, that, you know, there may be unintended  
6 consequences, you know, if we don't understand -- if we  
7 think it's going to sort of sort toward most efficient, the  
8 characteristics that exacerbate the reasons why less  
9 efficient are less efficient on that basis.

10 And finally, just a comment that, you know,  
11 marginal profits or contribution marginal ultimately is a  
12 reduction in the net losses, but the overall picture is  
13 that the hospitals are experiencing net losses on these  
14 patients, and the overall picture also demonstrates that,  
15 you know, a third of American hospitals have negative  
16 operating margins, a third are basically close to the  
17 margin of being in violation of their bond covenant, -2 to  
18 +2 percent, and then another third above that. So I just  
19 think that overall context is worthwhile.

20 So, you know, summarizing my recommendation is if  
21 we have a proviso that if this is not enacted and we don't  
22 have the HVIPs ironed out and we can go to the update, I'm

1 all in. Thanks.

2 DR. CROSSON: So let me just be clear what you're  
3 saying. You would say that our recommendation should be 2  
4 percent and then 0.8 percent, but if Congress didn't enact  
5 the 0.8 percent then the recommendation would be 2.8  
6 anyway?

7 DR. PERLIN: [Off microphone.]

8 DR. CROSSON: Yeah. I mean, I understand the  
9 position. I think part of the issue there would be by  
10 making the recommendation in the way we've had it, it then  
11 becomes, hopefully, incumbent on the industry to argue in  
12 favor of this, and increases the likelihood that the  
13 Congress would then act. If, in fact, we say, well, if you  
14 don't do it then it goes to 2.8 anyway, one concern I would  
15 have with that is that it would decrease the likelihood  
16 that the policy objective we have that formed the  
17 recommendation this way would be less likely to be  
18 achieved.

19 DR. MATHEWS: To put that differently, if the  
20 Congress does not act on this recommendation, current law,  
21 full market basket is indeed the update that will pertain.

22 DR. CROSSON: Okay. I had Warren next and then

1 Amol and Bruce.

2 MR. THOMAS: So this is my sixth payment update  
3 meeting, and last. So just a couple of comments, you know,  
4 broadly. I think the recommendation should be modified to  
5 be a full update, and I think if you just look at the  
6 summary that we've been given that a projected margin, you  
7 know, just going across the board, goes from 12.6 to 3.7 to  
8 12.7 to 17 percent to 2.4 in the various disciplines to, we  
9 heard the ASC maybe 20, 30, 40 percent, and then we're at -  
10 8 projected

11 So you just look at that and you're like, well,  
12 does that really make a lot of sense, as we kind of look at  
13 the broad spectrum. And then we have the comment, well,  
14 but hospitals are doing okay if you look at the overall  
15 margin. They've got access to capital. All the  
16 disciplines have access to capital. All of these  
17 organizations can grow. All of them are growing, for the  
18 most part. There's not a lot of closures of ASCs. You  
19 don't see a lot of ASC closures.

20 So I think the question I would ask us is why  
21 wouldn't we have a full update and then, you know, give  
22 efficient hospitals an opportunity to do better? Even

1 efficient hospitals, which there are 266 identified out of  
2 4,700, are running a negative margin, with 10 percent  
3 better mortality, or 9 percent better cost structure.

4           And then I think we sit here and we talk about,  
5 well, hospitals are doing, you know, this with drugs and  
6 consolidating and physicians and all that. Well, they're  
7 doing it because they're running a 9 percent negative  
8 margin on Medicare, which is the largest payer, generally,  
9 and it is increasing every day as people age from  
10 commercial into Medicare. So I think we sit here and we  
11 wonder like why are they doing these things? They're doing  
12 it to be sustainable. And if we don't like Part B drugs  
13 then let's put an inflator on it. Let's put an inflator  
14 cap on Part B drugs so they can't basically make more  
15 dollars on Part B drugs, which I think hospitals probably  
16 would not argue with an inflator cap on drug pricing,  
17 especially as it relates to inpatient, because I think it  
18 would help the cost structure.

19           So I would just ask us to maybe step back, and  
20 instead of getting all mired in every single detail, step  
21 back and just say the broad picture here is this doesn't  
22 make a lot of sense of how we're approaching it. We also

1 haven't put in here margins on other ancillary  
2 organizations out there, like PBMs and pharma companies,  
3 which are running significantly higher positive margins,  
4 and basically benefit from what's going on in the industry.

5           So, you know, I just -- just stepping back, and  
6 it isn't because I'm in the industry. It's really if you  
7 just look at the facts, the facts kind of speak for  
8 themselves as to kind of what's happening here.

9           So I would encourage us to think about a full  
10 update, see if we can start to blunt this trend. I mean,  
11 it looks like we've blunted it a little bit. And let's  
12 give upside for improved quality. And I think, Jay, going  
13 to your point, which I agree with you that if you just kind  
14 of have the caveat that they get the increase anyway, make  
15 it upside. I mean, for the organizations that do a great  
16 job from a quality perspective, give them, you know, the  
17 benefit from an upside perspective, or give them a benefit  
18 for being in, you know, advanced payment models and trying  
19 to take risk and trying to do a better job managing total  
20 cost of care. I mean, let's try to incent organizations,  
21 go that way.

22           But, you know, the numbers speak for themselves



1 on the results, and I think that if we want to exacerbate,  
2 you know, continued consolidation of physicians, continued  
3 consolidation in the industry, then we just should keep,  
4 you know, limiting the update factor and the industry will  
5 adjust to be sustainable. That's what will happen, because  
6 it has to.

7 DR. CASALINO: On this point, just very briefly?

8 DR. CROSSON: Yeah.

9 DR. CASALINO: I'm sympathetic to where you stand  
10 but I do have one question for you. Do you think if  
11 hospitals had more money they would say, okay, we're going  
12 to stop buying physician practices?

13 MR. THOMAS: No. I think what would happen --

14 DR. CASALINO: Because I'm not sure that's the  
15 case.

16 MR. THOMAS: -- no, but I think what would happen  
17 is, what you have right now is, I mean, that becomes part  
18 of the sustainability and you have a cost shift to  
19 commercial. I mean, basically that's what we saw in the  
20 physician practices, that's what we see in hospitals, is  
21 there is a cost shift to commercial. Well, that's going to  
22 continue to be limited because less people are in

1 commercial. That shrinks every single day as people age in  
2 to Medicare.

3           So it's going to create more pressure to do  
4 different things. I think it may make some organizations  
5 that are, you know, going to Jonathan's point, that are on  
6 the cusp, make them sustainable. But I do think these  
7 other issues we're talking about around Part B drugs and  
8 that sort of thing, I mean, I think we should take a harder  
9 line there on making sure there are caps so that those  
10 prices don't go up. I think that's a great idea.

11           But, you know, I think it will blunt the cost  
12 shift, definitely, I think, if we -- or will exacerbate it  
13 by kind of going in this direction. So I'm just looking at  
14 the overall, you know, impact, and you could say that to  
15 any other piece of the industry. You know, do you think  
16 it's, you know, going to stop rehabilitation if we, you  
17 know, make a certain change or don't? If we give 2.4  
18 percent to dialysis will that change dialysis  
19 consolidation? Probably not. So I think we've got to look  
20 at, you know, broader ways to move to a global payment  
21 model and get out of fee-for-service, understanding that  
22 right now we're talking about fee-for-service payments.

1           And Brian gave me a good lesson on this. He's  
2 like, you know, we've got to deal with fee-for-service  
3 while we're building the new model, and I get that. But  
4 the only way we're going to blunt costs, I believe, over  
5 time, is go to a global model where the providers are  
6 absolutely, 100 percent incented to do the best job taking  
7 care of patients in the most cost-effective way, and this  
8 is not the model to do that, unfortunately. But it's what  
9 we are talking about right now.

10           DR. CROSSON: Well, I can't argue with the last  
11 point there, but just to be clear, Warner, you're not in  
12 support of the current recommendation. You would offer a  
13 different recommendation, which would be 2.8 percent plus -  
14 - and here I'm putting words in your mouth -- plus the  
15 additional part of our recommendation, which would be 0.8  
16 percent.

17           MR. THOMAS: Or a portion of it. A portion of a  
18 quality incentive program. It may not be 0.8 percent. It  
19 might be some other piece of dollars. But for  
20 organizations that can be high-performing or perform a  
21 certain way from a quality perspective, I think getting  
22 back trying to blunt this change, and if you look at the

1 cost information here, the biggest piece of the cost -- I  
2 mean, the biggest one is labor. That is in here at -- I  
3 think it was about 3 percent, but I do think labor cost is  
4 escalating a lot more than 3 percent in most markets, and  
5 it is generally the largest single expenditure in a  
6 hospital. I don't see any change in the labor market over  
7 the next several years, so I think that's just -- I mean,  
8 that's a big input cost, that and drugs are big input costs  
9 to what happens in this industry.

10 DR. CROSSON: Paul, on this?

11 DR. PAUL GINSBURG: Yeah, I was just going to ask  
12 you to clarify, Warner. What I thought you were going to  
13 say, but it is not what you said, is in a sense, you know,  
14 we support this HVIP, you know, 2 percent plus the extra  
15 money in HVIP. If the Congress does not see fit to enact  
16 the HVIP, we support the full update. That's what I  
17 thought you were going to say, but I don't think that's the  
18 way it came out.

19 MR. THOMAS: No, that's not what I said, and  
20 actually part of it related back to what Jay and Jim were  
21 saying, that, you know, I think you want the hospital  
22 industry pushing to create the right incentive program, and

1 I think HVIP is -- although there's a lot of details that  
2 need to be worked out with it, I think it's a good program.

3 My confidence level that that is going to get  
4 adopted over the next years, though, is essentially zero.  
5 So I think that we need to be mindful of that as we look at  
6 what the recommendation is around an increase. That's part  
7 of why I modified what I think would make sense.

8 DR. PERLIN: I think there's another aspect --  
9 Bruce, I remember you and I had some conversation about  
10 this -- which is how will HVIP -- assume the unlikely, that  
11 it actually gets enacted. How will it behave as a  
12 conglomerate and aggregate set of measures I don't believe  
13 is entirely predictable. I've seen this, you know, time  
14 after time in relationships from measure sets from  
15 commercial payers and even CMS, certainly the ONC, the e-  
16 clinical quality measures. And so we've described the  
17 elements of what might go into a measure. We've identified  
18 some of the limitations of some of those elements  
19 inherently, and we're betting on something that's not only  
20 enacted but structurally and scientifically sound in this  
21 period of time. And I think that's something we just  
22 should take some caution on. And what I think amplifies

1 the wisdom of Warner's point is the ability to test that  
2 sort of notion over that period of time and actually  
3 provide something more structurally and methodologically  
4 sound for Congress to contemplate.

5 DR. CROSSON: Okay. Amol.

6 DR. NAVATHE: Thank you. So, first, let me just  
7 say that I generally support the recommendations. I have  
8 some additional thoughts that perhaps we could think about.

9 I think there is some wisdom in the idea of  
10 following the data, and I have a couple of explicit points  
11 to make there. I also think there's a challenge here. I  
12 think I'm sympathetic to the complexity of many different  
13 pieces. One is that there's variation on all hospitals are  
14 created equal. We have to worry about access. I think  
15 also by looking at these payment updates by each specific  
16 provider group, effectively we sometimes lose the forest  
17 for the trees, and there's a lot of interactions and  
18 downstream potential consequences. And where I'm going  
19 with this in some sense is that if we do follow data and  
20 look, I think one of the pieces you highlighted on Slide 4,  
21 I think we saw as part of some of the earlier work around  
22 the IME, DME, kind of IME payment pieces, that a lot of

1 care is shifting from inpatient to outpatient, right? And  
2 what I see this recommendation as in some sense is largely,  
3 especially if you take Jon's kind of modification, which is  
4 we keep the 2.8 percent if HVIP doesn't come about, is kind  
5 of keeping the status quo to a certain extent. And the  
6 status quo is there is some incentive for hospitals to  
7 repurpose effectively towards outpatient services. But a  
8 question that we could ask, especially as we think about  
9 the taxpayer dollar and the Medicare beneficiary, is:  
10 Should we actually be doing more to try to push the agenda  
11 of debedding in some sense or repurposing these beds.  
12 Maybe "debedding" is too strong. We seem to have excess  
13 inpatient capacity that could be shifted towards outpatient  
14 services. Right now our recommendation is something that  
15 is kind of across the board, IPPS and OPSS. We could  
16 actually make a recommendation that's more pushing towards  
17 outpatient services.

18           The reason that I think it needs more work before  
19 we could get there is then we have to think about the other  
20 complexities of HOPD and the other pieces that potentially  
21 aren't sort of stimulating the right incentives  
22 necessarily. But I think that's a question that I asked

1 myself. As we think about this, if we do follow the data,  
2 I agree with some of Warner's comments. At the same time,  
3 I think that there is a shift towards outpatient care, and  
4 so should we really be thinking about IPPS, OPPI,   
5 inpatient, outpatient, in the context of acute hospitals  
6 differently? And maybe that requires a little bit more  
7 work, but that might be more reflective of the direction  
8 that the Medicare program from a taxpayer accountability  
9 perspective really should go.

10 DR. CROSSON: I agree with the point that you're  
11 making. This is the problem with having been around here a  
12 long time. I have a tendency to preface things like,  
13 "Well, you know, the last time we talked about it..."

14 [Laughter.]

15 DR. CROSSON: But the issue of, you know, why  
16 we're doing a combined IPPS and outpatient at the same time  
17 has come up before, and I'd ask actually Jim and Jeff maybe  
18 to answer this, make sure I'm still correct. But it has  
19 been difficult to conceive of doing them separately, and I  
20 know that's not exactly what you're saying, but because  
21 they're too intertwined and there's too much ability to  
22 move costs from one bucket to the other. Is that still how



1 we think about this? Fixed costs, particularly.

2 DR. STENSLAND: I think there is a little bit of  
3 cost uncertainty there. In general, I think if we went  
4 into this, it would have to be a next cycle issue, because  
5 I think there would be some serious issues we would start  
6 having to contemplate. As Amol kind of obliquely hinted  
7 at, this would exacerbate the differential between the  
8 physician office and the HOPD, and we'd have to know, okay,  
9 is that what we want to do? And what are kind of the  
10 secondary and third effects of that?

11 So, if anything, I would maybe table this for a  
12 later time.

13 DR. CROSSON: And I think that's your intention.

14 DR. NAVATHE: My intention is not to say that  
15 this needs to exist for the January vote per se, but to tee  
16 this up that I think if we're thinking about payment  
17 updates and we're viewing them in a very siloed way, then  
18 we're missing the forest for the trees, and I would argue  
19 that we need to do exactly what you're saying. Maybe it's  
20 not going to happen this cycle, but then we should do it  
21 for next cycle and we should start to think that way.

22 DR. CROSSON: So we will examine this again

1 because maybe what I said is dated or needs  
2 reconsideration. Kathy.

3 MS. BUTO: I just want to, on this point, mention  
4 that these inpatient and outpatient are not similar buckets  
5 at all. So inpatient is an entirely bundled per admission  
6 payment, and outpatient is more like a fee schedule. And  
7 so to think about just increasing the update factor, say,  
8 more favorably to outpatient has a whole bunch of  
9 downstream effects that need to be thought of. And I think  
10 earlier today we talked about ASCs, OPDs, and physician  
11 offices. So if we're going to look at that -- I think Jay  
12 was alluding to this -- we really need to look at that  
13 bucket as well.

14 But I'd be very careful about thinking if you  
15 just move the update factor more favorably to outpatient,  
16 you're going to induce the right kind of utilization. I'm  
17 not at all convinced of that. So I'd be really careful  
18 there.

19 DR. NAVATHE: So I agree with you. I am not  
20 trying -- my intent is not to oversimplify the issue and  
21 say we should simply do that. It's to highlight, however,  
22 that I think it's an issue in the coordination of the

1 updates together. And the point that you're making, which  
2 is that if we made an OPPS adjustment, it would end up  
3 having these interactions. I agree, but I will posit that  
4 saying that it's -- that making an adjustment would have  
5 downstream effects that we're not sure about and so we  
6 shouldn't consider it in my view is not the right way to  
7 view it, because doing it the way we're doing it now still  
8 have the same downstream effects and the same interactions  
9 as you're describing. We're just looking at them in a sort  
10 of siloed fashion. So I would --

11 MS. BUTO: Let me just say I wouldn't want to  
12 induce inappropriate outpatient hospital use because  
13 hospitals find it's more advantageous to do that, when the  
14 appropriate placement would be inpatient. So I'm just  
15 saying there is that issue --

16 DR. NAVATHE: I don't disagree with that, but I  
17 think our prevailing system still has incentives, so --

18 DR. CROSSON: Let's not try to litigate it right  
19 now.

20 DR. NAVATHE: Yeah.

21 DR. CROSSON: We've identified it as something  
22 for future work. Last comment, Bruce.

1           MR. PYENSON: I'm generally in support of the  
2 recommendations, but I recall last year we had a rather  
3 heated set of discussions perhaps because the margins that  
4 were reported last year were worse than this year, and I  
5 think we got some advice from Jeff and Dan, well, don't  
6 worry too much about a one-year change. And so the margins  
7 have increased. We've identified sources of where  
8 hospitals, at least the industry in aggregate is doing  
9 better than we thought they were going to do, partly I  
10 think the materials identify some costs that update factors  
11 for case mix and things like that that were more than  
12 expected. So the hospitals did better than expected.

13           So I would say if we were happy last year with  
14 the 2 percent plus, this year we should probably be happy  
15 with a 1 or 1.5 percent plus the hospital value program.  
16 But then I recall the advice of staff, don't worry about  
17 fluctuations too much, but I would raise that as an issue  
18 just from a consistency standpoint with where we were a  
19 year ago, how the hospital industry appears to be better  
20 off than we would have thought.

21           DR. CROSSON: Okay. Good discussion. Long  
22 discussion. We do not have consensus at the moment, so we

1 will be bringing this back for discussion in full -- sorry?

2 MR. PYENSON: Are you sure? I mean, I know  
3 there's discussion, but is there anyone that wants to bring  
4 this back?

5 DR. CROSSON: Well, we have a proposal from  
6 Warner for a different update. Jon has a proposal --

7 PARTICIPANT: [off microphone] Warner's proposal.  
8 [Laughter.]

9 DR. CROSSON: Yeah, I mean, Jon -- I think Jim  
10 made a good point, which is your proposal is sort of moot  
11 anyway because that's what would happen. But we could  
12 discuss it more. But, no, we have another member -- the  
13 way we do this is we either have unanimity or we don't.  
14 And we have another proposal on the table, so we'll model  
15 both proposals, both in terms of their -- whatever --  
16 economic impact, probity, and we'll come back, and we will  
17 discuss more than one option in January, and we'll proceed  
18 to vote in January on that basis.

19 Okay. So we now have an opportunity for public  
20 comment. If there are any members of the public here or  
21 guests who would like to make a comment, please come to the  
22 microphone.

1 [No response.]

2 DR. CROSSON: Seeing none, we are adjourned for  
3 lunch or whatever until 1:30.

4 [Whereupon, at 12:37 p.m., the meeting was  
5 recessed, to reconvene at 1:30 p.m. this same day.]

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AFTERNOON SESSION

[1:35 p.m.]

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DR. CROSSON: Okay. I think we can start. Good afternoon, everybody. We welcome our guests to the afternoon session. This is a continuation of the work of this morning and what will go on tomorrow morning, which is a discussion of recommended updates for the fiscal year 2021 and each of the -- or most of, anyway, the parts of the Medicare program.

We're going to start with the skilled nursing facilities, and Carol is here to take us through that.

DR. CARTER: Good afternoon, everyone.

Before I get started, I wanted to thank Carolyn Sans Soucie for her help with this chapter.

Here's an overview of the SNF industry. In 2018, there were about 15,000 providers, and most of them also provided long-term care services.

About 1.5 million beneficiaries, or about 4 percent of fee-for-service beneficiaries, used SNF services in 2018.

Program spending totaled \$28.5 billion.

Medicare makes up a small share of most nursing facilities' volume and revenues, about 10 percent of days

1 and about 18 percent of revenues. Both of these have  
2 declined in recent years in large part due to the expanded  
3 enrollment of beneficiaries into Medicare Advantage plans.

4 To update you on where things stand regarding a  
5 revised SNF prospective payment system, CMS implemented a  
6 new PPS in October. As background, historically, the SNF  
7 PPS had included incentives for providers to furnish  
8 therapy and to avoid medically complex patients, such as  
9 those with high drug costs, because it was more profitable  
10 to do so. The Commission recommended that the PPS be  
11 redesigned in 2008 and reiterated this recommendation each  
12 year after that.

13 The redesign bases payments on patient  
14 characteristics, such as comorbidities, functional status,  
15 and cognitive impairment, and not on the provision of  
16 rehabilitation therapy. The design and its estimated  
17 impacts are consistent with the Commission's  
18 recommendation. CMS estimates that the new design will  
19 redistribute payments from high-therapy patients to  
20 medically complex patients. CMS noted that the redesign  
21 will bring the SNF PPS closer to an eventual PAC PPS.

22 The data presented here and in the chapter do not



1 reflect the new payment system.

2           Consistent with MedPAC's common payment adequacy  
3 framework, we'll assess the adequacy of SNF payments by  
4 looking at four categories of payment adequacy factors,  
5 including beneficiary access to care, such as supply and  
6 volume of services. Then we'll look at indicators of  
7 quality of SNF care. Then we'll look at SNFs' access to  
8 capital, and last, we'll examine Medicare's payments and  
9 costs, including actual and projected Medicare margins.

10           Based on these indicators, we will present the  
11 Chairman's draft update recommendation.

12           Regarding access, our assessment is that access  
13 is adequate. Supply was stable, with less than 1 percent  
14 of facilities terminating their participation in the  
15 Medicare program.

16           Eighty-eight percent of beneficiaries lived in  
17 counties with at least three SNFs, and another 11 percent  
18 lived in counties with one or two facilities.

19           Occupancy rates were down slightly but remained  
20 high, at 84 percent.

21           Between 2017 and 2018, covered admissions per  
22 1,000 fee-for-service beneficiaries decreased over 3

1 percent, consistent with a decline in inpatient hospital  
2 stays that were three days or longer, which is a  
3 requirement for Medicare coverage.

4 SNF stays were shorter. So total days declined  
5 almost 4 percent.

6 These changes are also consistent with the  
7 expanded participation in alternative payment models such  
8 as BPCI, CJR, and ACOs. The decline in service use are not  
9 a signal about the adequacy of Medicare's payments.

10 The marginal profit, a measure of whether  
11 providers have an incentive to treat Medicare  
12 beneficiaries, was very high, about 18 percent, and we see  
13 that as another positive indicator of patient access.

14 Turning to quality, the Commission tracks three  
15 groups of risk-adjusted quality measures: discharge to the  
16 community; potentially avoidable readmissions, both during  
17 and after the SNF stay; and changes in function.

18 Because the function measures are provider-  
19 reported, the Commission is concerned that the information  
20 may not be reliable, as we reported in our June 2019  
21 report. I've not included the function information here,  
22 but it is in the chapter.

1           Changes in the claims-based measures between 2012  
2 and 2018 are shown here, with discharge to community on the  
3 left, readmissions during the stay in the middle, and  
4 readmissions in the 30 days after discharge on the right.  
5 All rates are risk adjusted.

6           I'll focus on the changes between '17 and '18  
7 since these are the most relevant to the update discussion.  
8 All three measures improved. The average rate of discharge  
9 to community increased, and both average readmission rates  
10 decreased.

11           Material in the chapter shows that the variation  
12 in these three rates were substantial and suggests plenty  
13 of room for improvement.

14           Turning to access to capital, because the vast  
15 majority of SNFs are also nursing homes, we assess the  
16 adequacy of capital to nursing homes. Industry analysts  
17 report that capital is adequate and expected to remain so  
18 in 2020. Buyer demand remains strong, fueled by aging  
19 demographics and the lower costs of this setting compared  
20 with other institutional PAC.

21           The transactions reflect several trends. Many  
22 included facilities owned by large entities, such as real

1 estate investment trusts that were right-sizing their  
2 portfolios to select markets, leaving those properties to  
3 be picked up by smaller, often regional operators.

4 Other transactions involved solo operators and  
5 very small chains that lacked the economies of scale or  
6 organizational backing to deal with a more complex  
7 operating environment.

8 Some were the result of facilities with high  
9 Medicaid volume and low Medicaid rates.

10 There is some lender wariness, and it reflects  
11 three factors. First, their low total margins; that is,  
12 the margin across all payers and all lines of business.  
13 And it was modestly negative, negative 0.3 percent in 2018.  
14 Second, SNF use is declining, and third, the growing share  
15 of nursing facility revenues from lower-paying payers,  
16 including Medicaid and MA plans.

17 We expect all of these trends to continue. But  
18 investor reluctance does not reflect the adequacy of  
19 Medicare's payments. Medicare continues to be a payer of  
20 choice.

21 We report freestanding margins, and freestanding  
22 facilities make up about 96 percent of the industry. In

1 2018, the average margin was 10.3 percent, and that's the  
2 19th year in a row that the margin was above 10 percent.  
3 These margins illustrate why Medicare is a preferred payer.

4           Across facilities, margins varied substantially.  
5 One quarter of SNFs had margins of negative 0.7 percent or  
6 lower, and one quarter had margins of at least 19.7  
7 percent. There continues to be more than a 10-percentage-  
8 point difference in Medicare margins between nonprofits and  
9 for-profits.

10           Variations in Medicare margins reflect several  
11 factors, including differences in case mix and therapy  
12 practices and differences in economies of scale. Nonprofit  
13 facilities are typically smaller, and they have higher  
14 average costs per day.

15           Also, facilities differed in their cost growth.  
16 For the past several years, nonprofits have had higher cost  
17 growth compared with for-profit SNFs.

18           As required by law, we consider the costs  
19 associated and the margins associated with efficient  
20 providers. To understand differences in performance and  
21 the level of Medicare's payments, we identify a relatively  
22 efficient set of providers and compare them to other SNFs.

1 Efficient providers are those that perform relatively well  
2 on both cost and quality measures for three years in a row,  
3 and then we look at their performance in the next year, and  
4 this year will be 2018.

5           The metrics we are looking at are standardized  
6 cost per day, rates of readmission during the SNF stay, and  
7 rates of discharge to community. In 2018, 959, or about 8  
8 percent of the industry, were relatively efficient.

9           Compared to other SNFs, relatively efficient  
10 providers had better outcomes--higher community discharge  
11 rates and lower readmission rates. Because relatively  
12 efficient SNFs were typically larger and had higher daily  
13 census, they achieved greater economies of scale. As a  
14 result, their standardized costs were 8 percent lower than  
15 other SNFs, and on the revenue side, their revenues per day  
16 were 10 percent higher, in part reflecting their higher  
17 share of the most intensive therapy case-mix days, which  
18 are the highest paying. The combination of lower costs and  
19 higher revenues per day resulted in a median Medicare  
20 margin of 16.9 percent, an indication that Medicare's  
21 payments are too high relative to the cost to treat  
22 beneficiaries.

1           We also look at payment rates that some MA plans  
2 pay for SNF care. In three publicly traded companies that  
3 own SNFs, fee-for-service payment rates averaged 21 percent  
4 higher than MA payment rates.

5           In a different survey of almost 1,400 SNFs  
6 conducted by the National Investment Center for Senior  
7 Housing and Care, they found that fee-for-service payments  
8 were 22 percent higher than MA rates.

9           Our analysis of the characteristics comparing  
10 beneficiaries enrolled in MA and fee-for-service found that  
11 there are differences between the two sets of  
12 beneficiaries, but they would not explain these large  
13 differences in payments.

14           Finally, the publicly traded PAC companies with  
15 SNF holdings also report seeking managed care business,  
16 suggesting that the lower MA rates are attractive.

17           To estimate the Medicare margins in 2020, we  
18 project costs and payments from 2018 to 2020. On the cost  
19 side, we increased 2018 costs to 2020 by the five-year  
20 average cost growth. We also reduced costs in 2020 by  
21 CMS's estimate of lower provider costs that result from  
22 fewer reporting requirements in the new revised payment

1 system.

2 To project revenues, we updated 2018 revenues to  
3 2020 using the mandated updates. In 2019, we also lowered  
4 the payments by the share of the value-based purchasing  
5 withhold that was retained by the program, and our  
6 projected margin for 2020 is 10 percent.

7 In summary, our indicators are positive.  
8 Beneficiaries appear to have access to services. Supply  
9 was stable, and the volume declines paralleled the changes  
10 in inpatient hospital care. The marginal profit was high.

11 With regards to quality of care, all of the  
12 indicators are moving in the right direction, with all  
13 three measures improving.

14 SNFs have adequate access to capital, and this is  
15 expected to continue. The total margin reflects low  
16 payments from other payers.

17 Medicare margins are high and are expected to  
18 remain so in 2020. The Medicare margin for the efficient  
19 provider is very high, indicating that Medicare's payments  
20 are too high.

21 In considering how payments should change for  
22 2021, the summary indicators are positive. The wide



1 variation in Medicare margins reflect differences in  
2 patient selection, service provision, cost structures, and  
3 cost control. The projected margin in 2020 is expected to  
4 remain high.

5           The recently implemented changes to the payment  
6 system will likely change providers' cost structures, case  
7 mix, and service provision.

8           CMS plans to monitor a variety of trends to  
9 ensure that changes in provider behavior appear  
10 appropriate. We also plan to monitor provider responses  
11 and will report on these at a future meeting.

12           This brings us to the Chairman's draft  
13 recommendation, and it reads: "The Congress will eliminate  
14 the fiscal year 2021 update to the Medicare-based payment  
15 rates for skilled nursing facilities. The level of  
16 Medicare payments indicate that a reduction to payments is  
17 needed to more closely align aggregate payments to  
18 aggregate costs. However, we expect the SNF industry to  
19 undergo considerable changes as it adjusts to the redesign  
20 PPS. Given the impending changes, the Commission will  
21 proceed cautiously in recommending reductions to payments.  
22 A zero update will begin to bring payments aligned with

1 costs while exerting some pressure on providers to keep  
2 their cost growth low. The Commission will monitor  
3 beneficiary access, quality of care, and financial  
4 performance, and may consider future recommendations based  
5 on industry responses to the new payment system. In terms  
6 of implications, spending would be lower relative to  
7 current law. Given the high level of Medicare's payments,  
8 we do not expect adverse impacts on beneficiaries.  
9 Providers should be willing and able to continue to treat  
10 beneficiaries."

11 And with that, I'll turn things back to Jay and  
12 look forward to your discussion.

13 DR. CROSSON: Thank you, Carol.

14 We'll start with clarifying questions with David,  
15 Jonathan, Sue, and Amol.

16 DR. GRABOWSKI: Thanks, Carol. This is great  
17 work.

18 I wanted to ask about the transition of the  
19 patient-driven payment model. I know it's really early. I  
20 think we're in week nine. Have you heard anything yet on  
21 the ground? How is that working? Just anything you can  
22 tell us because it is a big change in how SNFs are paid.

1 DR. CARTER: I've heard there's been a little bit  
2 in the trade, trade press, but it is early. I think people  
3 are pretty optimistic. The industry analysts are  
4 optimistic.

5 Early there were rumblings about some therapy  
6 layoffs. I looked at some of those companies where those  
7 were occurring, and those were exactly the companies that  
8 were providing a lot of therapy, including one that had  
9 already settled a case with the Justice Department.

10 So, I mean, in some sense, that might have been  
11 right-sizing. So I think we need to wait and see kind of  
12 what's happening on the therapy side. I've said before  
13 there's nothing inherent in this payment system that  
14 discourages the provision of therapy. I think people are  
15 optimistic.

16 DR. CROSSON: Jonathan?

17 DR. JAFFERY: Thanks. Thanks, Carol. This was  
18 great.

19 The question about assessment of access being  
20 adequate, so in Slide 5, you talk about how the supply was  
21 stable and most beneficiaries live with three-plus SNFs, in  
22 a county with at least three SNFs. You talk about the

1 occupancy rates being high at about 84 percent, and so I'm  
2 just thinking geographically. Do you have any sense of  
3 what the spread is? Are there places where the occupancy  
4 rate is so high that even if you have three or more nursing  
5 facilities, you actually may have limited access?

6 DR. CARTER: I think that can be an issue in  
7 select markets. I haven't done a deep dive on that, but I  
8 have looked at the variation in occupancy. And there is  
9 some, of course, and they tend to be lower in rural areas.  
10 But I'm sure that there are markets where beds can be  
11 tight.

12 In particular, if you have patients with  
13 particular care needs, then that might be especially tight.

14 DR. JAFFERY: Yeah. That makes sense. I worry  
15 that because of some of those idiosyncratic aspects of SNF  
16 care that maybe these exact parameters don't necessarily  
17 always tell us the same story that they do in some other  
18 sectors for some of those reasons.

19 DR. CARTER: But remember these are patients that  
20 are in the hospital. So they may need to wait for  
21 placement, but most of these patients are coming directly  
22 from a hospital.

1 DR. CROSSON: Sue is next.

2 MS. THOMPSON: My question was asked and answered  
3 by David, so thank you.

4 DR. CROSSON: Okay. Thank you, Sue.  
5 Amol?

6 DR. NAVATHE: Thanks, Carol, for the chapter.  
7 So you noted on page 29 of the writeup itself  
8 that small, meaning 25 to 50 beds, in low-volume  
9 facilities, bottom quintile total facility days, had low  
10 average Medicare margins. Those were the ones primarily  
11 with the negative margins.

12 I was curious if you have a sense of how they're  
13 distributed. Is it true that these are primarily in rural  
14 areas? Is this true that most of these are actually  
15 together in the same markets, or are most markets a mix of  
16 larger and smaller facilities?

17 DR. CARTER: I actually haven't looked at that.  
18 My guess is there is a mix. Rural facilities tend to be  
19 smaller, but I'm sure in the larger markets, there's a mix.  
20 And I do know where there has been new construction, like  
21 in Texas, those facilities tend to open in markets where  
22 there already are SNFs, but that doesn't really get at your

1 question. And I haven't looked at it.

2 DR. NAVATHE: Okay. Thank you.

3 DR. CROSSON: Okay. Pat and then Marge.

4 MS. WANG: This is a question related to David's.  
5 Was there any expectation or is there an expectation that  
6 the new payment model is going to shift the distribution of  
7 where the margin might be? I'm just struck by sort of the  
8 two ends of the spectrum of for-profit versus not-for-  
9 profit, SNFs and the increasing movement, it seems like,  
10 towards for-profit. I was just curious about that because  
11 when you did your PAC PPS work and you did some impact  
12 analysis, there was some shifting around among the sectors,  
13 and my recollection is that hospital days not-for-profit  
14 seem to do better when the payment system was corrected.  
15 Do we expect the same thing with the new SNF payment model?

16 DR. CARTER: I do, and I don't have the CMS  
17 impact tables in front of me, but I remember thinking, oh,  
18 these are really similar both to the modeling we did back  
19 in 2006, but also with the PAC PPS. I mean, there is a  
20 narrowing of the difference, and the -- I mean, one of the  
21 whole purposes of redesigning this payment system is to  
22 make the payments more equitable across different types of

1 patients. And so there would be much less incentive to  
2 select particular types of patients, and that is, actually,  
3 another thing I have heard a little bit, that SNFs are  
4 slowly starting to take more medically complex patients.  
5 That's an early thing that I've heard. But I do expect the  
6 margins to narrow, yeah.

7 DR. GRABOWSKI: On this point, I agree with  
8 everything you just said, Carol. The only thing, and I  
9 think it should be flashing in red lights here, that all of  
10 that assumes no behavioral response. And it will be really  
11 interesting to see what for-profits and nonprofits do,  
12 hospital-based, freestanding. So I think it's exactly  
13 right. When you kind of rework the numbers without any  
14 behavioral response that's exactly where you see this  
15 shifting, but we will see how it actually plays out.

16 DR. CROSSON: Marge.

17 MS. MARJORIE GINSBURG: That's a great report,  
18 Carol. I was very interested in the last part of the  
19 report that deal with all Medicaid statistics, but I don't  
20 think there was a part of this that sort of brought those  
21 two together, what percent of nursing homes serve both  
22 Medicare and Medicaid. And since we know that the

1 reimbursement for Medicaid-only patients is much lower than  
2 it is for Medicare, the extent to which facilities that  
3 serve both populations is, in fact, the Medicare  
4 reimbursement helping to support Medicaid population.

5 DR. CARTER: Almost all SNFs also serve Medicaid  
6 in our long-term care facilities, so there isn't really --  
7 there is obviously a range, and hospital-based tend to only  
8 be SNF focused, but most providers are doing both lines of  
9 business, if you will. We don't have -- the average share  
10 of Medicaid days at a facility is like 63 percent, but that  
11 varies. But we don't have Medicaid revenues in the cost  
12 report so I can't tell you what share of revenues are  
13 Medicaid.

14 And you had a third question in there.

15 MS. MARJORIE GINSBURG: I guess -- I'm not sure I  
16 did, but perhaps I did. I was looking at the whole --  
17 trying to look at the whole package. So for the SNFs that  
18 have very large Medicare populations and relatively small  
19 Medicaid, are they the ones with the higher margin?

20 DR. CARTER: Oh yeah. So, right, you asked about  
21 the cross-subsidization, and that definitely goes on, and I  
22 think it's, you know, it's not kept secret. I mean, I



1 think that's a very explicit argument that providers, the  
2 provider community will make is they need the high margins  
3 on the Medicare side to cross-subsidize the lower payers.  
4 We have a text box in the chapter that suggests why we  
5 think that's particularly bad policy, because it's really  
6 not targeted. What it means, then, is when Medicare is  
7 paying more it is going to exactly the facilities that need  
8 it the least, because they will be having relatively lower  
9 shares of Medicaid. So it's exactly the opposite targeting  
10 than you would like, but that subsidy argument is there and  
11 we hear it.

12 DR. CROSSON: Okay. Seeing no further questions  
13 we will proceed to the discussion, and Carol, you could put  
14 up the recommendation. The recommendation is for zero  
15 update, for the reasons that Carol laid out. Discussion  
16 pro or con the recommendation.

17 David?

18 DR. GRABOWSKI: So I'll be brief. I'm very  
19 supportive of the recommendation and I really like the --  
20 it wasn't part of the recommendation but Carol mentioned  
21 continuing to track what happens here under the patient-  
22 driven payment model. I'll try to say this nicely. This

1 is a very nimble industry. They are very responsible to  
2 payment incentives. And so I know Carol took that into  
3 account in her projected margin. I would bet higher, and  
4 that would be my -- if we were taking wagers.

5 So I just hope that we'll continue to track that  
6 and revisit this. Thanks.

7 DR. CASALINO: David, what behavioral changes  
8 would you expect to see?

9 DR. GRABOWSKI: So the PDPM is based around  
10 patient characteristics, so it's all about coding. So  
11 there were a lot of boot camps on how to code leading up to  
12 the introduction of the PDPM, so you're going to see a  
13 dramatic shift, not only in the types of patients that are  
14 being admitted but also kind of the completeness of their  
15 coding. So I think a lot of it is going to be on that  
16 margin.

17 There is also the therapy margin Carol mentioned.  
18 I think I'm more worried about sort of just the coding  
19 creep than I am about the sort of therapy, the bottom  
20 dropping out on therapy.

21 DR. CROSSON: I would note, perhaps in humor,  
22 that nimbleness is not limited to this particular segment,

1 and, in fact, in many ways it keeps us in business.

2 Other comments? Marge.

3 MS. MARJORIE GINSBURG: This probably isn't  
4 kosher. I support this but I'm troubled by the lack of  
5 support from Medicaid beds, and I'm very aware of that. I  
6 don't know how many of you saw the op-ed piece in the New  
7 York Times about the Alzheimer's patient. I'm sure you  
8 did. And there was one very brief reference -- I think the  
9 family was in New Jersey -- about the lack of Medicaid beds  
10 for her father with Alzheimer's. Okay, so that's case one.

11 But I wonder, and I guess I'm just throwing this  
12 out for very brief discussion, would it be possible to  
13 orient our support, or lack of support, for SNF  
14 compensation depending on the number of Medicaid beds they  
15 serve? And I don't know what the average is. I suspect  
16 it's a chronic problem nationally, to get the number of  
17 Medicaid beds necessary. But I don't know whether this  
18 topic has ever been broached at all with this Committee.

19 I mean, in acute care hospitals we expect the  
20 commercial plans are, in essence, kind of supporting  
21 Medicare patients. Is there not a consideration to  
22 consider the reverse, of having Medicare compensation help

1 support Medicaid patients in SNF beds?

2           So I just wanted to throw that out, and you can  
3 all take it off the table if you want, but I wanted to  
4 mention it.

5           DR. CROSSON: It's not a simple issue. Kathy?

6           MS. BUTO: I'm going to let Jay take -- no.

7           [Laughter.]

8           MS. BUTO: I wanted to mention, Marge, I think my  
9 gut tells me no, we wouldn't do that, because why would you  
10 use Medicare, which is already in all sorts of fiscal  
11 difficulty to, in a sense, help subsidize, if you will, the  
12 sustainability of Medicaid beds. But having said that, I  
13 think there is an adjustment, or should be an adjustment, I  
14 think -- Carol, right? -- for dual eligible. So many of  
15 the Medicaid individuals are actually dually eligible, and  
16 that is totally in our purview, it seems to me, to be  
17 concerned about. But that's more about the methodology.

18           MS. MARJORIE GINSBURG: But they're not still in  
19 Part A. They're not being compensated.

20           MS. BUTO: No, but to the extent you were going  
21 to use Medicare payment anyway, my point is there is a way  
22 to adjust for the dual eligibles. I think they may already

1 get an adjustment for dual eligible status now?

2 DR. CARTER: No. There isn't one.

3 MS. BUTO: There isn't one. But that's a policy,  
4 you know, approach that would be different than just the  
5 update, I think.

6 DR. CROSSON: But there is higher payment  
7 particularly incident to hospitalizations and  
8 rehospitalizations. Right.

9 I mean, this is intentionally philosophical and I  
10 think, you know, it's becoming more and more -- it's always  
11 been, but it's particularly more and more an acute social  
12 problem, actually, provision of long-term care for the  
13 populations considered back in the 1960s, when the Johnson  
14 administration was working with Congress to draft the  
15 Medicare legislation. And because even then the projected  
16 cost, it was not put there.

17 It was put in the Medicaid program, and this is  
18 my assumption, that it was based on some idea that the real  
19 vulnerability was for the people with lower incomes who had  
20 no way, really, to support themselves or their elderly  
21 relatives, and that other parts of the population could  
22 figure out how to do that. And that's my belief, anyway,

1 of how the thinking was at the time.

2           There has been substantial change in terms of the  
3 burden that this creates, because people are living longer,  
4 a lot longer in some cases, and because of what appears to  
5 be -- and perhaps it's just related to that -- but what  
6 appears to be an increased incidence in dementia and  
7 Alzheimer's disease, the care of which can turn out to be,  
8 you know, beyond the capacities of even upper middle class  
9 families.

10           So your instinct is a good one. We need, as a  
11 society, a way of figuring out how to care for and pay for  
12 this phenomenon, which is only increasing. That said, I  
13 think, you know, traditionally we have, at this Commission,  
14 been, you know, for rightly or wrongly, sort of defenders  
15 of the Treasury as it relates to Medicare expenditures.  
16 And so even though there are subsidies, actually, that go  
17 both ways, between Medicare and Medicaid and Medicaid and  
18 Medicare, we've tended to not consider increasing that. If  
19 that's fair.

20           Yeah, David.

21           DR. GRABOWSKI: Yeah, I'm so glad, Marge, that  
22 you raised this, because this has bothered me as well.

1 Every one of those -- almost every one of those sort of  
2 long-stay Medicaid recipients is a dual, is a Medicare  
3 beneficiary, and I think our sort of underinvestment in  
4 Medicaid is leading to higher costs downstream for  
5 Medicare. And we've shown that in a lot of research yet,  
6 as Carol really noted, and I thought really did a nice job.  
7 It's not the way you'd ever want to fund this, with these  
8 separate programs. That's why I think some of the models  
9 that Eric has presented on in the past area really  
10 important here, the fully integrated dual eligible SNPs,  
11 the financial alignment initiative, their model PACE, where  
12 we could integrate the Medicaid and Medicare and actually  
13 offer a more complete product. I think that's the way to  
14 get at this, but I share your concern about we're using  
15 Medicare to cross-subsidize Medicaid. It's a fact that it  
16 happens. It's just -- it's not the way you'd ever want to  
17 design this system, with Medicare and Medicaid separate.

18 DR. CROSSON: Okay. Jon.

19 DR. CASALINO: On this point I think it's not --  
20 it doesn't have practical relevance for our deliberations,  
21 but speaking as a physician, if you've ever spent time in  
22 the Medicaid part of a nursing facility that has a high

1 percentage of Medicaid patients, I always used to -- I  
2 hated to go there. Honestly, I felt like I was descending  
3 into like the seventh circle of hell. It was just  
4 unbelievable. And it's not the staff's fault. They're  
5 doing the best with what they have. And even under the  
6 best circumstances people who are severely demented, it's a  
7 very hellish thing to see. But these places are really,  
8 really horrible.

9 I don't think we can do anything about it here,  
10 although what you're saying, David, may argue a little bit  
11 differently. But it truly is -- if you haven't seen it,  
12 you would not believe it. It's painful to walk into such a  
13 place.

14 DR. PERLIN: My comment really triangulates with  
15 my colleagues, is that there are a lot of moving parts  
16 here, and, you know, David, you brought up the behavioral  
17 economics, and Marge, on the issues of cross-subsidization,  
18 and Larry also just commented on. You know, the premise  
19 behind our policy direction in post-acute care has been  
20 matching the acuity with the capabilities of the facility,  
21 but specifically geared to making sure that a patient was  
22 not in the higher level of care necessary in terms of the



1 expense.

2           At the same time, the premise of this economic  
3 argument is that, you know, the adaptations will include  
4 de-staffing, de-skilling, perhaps, to meet, you know, the  
5 change in reimbursement. It's going to be interesting to  
6 watch, and I think this is really a call for the importance  
7 of quality measures to be able to really watch what the  
8 effects are on the care and the care outcomes as we move  
9 these parts. Because the other part, related to the  
10 discussion of Medicaid, is the impact of waivers on the  
11 resources that are available for Medicaid patients that may  
12 even necessitate de facto more cross-subsidization.

13 Thanks.

14           DR. CROSSON: Okay. Yes, Brian.

15           DR. DeBUSK: Actually, the discussion raised a  
16 question. You know, when you look at the PAC PPS, it was  
17 modeled off of the payments from the other, all four  
18 venues. You know, you're building one model. This  
19 subsidization that's just inherent in our SNF payments, in  
20 the PAC PPS, does that subsidization get undone, or is that  
21 swept up and captured in the model? Because I want to say  
22 it's the latter.

1 DR. CARTER: So the level of revenues are  
2 included, but they would then be redistributed in sort of  
3 setting the average payment.

4 DR. DeBUSK: But it would be redistributed based  
5 on patient characteristics.

6 DR. CARTER: That's right.

7 DR. DeBUSK: So you wouldn't inherently take  
8 money out of -- we're not going to undo this SNF  
9 subsidization through the PAC PPS, because the model was  
10 built around -- you know, you have to think, with \$30  
11 billion in SNF, home health is running, what, four or -- I  
12 mean, not -- no, no, no -- IRFs and LTCHs are running at a  
13 fraction of that. So the model is going to be home health  
14 and SNF are going to be what dominate the coefficients as  
15 well.

16 DR. CARTER: That's right.

17 DR. DeBUSK: So this overpayment, just again, for  
18 the record, this overpayment, if the PAC PPS goes forward,  
19 will have that subsidization built into the SNF payments,  
20 even though it will be based on patient characteristics,  
21 not necessarily on provision of therapy.

22 DR. CARTER: Right, but by the time -- and that's

1 all true -- by the time the PAC PPS is implemented, a lot  
2 of that redistribution should have already happened, right,  
3 because they're going to be happening internally within  
4 SNF, and Evan is going to tell you about the new payment  
5 system in his sector, and a lot of that redistribution  
6 should have occurred.

7 DR. DeBUSK: Based on the October 1st changes.

8 DR. CARTER: Well, and this starts in January of  
9 next year.

10 DR. DeBUSK: So this should cushion the  
11 implementation of the PAC PPS.

12 DR. CARTER: That's right.

13 DR. DeBUSK: That's what I was trying to get at  
14 and make sure that we weren't sort of tacitly undoing the  
15 SNF subsidy. So we aren't. Okay, good.

16 DR. CROSSON: Okay. Seeing no further comments I  
17 am going to assume support for the recommendation. Seeing  
18 no objection we will proceed with expedited voting on this  
19 issue in January.

20 Thank you so much, Carol. Excellent job.

21 [Pause.]

22 DR. CROSSON: The next issue is home health care

1 services, payment adequacy and updates, and Evan is going  
2 to take us through it.

3 MR. CHRISTMAN: Thank you. As you mentioned, we  
4 are going to look at home health, and as an overview of the  
5 presentation we'll cover the basics of the benefit, the  
6 current issues the Commission has identified, and the bulk  
7 of this presentation will review the payment adequacy  
8 framework and present the Chairman's draft recommendation.

9 As background, Medicare spent \$17.9 billion on  
10 home health services in 2018, and there were over \$11,500  
11 agencies. The program provided about 6.3 million episodes  
12 to 3.4 million beneficiaries.

13 In terms of the payment system, the Commission  
14 has noted two problems. The first issue is the high level  
15 of payments. Medicare has overpaid for home health since  
16 the PPS was established. The fact that home health can be  
17 a high-value service does not justify these excessive  
18 overpayments. As discussed in the paper, Medicare margins  
19 have averaged better than 16 percent in the 2001 to 2017  
20 period. These overpayments do not benefit the beneficiary  
21 or the taxpayer. For many years, the Commission has  
22 recommended payment reductions to address these

1 overpayments.

2           The second issue is an incentive in the current  
3 system. The current PPS uses the number of therapy visits  
4 provided in an episode as a payment factor. Payments  
5 increase as more therapy visits are provided. This trend,  
6 and the fact that more profitable agencies tended to favor  
7 therapy episodes, raised concerns that the financial  
8 incentives of the payment system were influencing the type  
9 of care provided, and the Commission recommended the  
10 removal of therapy as a payment factor in 2011.

11           As mentioned earlier, major revisions to the home  
12 health PPS will be implemented in 2020. The first is a  
13 policy that is consistent with our recommendation to  
14 eliminate the therapy thresholds. The second is the  
15 implementation of a 30-day unit of payment. Concurrently,  
16 CMS also plans to revise the home health PPS with a new  
17 case-mix system, known as the patient-driven groupings  
18 model, or PDGM, and other payment adjusters. These will be  
19 the most significant changes to the PPS since it was  
20 implemented

21           These changes are intended to be budget neutral  
22 but will redistribute payments among providers. Estimates

1 of the redistribution have some uncertainty because  
2 agencies have a history of changing coding and operational  
3 practices when the payment system is altered. But based on  
4 current patterns, CMS expects payments for nonprofit,  
5 facility-based, and rural agencies will increase, and  
6 decrease for for-profit, freestanding, and urban agencies.

7 CMS has also made a budget neutrality adjustment  
8 to payments in 2020 to offset expected changes in  
9 utilization and coding under the new system, and I will say  
10 more about that later.

11 As a reminder, here is our framework. It's  
12 similar to the ones you've seen in other sessions.

13 We begin with supply. As in previous years, the  
14 supply of providers and the access to home health appears  
15 to be very good. Eighty-three percent of beneficiaries  
16 live in a Zip code served by five or more home health  
17 agencies; 98 percent live in a Zip code served by at least  
18 one home health agency.

19 Turning from access to supply, the number of  
20 agencies was over 11,500 by the end of 2018. There was a  
21 slight decline of about 1.2 percent in 2018 relative to the  
22 prior year in supply, and it has been slowly trending down

1 since 2013. However, in the 2002-2013 period, the number  
2 of agencies increased by over 80 percent.

3 I would also note that the recent decline is  
4 concentrated in a few areas such as Texas, Florida, and  
5 Michigan that have been the targets of efforts to reduce  
6 fraud. These areas also experienced rapid growth in prior  
7 years.

8 Episode volume declined slightly in 2018, as it  
9 generally has since 2011. However, prior to 2011, volume  
10 grew significantly, and between 2002 and 2011, it increased  
11 by over two million episodes, or about two-thirds.

12 Per capita utilization is significantly higher  
13 than the earlier years of PPS. The number of episodes per  
14 100 beneficiaries has increased from 11.3 episodes per 100  
15 beneficiaries in 2002 to 16.3 episodes per 100  
16 beneficiaries in 2018. Though per capita utilization has  
17 declined slightly since 2011, it remains high relative to  
18 the utilization that occurred in the earlier 2000s. And I  
19 would also note that the marginal profit of home health  
20 agencies in 2018 was 18 percent.

21 Our next indicator is quality, and I would remind  
22 you that we have observed a difference in performance on

1 measures based on data collected from home health agencies  
2 compared to quality measures based on Medicare claims data.  
3 And you can see that on this graph.

4           The first group of measures on the left are based  
5 on provider-reported data collected by home health staff at  
6 the start and end of home health care. The group of  
7 measures on the right are claims-based measures that use  
8 Medicare claims data to detect the incidence of  
9 hospitalization or emergency care use for home health.

10           The first group shows that the frequency of  
11 patient improvement in walking or transferring was steadily  
12 improving from year to year. In contrast, hospitalization  
13 and ER use rates have had a mixed annual trend, but have  
14 not changed significantly in most years and do not show the  
15 same substantial improvement as the functional measures.

16           The contrast in these two groups of measures is  
17 striking, and though many factors may explain them, it is  
18 important to keep in mind that differences in the methods  
19 of collection may account for some of the divergent trends.

20           Next we look at capital. It is worth noting that  
21 home health agencies are less capital-intensive than other  
22 health care providers, and few are part of publicly traded



1 companies.

2 Financial analysts have concluded that the  
3 publicly traded agencies have adequate access to capital in  
4 2018 and 2019. In these years, the firms added capacity in  
5 the industry and acquired new businesses, and the all-payer  
6 margins for home health agencies are 4.3 percent.

7 Turning to Medicare margins for 2018, we can see  
8 that the margins for this year were 15.3 percent. The  
9 trend by type of provider is similar to prior years, with  
10 for-profits having better margins than nonprofits and  
11 urbans being a little bit higher than rural. These margins  
12 did not change significantly from the 2017 level.

13 The high margins in 2018 are notable because the  
14 Affordable Care Act mandated four years of payment  
15 reductions in 2014 through 2017. However, the reductions  
16 were offset with an annual market basket update. The net  
17 effect was that payments were reduced by less than 1  
18 percent a year, and the Commission has long expressed that  
19 the ACA reductions would not significantly lower margins.

20 The net effect is that, despite the ACA policies,  
21 average payment per full episode in 2018 is 7 percent  
22 higher than the average payment in 2013, the year before

1 rebasing began. In addition, the Medicare margins in 2018,  
2 the year after rebasing, were higher than those before  
3 rebasing.

4           This year we also examined the performance of  
5 relatively efficient home health agencies. Recall that we  
6 define "relatively efficient providers" as those that are  
7 in the lowest third of providers in cost, or the best  
8 performing third of providers for quality, without having  
9 extremely low performance on either measure. About 7  
10 percent of agencies meet this standard.

11           Compared to other providers, efficient home  
12 health agencies had lower hospitalization rates. They  
13 typically had higher patient volume, and their standardized  
14 costs were 14 percent lower than other home health  
15 agencies, likely reflecting economies of scale from their  
16 larger size.

17           The average payment for efficient home health  
18 agencies was about 7 percent higher, and the relatively  
19 efficient providers had margins of 23 percent.

20           We estimate that margins for 2020 will equal 17  
21 percent. This is a result of several payment and cost  
22 changes.

1           On the payment side, we included the market  
2 basket updates for 2019 and 2020. We assumed a nominal  
3 case mix growth of a half percent in 2019, and we included  
4 the rural add-on policy mandated by the Bipartisan Budget  
5 Act for 2019 and 2020.

6           For 2020, we assumed the case mix growth CMS  
7 expects to the new case mix system and other changes in  
8 effect this year, which it also offset with a budget  
9 neutrality adjustment, and I will talk about this more in a  
10 moment.

11           For costs, we assumed costs will increase by 0.75  
12 percent per year in 2019 and 2020, which is higher than the  
13 recent trend.

14           Before I summarize our indicators, I want to  
15 explain a payment reduction for 2020 that is statutorily  
16 required by the Bipartisan Budget Act. Recall that three  
17 changes are happening as a result of that act: a new unit  
18 of payment, removal of therapy as a payment factor, and a  
19 new case mix system. BiBA requires that the changes be  
20 budget neutral.

21           CMS has projected that behavioral responses by  
22 home health agencies to the new policies will increase

1 payments by 4.36 percent in 2020, which would, in the  
2 absence of an offset, increase payments by about a \$800  
3 million.

4           Consequently, CMS will implement a 4.36 percent  
5 reduction in 2020. This reduction is necessary to offset  
6 the spending spike in 2020 due to the expected behavioral  
7 changes; it does not address payment adequacy. Our margin  
8 estimate for 2020 includes the 4.36 percent increase in  
9 average reported case mix expected by CMS, and it also  
10 includes the offsetting budget neutrality adjustment they  
11 made.

12           In effect, our estimate states that margins will  
13 be 17 percent, well in excess of costs, even with the other  
14 changes in 2020.

15           In summary, the indicators for home health  
16 overall are positive: 98 percent of beneficiaries live in  
17 an area with at least one home health episode; the episode  
18 volume is slightly decreased but is still high on a per  
19 capita basis; and agencies have positive marginal profits.  
20 The quality measures show the trends we've seen in the past  
21 with functional measures continuing to improve, but the  
22 rate of adverse events relatively unchanged, with the

1 caveats I noticed earlier.

2 Overall, agencies appear to have adequate access  
3 to capital, and Medicare payments are well in excess of  
4 costs, with margins of 15.3 percent in 2018 and the  
5 efficient provider having margins of 23 percent. And we  
6 expect the margins to increase to 17 percent in 2020.

7 This brings me to the Chairman's draft  
8 recommendation. The recommendation reads:

9 For 2021, the Congress should reduce the calendar  
10 year 2020 Medicare base payment rate for home health  
11 agencies by 7 percent.

12 In terms of implications, we expect that this  
13 would lower payments relative to current law. For  
14 beneficiaries and providers, access to care should remain  
15 adequate and should not affect the willingness of providers  
16 to serve beneficiaries, but it may increase cost pressures  
17 for some providers.

18 This completes my presentation, and I look  
19 forward to your questions.

20 DR. CROSSON: Thank you, Evan. And I'd like to  
21 congratulate you particularly for the chapter, which I  
22 thought was excellent, very clear, and I liked particularly

1 the beginning where you set the context for the  
2 considerations.

3 So we'll take clarifying questions. Brian and  
4 then David.

5 DR. DeBUSK: Thank you again for a really good  
6 chapter. It was really well written. Great read.

7 When you talk about the all-payer margins for  
8 home health care and for Medicare -- and I apologize if it  
9 was in the reading, but I did not see it -- what percentage  
10 of industry revenue comes from Medicare?

11 MR. CHRISTMAN: It's a little over 50 percent.  
12 It's around 55 percent of the action is Medicare revenue  
13 for the average agency.

14 DR. DeBUSK: Okay. So --

15 MR. CHRISTMAN: Fee-for-service. Sorry.

16 DR. GRABOWSKI: That's fee-for-service.

17 MR. CHRISTMAN: Yes, I'm sorry. Exactly. Thank  
18 you, David.

19 DR. DeBUSK: So it's a little over 50 percent  
20 fee-for-service, so probably 15, 18 percent of it is MA  
21 then, I would think, proportionally. Fifteen-ish percent?

22 MR. CHRISTMAN: Yes, right. I think that's right

1 based on the overall program, right, yes.

2 DR. DeBUSK: Is MA. And I'm sorry, David, I just  
3 stole your question because he and I were chatting. But  
4 what are the MA rates comparable to?

5 MR. CHRISTMAN: So the general consensus is that  
6 just about every other payer pays less to home health  
7 agencies for the services. That's on, you know, the  
8 Medicaid side, which is obviously a different set of  
9 services in many cases than what Medicare covers, but also  
10 on the MA side. And home health agencies have  
11 traditionally complained that the MA side does not pay as  
12 well.

13 I would say that over these ten-plus years I've  
14 been following home health for MA, I think that picture  
15 generally remains true, but it has changed in two ways, and  
16 one is, you know, ten years ago, agencies tried to divorce  
17 themselves from the MA business if they could, but many of  
18 them in the urban areas saw that the MA population  
19 expanded, and they would not be able to maintain the volume  
20 that they were used to having if they didn't get serious  
21 about the MA business.

22 And so we've seen in recent years agencies

1 serving more of that population, and we've heard  
2 anecdotally that some plans, they've been successful and  
3 the agencies have been successful in getting better rates.  
4 I don't think they would characterize them as favorable  
5 relative to fee-for-service, but I think today in general  
6 the complaint is they're paid less on a per visit basis  
7 than the fee-for-service business, but probably in many  
8 cases they're paid a little better than they were ten years  
9 ago.

10 DR. DeBUSK: Okay. Well, then a final question  
11 just to check some math. If 55 percent of the business is  
12 at 15 percent margin and 100 percent of the business is at  
13 4.3 percent, it means that -- I mean, the non-Medicare  
14 business is somewhat negative, probably high single digits  
15 negative.

16 MR. CHRISTMAN: Right. Yeah, no, I think that's  
17 the implication. I mean, I think -- and I think that, you  
18 know, that's sort of been the case for many years. But the  
19 overall margins haven't changed that much, but, yeah, you  
20 know, we don't have a lot of visibility into what the  
21 different payers are doing on the other side of the ledger.  
22 And so, you know, I would guess it's a mix of people who



1 pay relatively well and others who don't pay at all.

2           You know, off the top of my head, I can't really  
3 tell you the exact role that Medicaid plays in that, but I  
4 would assume that that's a piece of it.

5           DR. DeBUSK: Thank you.

6           DR. CASALINO: On this point?

7           DR. CROSSON: Yeah, all right.

8           DR. CASALINO: Evan, do you have a sense of why  
9 in some sectors that we talk about Medicare pays so much  
10 less than other payers, but for home health, following up  
11 on Brian's math, seems to pay so much more than other  
12 payers?

13           MR. CHRISTMAN: Why does fee-for-service pay more  
14 than other payers?

15           DR. CASALINO: Yes.

16           MR. CHRISTMAN: I guess the simplest answer I  
17 have to that is twofold, I guess. I would just say in  
18 every year I've been here, the Commission has recommended a  
19 reduction to payment, and sometimes congressional policy  
20 has gone some in that direction and sometimes it hasn't.  
21 So that's one reason.

22           The other reason I would say is that if you look

1 at -- when the home health base rate was established, it  
2 was based on 1998 utilization, and when they implemented  
3 the PPS in 2001, the visits came down much more than they  
4 expected, and there's been a gap between payments and costs  
5 since 2001. And we've made efforts over the years to --  
6 there have been cuts to Medicare payments over the years to  
7 try and close that gap, but they've never really come  
8 close. You know, that's why the margins have averaged 16  
9 percent. So I guess sort of the two parts of your answer  
10 is, you know, we set the payments much higher than costs  
11 originally, and policies since then have not been adequate  
12 to bring the two into balance.

13 DR. CROSSON: David.

14 DR. GRABOWSKI: [off microphone].

15 DR. CROSSON: Oh, asked and answered. Other  
16 questions for Evan?

17 [No response.]

18 DR. CROSSON: Okay. Seeing none, we'll proceed  
19 with the discussion. You have the recommendation before  
20 you, which is to reduce the base payment rate by 7 percent  
21 for 2021. Kathy.

22 MS. BUTO: Can you tell us where you got the 7

1 percent? Where does that come from?

2 DR. CROSSON: More than 5.

3 MR. CHRISTMAN: I guess what I would say is that  
4 -- I think there's two things. One is the sense that there  
5 has been some persistence in these margins even though  
6 we've done -- you know, there have been efforts to reduce  
7 the payments in the past. Last year, the Commission  
8 recommended a 5 percent reduction, and this year I think  
9 what makes 2018 at least for me a little different is we're  
10 seeing the first year of data after the ACA policy, which  
11 was supposed to be a big change to home health payments.  
12 It was referred to as rebasing. The idea is we would  
13 recover this original sin of this big gap between the  
14 expected and the actual visits. But because of the way  
15 that policy was written and implemented, that was mostly --  
16 it didn't have a serious effect.

17 And so I think what we're saying is the industry  
18 has come out of this period where their payments were  
19 supposed to undergo a big adjustment. It didn't have an  
20 effect, and since we can see in 2018 they're basically in  
21 as good or better shape than they were in 2013 before  
22 rebasing, it's time for some more serious action. I think

1 that's...

2 DR. MATHEWS: One additional point to amplify  
3 what Evan just said. You'll note the margin projection for  
4 2020 is actually expected to increase to 17 percent. That  
5 margin projection does take into account all of the  
6 statutory and regulatory factors that govern increases in  
7 payments to home health, including the prospective case mix  
8 adjustment that CMS has made as the new payment system gets  
9 implemented.

10 I think Evan has been extremely conservative in  
11 making his projections, and if I were to bet Evan's salary  
12 on it --

13 [Laughter.]

14 DR. MATHEWS: -- it would be a safe bet to say  
15 that margin might end up being a big higher.

16 MS. BUTO: I was going to say, why not go to 10?

17 DR. CROSSON: We have a bid on the table.

18 [Laughter.]

19 DR. GRABOWSKI: Jay, can I -- oh, sorry.

20 DR. CROSSON: I'll take that as an editorial  
21 comment at the moment. Okay.

22 DR. GRABOWSKI: Yeah, I was just going to also

1 say I'm supportive of 7 and, much like Kathy, could even go  
2 higher, and I just wanted to emphasize I can't ever  
3 remember -- and, Kathy, you've been doing -- with CMS, do  
4 you ever remember kind of working in a behavioral  
5 adjustment into a policy where we know they're going to up  
6 -- we know there's going to be this creep, why not take it  
7 right off the top?

8 MS. BUTO: Yeah.

9 DR. GRABOWSKI: And there may be other examples  
10 of that; it may be common. But I'm not used to seeing --

11 MS. BUTO: Yeah. It's done.

12 DR. GRABOWSKI: It's done, and it needs to be  
13 done here, and that's telling.

14 DR. CROSSON: Okay. I'm getting a sense of  
15 general support for this recommendation, so we will bring  
16 this forward in January through the expedited voting  
17 process. Evan, thank you again. We'll move ahead.

18 [Pause.]

19 DR. CROSSON: Okay. We are going to move along to  
20 the third presentation of the afternoon, and that's the  
21 update recommendation for inpatient rehabilitation  
22 facilities. We have Jamila and Dana here to present.

1 Dana, are you the same Dana that sits over there?

2 [Laughter.]

3 DR. CROSSON: Jamila, are you going to start?

4 DR. TORAIN: I am.

5 DR. CROSSON: All right. Thank you.

6 DR. TORAIN: Good afternoon.

7 Before we start, I will outline today's  
8 presentation for inpatient rehabilitation facilities, also  
9 known as IRFs.

10 First, I will briefly review Medicare's payment  
11 system for IRFs. Next, I will give a quick overview of  
12 some continuing concerns we have about the system. Then I  
13 will present our payment adequacy analysis and  
14 recommendation.

15 In general, we see a continuation of trends we  
16 observed last year, when you'll recall we recommended a 5  
17 percent reduction in the IRF payment rate.

18 After illness, injury, or surgery, many patients  
19 need intensive rehabilitative care, including physical,  
20 occupational, or speech therapy. Sometimes these services  
21 are provided in IRFs.

22 To qualify as an IRF, facilities must meet

1 Medicare's conditions of participation as well as several  
2 additional requirements.

3           In addition, for a stay to be covered, there are  
4 certain patient requirements that must be met that are  
5 outlined in your paper.

6           Per-case payments to IRFs are based on patients'  
7 condition, level of impairment as measured by the IRF, age,  
8 and comorbidity.

9           In 2018, Medicare accounted for about 59 percent  
10 of IRF discharges, and the average length of stay was 12.7  
11 days.

12           We have concerns with the IRF payment system.  
13 For example, how IRFs assess their patient's functional  
14 status affects their payments. In previous research, we  
15 have found that patients in high-margin IRFs were less  
16 severely ill during their preceding hospital stay, compared  
17 with patients in low-margin IRFs, but once patients were  
18 admitted to and assessed by IRFs, the patients were coded  
19 as being more impaired on average.

20           Second, we have observed that high-margin IRFs  
21 have a different mix of cases than other IRFs do. This  
22 suggests that some case types may be more profitable than

1 others.

2           To assess payment adequacy for IRFs, we used the  
3 same framework you've seen in earlier presentation. We'll  
4 start by considering access of care, which includes  
5 analysis of the supply of providers, volume of services,  
6 and marginal profit.

7           We first look at the supply of IRFs. In 2018,  
8 there were 1,170 nationwide, a slight decrease from 2017.  
9 However, despite this decline in number of facilities, the  
10 total number of IRF beds edged up slightly, with a little  
11 more than 37,000 bed in 2018.

12           As you can see in the facilities column on the  
13 chart, only 25 percent were freestanding facilities, but  
14 these IRFs tend to be bigger, so they accounted for about  
15 half of Medicare discharges in 2018. So even though the  
16 total number of facilities declined slightly in 2018, the  
17 total number of freestanding facilities continues to grow.

18           The number of for-profit IRFs is also growing  
19 steadily. Overall, 34 percent of IRFs were for-profit,  
20 accounting for 56 percent of all Medicare discharges.

21           We move on to beneficiary access to care. In  
22 2018, there was an increase in the volume of IRF cases and



1 the number of cases per fee-for-service beneficiary.

2           Payments per case also continued to increase. If  
3 we look at marginal profit, we see a robust 41 percent for  
4 freestanding IRFs and 20 percent for hospital-based IRFs,  
5 meaning that both sets of providers have an incentive to  
6 serve additional beneficiaries, assuming that they qualify  
7 for IRF-level care.

8           In terms of quality, we find some improvement in  
9 our risk-adjusted quality measures. The rate of  
10 potentially avoidable readmissions during an IRF stay was  
11 2.6 percent in 2018 and 4.8 percent during the 30 days  
12 after discharge, both improving slightly from 2012.

13           We saw improvements in the share of patients  
14 discharged to the community rising from 74.4 percent in  
15 2012 to 76.4 percent in 2018.

16           We also saw improvements on gains in motor  
17 function and cognitive function over this period, but  
18 remember that function scores are provider-reported and  
19 affect payment, so should be viewed with some caution.

20           Turning now to access to capital. Three-quarters  
21 of IRFs are hospital-based units, which access needed  
22 capital through their parent institutions. As you heard

1 this morning, hospitals maintained good access to capital.

2 As for freestanding IRFs, close to half of these  
3 facilities are owned or operated by one large chain.

4 Market analysts indicate that this chain has good access to  
5 capital. The company has continued its pursuit of vertical  
6 integration by expanding its business to include the  
7 purchase of home health agencies and hospice providers and  
8 entering in joint ventures with acute care hospitals to  
9 build new IRFs. The all-payer margin for freestanding IRFs  
10 is a robust 10.7 percent.

11 Moving on to discuss payments and costs, we find  
12 that payment have been increasing faster than costs since  
13 2010, with payments rising a cumulative 19.6 percent since  
14 2010 and costs rising a cumulative 13 percent. You will  
15 note that cost growth was particularly low from 2010 to  
16 2015, averaging just 1.2 percent per year.

17 These differences in per-case costs and payment  
18 growth have led to steady rise in aggregate margins for  
19 IRFs, which climbed from 8.6 percent in 2010 to 14.7  
20 percent in 2018. For the past three years, aggregate IRF  
21 margins have remained above 13 percent.

22

1           Financial performance varies by type of IRF.  
2   Freestanding IRFs have margins of 25.4 percent, while  
3   hospital-based IRFs have an aggregate margin of 2.5  
4   percent.

5           The primary driver of profit margins is cost,  
6   which tend to be lower in freestanding and for-profit IRFs.

7           So why do we see such a disparity between  
8   hospital-based and freestanding margins? We think there  
9   are a number of factors.

10           First, hospital-based IRFs are more likely than  
11   freestanding IRFs to be nonprofit, and so they may be less  
12   focused on reducing costs to maximize return to investors.

13           They also have fewer economies of scale.  
14   Hospital-based IRFs tend to be much smaller than  
15   freestanding IRFs, and they have fewer total cases. Their  
16   occupancy rates are also somewhat lower, 61 percent in  
17   hospital-based IRFs versus 69 percent in freestanding.

18           Hospital-based IRFs also tend to have a different  
19   mix of cases. It's not clear why this is the case. As we  
20   mentioned earlier, some case types may be more profitable  
21   than others, resulting in higher margins for facilities  
22   that admit larger shares of those cases.

1           Finally, hospital-based IRFs may assess and code  
2 their patients differently, contributing to differences in  
3 payments for similar patients.

4           Next, we will examine relatively efficient IRFs.  
5 We find that these IRFs had better performance on quality  
6 metrics, with readmission rates 11 percent lower and  
7 discharge rates to SNFs that were 27 percent lower than  
8 other IRFs.

9           Relatively efficient IRFs were also larger and  
10 had higher occupancy rates than other IRFs, leading to  
11 lower costs.

12           Payment rates, however, were similar between both  
13 groups, but with the large cost difference, Medicare  
14 margins were much higher in the relatively efficient group,  
15 17.8 percent in 2018 compared with 1.1 percent for other  
16 IRFs.

17           The mix of cases was also different, and we have  
18 discussed this before as relatively efficient IRFs have a  
19 smaller share of stroke cases and higher share of other  
20 neurological condition cases. Freestanding and for-profit  
21 facilities were disproportionately represented in the  
22 relatively efficient group, but there were some hospital-

1 based facilities as well.

2           We note that the results of the efficient  
3 provider analysis must be interpreted with caution due to  
4 our concerns about the accuracy of IRFs' payment patient  
5 assessments, which in turn determine payment amounts.

6           Our projected Medicare margin for IRFs in 2020  
7 is 12.7 because we expect cost growth to exceed payment  
8 growth in 2019 and 2020. Payment growth will be limited  
9 because payment updates for fiscal years 2019 and 2020 were  
10 set in statute at below-market basket levels, 1.35 percent  
11 and 2.5 percent respectively. And though cost growth in  
12 this industry was very low from 2010 to 2015, cost growth  
13 was higher from 2016 to 2018, and we expect this higher  
14 level of cost growth to continue with costs rising faster  
15 than the payment updates in 2019 and 2020.

16           In summary, we found that the IRF payment  
17 adequacy indicators were positive.

18           With regards to beneficiaries' access to care,  
19 IRFs continue to have capacity that appears to be adequate  
20 to meet demand.

21           With regards to quality of care, our risk-  
22 adjusted outcome measures have improved slightly over time.

1           With regards to IRFs' access to capital, these  
2 facilities maintain good access to capital markets. The  
3 all-payer margin for freestanding IRFs is a robust 10.7  
4 percent in 2018.

5           With regards to Medicare payments and IRF cost  
6 indicators, they were positive. In 2018, the Medicare  
7 margin was 14.7 percent, and we project a margin of 12.7  
8 percent in 2020.

9           So, to summarize, we observe capacity that  
10 appears to be adequate to meet demand and that providers  
11 should have an incentive to take more Medicare  
12 beneficiaries that qualify for IRF-level care, given the  
13 strong marginal profits for both freestanding and hospital-  
14 based facilities.

15           That brings us to the update for 2021. As we did  
16 last year, the Chairman's draft recommendation reads "For  
17 2021, the Congress should reduce the fiscal year 2020  
18 Medicare base payment rate for inpatient rehabilitation  
19 facilities by 5 percent."

20           To review the implications, relative to current  
21 law, Medicare spending would decrease because current law  
22 would give an update of 2.9 percent instead.

1           We anticipate no adverse effect on Medicare  
2 beneficiaries' access to care, given IRFs' high profit  
3 margins, although the recommendation may increase financial  
4 pressure on some providers.

5           The Chairman's draft recommendation will also  
6 include a reiteration of 2016 recommendations.

7           The first one addresses concerns about coding.  
8 MedPAC recommended that CMS ensure payment accuracy through  
9 focused medical record review, and we encourage the  
10 Secretary to reassess provider integrator reliability  
11 across IRFs.

12           The second recommendation addressed differences  
13 in the profitability of case mix groups. MedPAC  
14 recommended that CMS pay for a higher share of the cost of  
15 outlier patients who are extremely costly by expanding  
16 Medicare's IRFs' high-cost outlier pool. These outlier  
17 payments would tend to go to hospital-based and nonprofit  
18 facilities.

19           These recommendations were intended to be short-  
20 term fixes until improvements can be made to the IRF  
21 payment system.

22           With that, I will close. I am happy to take any

1 questions. Thank you.

2 DR. PAUL GINSBURG: Thank you very much for the  
3 clear presentation.

4 We'll take clarifying questions now. Jon?

5 DR. PERLIN: Yeah. Let me thank you really for a  
6 thoughtful chapter and great job presenting.

7 This really gets sort of in reference to the  
8 second of last year's recommendations. Since you've noted  
9 systematic differences between the patients and inpatient  
10 facilities, freestanding, would there be utility in looking  
11 at most efficient providers in two categories inpatient  
12 against inpatient, inpatient against freestanding, given  
13 that systematic difference in the complexity of patients?

14 DR. TORAIN: Yes. So that's something we can  
15 consider. We haven't looked at -- I think there was a  
16 previous recommendation in the past to break down the  
17 efficient provider analysis, but that is something that we  
18 can consider.

19 DR. PERLIN: Thanks.

20 DR. PAUL GINSBURG: Amol?

21 DR. NAVATHE: On that point, actually one of my  
22 comments was going to be to just look at it based on the



1 case types as opposed to the type of facility, per se,  
2 which would allow some heterogeneity and the hospital-based  
3 versus not but would try to normalize, sort of like we do  
4 peer groups, except we do peer groups based on the case.

5 MS. KELLEY: Yeah. And that's something that we  
6 are intending to look at is differences in profitability  
7 across case types to try to dig down a little bit deeper to  
8 see what's going on there.

9 DR. PAUL GINSBURG: Pat?

10 MS. WANG: I'm kind of interested in the same  
11 subject and so struck by -- it's great that you called it  
12 out on Slide 12 to talk about the difference and the  
13 difference in margins.

14 DR. PAUL GINSBURG: Pat, I'm having trouble  
15 hearing.

16 MS. WANG: Sorry.

17 Persisting over time. I just wanted to follow up  
18 on the same questions of inpatient versus freestanding,  
19 not-for-profit versus for-profit, because the margin  
20 difference over time has widened, and there's market  
21 movement in the sponsorship of the IRFs.

22

1 I guess one question, because I just don't  
2 remember -- and it's great that Carol Carter is still here.  
3 In the PAC PPS work, if that were fully implemented, would  
4 there be a narrowing of the margins or a change in the  
5 margins as between freestanding and hospital-based, for-  
6 profit versus not-for-profit? I don't remember. Very  
7 small? Very small. Okay. That's interesting.

8 So you highlighted and people talked about the  
9 different conditions perhaps that are being treated that  
10 may drive some of this. I wanted to ask if an IRF is  
11 hospital-based and the hospital is a teaching hospital, are  
12 there IME adjustments to the IRF stay?

13 DR. TORAIN: Yes, there are.

14 MS. WANG: There are, okay.

15 Is it the same basis? Like is it considered  
16 freestanding like in turn resident's bed ratio is like the  
17 whole enterprise?

18 MS. KELLEY: It's not the same formula, same  
19 application of the formula, that's used in the IPPS, but  
20 it's a similar payment adjustment.

21 MS. WANG: Okay. Are there other things that you  
22 have thought of that would explain the vast disparity in

1 financial performance between these different auspice, for-  
2 profit, not-for-profit, freestanding versus, you know,  
3 acute care hospital sponsored?

4 DR. TORAIN: So cost is a large driver; in  
5 particular, the direct cost to the hospital and therapies  
6 being very specific. And so cost is really what -- it's  
7 specifically in the period of 2010 to 2015, we observed  
8 that freestanding for-profit, the payments were like 14.9,  
9 and the cost itself was 4.1. So that's really the driver  
10 of the margins.

11 MS. KELLEY: One of the interesting things that  
12 we've seen in this industry is that particularly over that  
13 earlier period that Jamila referred to, we've seen  
14 increasing case mix in freestanding for-profit facilities,  
15 but cost growth has been very low and even negative in some  
16 years, which again kind of lends to our interest in sort of  
17 what's going on with coding in this industry.

18 DR. DeSALVO: Just on that point, they were later  
19 in the cycle than others in adopting electronic health  
20 records. So there may have been some bump that they gained  
21 for coding intensity from using technology.

22 MS. KELLEY: I hadn't thought of that. Thank

1 you.

2 DR. CROSSON: Amol, Larry.

3 DR. NAVATHE: So I couldn't help but notice that  
4 the IRF admission rate or number of admissions is going up.  
5 Whereas for SNFs, it's going down. I'm somewhat  
6 embarrassed to admit that I didn't realize that was the  
7 case. I don't know, David or others, if you have observed  
8 that in the past.

9 I was curious if there was any sense of what is  
10 explaining that divergence when we, I think, generally have  
11 felt that there's quite a bit of overlap that has existed  
12 between the types of patients that can go into those  
13 facilities.

14 DR. TORAIN: So we noticed, too. And so during  
15 fiscal year 2018 there was a program implemented by CMS  
16 called the Targeted Probe and Educate, with the overall  
17 goal of decreasing the number of claims denials through  
18 education. And so basically if an IRF is identified as a  
19 higher-error IRF, the Medicare administrative contractors  
20 will contact that specific IRF and give them an opportunity  
21 to rectify their claims up to three rounds, and most IRFs  
22 do not make it to the third round. And so we think that

1 what we're seeing, really, is just more claims being  
2 accepted during that time.

3 MS. KELLEY: The other thing, I think we've seen,  
4 I think, exactly as Jamila has said, cases may have gotten  
5 a one-time boost as some claims kind of pushed through that  
6 otherwise would have been held up. But we also think the  
7 less focus on claims denials and the attempts to deny fewer  
8 claims has perhaps provided an opportunity for some IRFs to  
9 admit patients that are more on sort of, maybe on the line  
10 of whether or not they qualify for IRF care, because they  
11 may be less concerned about denials, in general. So we  
12 suspect it's kind of those two things going on at the same  
13 time.

14 DR. MATHEWS: And if I could add one more factor.  
15 If you will recall from the hospital session this morning,  
16 we do see a very small decline in inpatient hospital  
17 admissions, I think 1.6 percent between 2017 and 2018. And  
18 inpatient admission being a prerequisite for SNF, it would  
19 be expected that the decline in inpatient admissions would  
20 have a ripple effect on SNF.

21 DR. CROSSON: All right.

22 MS. KELLEY: And I just would add one more thing,

1 that I think we saw when you were looking at the types of  
2 cases that were increasing, what we saw is a larger than  
3 expected increase in the number of cases with debility.  
4 And that is kind of a catch-all category of patients, not  
5 stroke, not neurological, and more the type of patient you  
6 might think would be admitted to an IRF if perhaps they  
7 didn't have a hospital stay and so couldn't go to a SNF.

8 DR. CASALINO: Excellent presentation and paper.  
9 Thanks. I think I know the answer to this but maybe you  
10 could just lay it out explicitly. So the first bullet  
11 point recommendation you have up there about conducting  
12 focused medical record review, I mean, you could say that  
13 in pretty much any session we're having today, and  
14 particularly it may be the afternoon sessions. Is this --  
15 I don't mean this as a critical question, but to make sure  
16 I understand it -- is there something really special about  
17 IRFs that makes us call it out here, and not for the other  
18 sectors?

19 DR. TORAIN: Part of the case mix classification  
20 system, that motor score that's a part of giving the  
21 patient the -- or placing the patient in a CMG, is provider  
22 reported in the IRF system, and so it is very subjective.

1 So we put it there specifically because of that part of the  
2 case mix system that is very subjective. And so that's why  
3 we pointed out more so than other sectors.

4 MS. KELLEY: And I'll just add to that, that  
5 although the functional scores are part of the home health  
6 and - well, different functional scores but function as  
7 assessed by the provider are a part of the SNF and the home  
8 health payment systems as well, in both those other payment  
9 systems there have been other incentives driving behavior,  
10 such as additional payment for providing more therapy. So  
11 for providers who are looking to capitalize on those types  
12 of incentives, the goal has been to increase the amount of  
13 therapy that patients receive.

14 In the IRF payment system, we've seen sort of a  
15 different incentive focused on, and here it seems to be  
16 much more focused on function. And I think I'll just  
17 remind us of the analysis that Carol did last spring, where  
18 she looked at discharge assessment for patients who used  
19 two PAC services in a row -- discharge from one PAC  
20 provider to another, and she looked at the discharge  
21 assessment from the first PAC provider and the admission  
22 assessment for the second PAC provider.

1           And what she found was quite a bit of  
2 misalignment, if you will, between the two. And  
3 interestingly, it did not seem to be in kind of a random  
4 way. The discharge assessment from the first provider,  
5 which would have been used, in part, to measure quality  
6 improvement, was relatively high, so showing, you know, a  
7 high improvement, and the admission assessment for the  
8 second PAC provider tended to be lower, which is where  
9 payment was established, at the admission, with the  
10 admission assessment of the second provider.

11           So, you know, there does seem to be some  
12 behavioral incentive here that we're kind of seeing in  
13 action.

14           DR. CASALINO: But stronger for IRFs than for  
15 home health?

16           MS. KELLEY: At this time, and I'll just remind  
17 you that we are moving to payment systems in home health  
18 and SNF that, we are happy to say, are no longer reliant on  
19 provision of therapy but they are going to be more reliant  
20 on patient characteristics, such as function.

21           DR. CASALINO: Yeah. Actually, that is what I  
22 was thinking. We might want to think about that more in



1 the future for these other sectors. And is the intention  
2 to make these two recommendations, again, along with the  
3 payment update recommendation, or is this just for us to  
4 see?

5 MS. KELLEY: Last year we reiterated -- the last  
6 two years we've reiterated these along with our updated  
7 recommendation, and the Chairman's draft was to do the same  
8 this year.

9 DR. CROSSON: Paul?

10 DR. PAUL GINSBURG: Yes. This was -- I've been  
11 reading the chapters in order and this was the third one on  
12 post-acute care, and it started to dawn on me about issues  
13 which come up, you know, in all of these different  
14 settings. And, you know, I was wondering if the staff  
15 might think about, after the meeting, whether to construct  
16 an introductory chapter to these next three or four, which  
17 just, you know, explains some of the issues that cut across  
18 that each one has to deal with, and then it can be referred  
19 to as the chapters go through.

20 DR. MATHEWS: Yeah, so in the past we have done,  
21 you know, what we've referred to as PAC preamble chapter,  
22 where we are dealing with specific cross-cutting issues.

1 For example, we looked at quality measurement a year or two  
2 ago, and as we were working up our unified PAC PPS work we  
3 did PAC preambles a couple of times. We could do the same  
4 this time around if there were select issues, but at the  
5 moment we would have to think about it.

6 DR. PAUL GINSBURG: Sure. It is certainly up to  
7 you. I was thinking provider reporting is the one thing  
8 that really struck me, and it may be you don't gain enough.

9 MS. BUTO: Jim, I would also throw into that same  
10 preamble eligibility, which I don't think we highlight  
11 enough. For example, in home health, homebound, the IRF  
12 has certain specific criteria. SNF requires three-day  
13 prior hospitalization. I mean, it helps to set the context  
14 for the fact that I think we tend to think of the PAC PPS  
15 as being the ability to go across these settings, but as  
16 long as these other criteria are still there, we just need  
17 to be aware that there are some sort of barriers to that  
18 kind of, I don't know, I guess site-neutral payment, if you  
19 will, even for the same kind of patient. So if there's  
20 some way to highlight that, I think it's helpful.

21 I had to go back and look to see whether  
22 homebound was even still a criterion, because I think

1 people tend to think of home health as one of the easier  
2 post-acute care benefits to access, and in a way it is, but  
3 that's because they do not enforce the homebound  
4 requirement.

5 MS. MARJORIE GINSBURG: Isn't the definition of  
6 homebound pretty loose anyway?

7 MS. BUTO: Actually, it's pretty specific and  
8 pretty tight, but it's not enforced.

9 MS. MARJORIE GINSBURG: Okay.

10 MS. BUTO: I mean, things like you can go to  
11 church. I mean, very specific as to what constitutes being  
12 able to leave home or not leave home.

13 MS. MARJORIE GINSBURG: But it does make you  
14 think that the true definition of homebound is so strict  
15 that nobody would qualify for home care.

16 MS. BUTO: Right, or very few people.

17 DR. CROSSON: Okay. Okay.

18 DR. DeBUSK: The exchange between Lawrence and  
19 Dana, actually, just to clarify, the PAC PPS that we've  
20 been working on, I remember most of the patient  
21 characteristics that fed into the model. I don't remember  
22 assessments. Were assessments big inputs into that model?

1 MS. KELLEY: No, we don't -- the model that we  
2 developed does not have a functional component to it.

3 DR. DeBUSK: Yeah, I didn't remember one. Now  
4 the model, though, that CMS has switched to in October for  
5 SNF, and it will in January for home health, does that have  
6 assessments in it, or is it truly patient characteristics?

7 MS. KELLEY: It does use the SNF and the home  
8 health assessment tools, yes, which include a functional  
9 component.

10 DR. DeBUSK: So it does pick up increased  
11 vulnerability to -- what did you call it? -- behavioral  
12 incentives or something. Because I remember we don't use  
13 the gaming word anymore. Behavioral incentives, right?

14 MS. KELLEY: I would say yes. I'm looking at  
15 Carol, and yeah, we are agreeing.

16 DR. DeBUSK: So the change, while it is an  
17 improvement away from therapy, it does expose us to some  
18 risk for behavioral incentives on the coding side, but if  
19 we move to the PAC PPS we will be okay because those inputs  
20 aren't -- so the transition to the PAC PPS addresses that  
21 really in all three venues.

22 MS. KELLEY: Right. I mean, I would just say --

1 you're absolutely right in your characterization of that,  
2 and I would just say that I think, you know, for many years  
3 the Commission talked about the need for good, functional  
4 assessment for post-acute care patients, because, you know,  
5 that seems to be the ideal, to see functional improvement  
6 for most -- or many patients. Not all patients will  
7 improve.

8           But I think, you know, what we're seeing over  
9 time, as we look at the assessment data more closely, is,  
10 you know, we've started to have more and more concerns  
11 about the data. And so I think ideally we would -- in an  
12 ideal world we would still want information on patients'  
13 functional status, even in a PAC PPS. I do think that  
14 would help if we had some objective measures. That would  
15 help differentiate for some patients. The question is how  
16 we can get there.

17           DR. DeBUSK: So the changes that are in effect  
18 now are really around getting us away from dependency on  
19 therapy as a payment.

20           MS. KELLEY: Correct.

21           DR. DeBUSK: Determination of payment. But we  
22 still have the glitch, if you will, that we still have some

1 assessments in the current model. But again, the PAC PPS  
2 is a step in that next direction, but philosophically,  
3 we're moving away from provider -- basically provider  
4 assessment.

5 MS. KELLEY: Well, yes, and I would just add  
6 that, you know, the term "assessment," the assessment tools  
7 do carry information on them that's not about function.  
8 There are some special services that might be important for  
9 payment, for example, a patient who is using a ventilator  
10 or receiving particular types of expensive antibiotic  
11 therapy, and that information is on an assessment tool and  
12 could be useful, and it is information that we did use in  
13 our PAC PPS.

14 DR. DeBUSK: Thanks. Great.

15 DR. CROSSON: Jon.

16 DR. PERLIN: Thanks. I want to go back to Paul's  
17 comment about a preamble, and I realize that has, you know,  
18 a lot of implications in terms of effort. But the point  
19 behind that is that we're working with a presumption that  
20 there is a continuum of progressively intense services, and  
21 the most appropriate venue is the, you know, lowest  
22 appropriate for the level of care needs.

1           And, you know, in that regard, I think the  
2 framing, as we think about this progression of complexity,  
3 to have the different puts and takes that Kathy and Marge  
4 had alluded to earlier. But also, you know, when I think  
5 about what are the other issues that could skew where a  
6 patient goes? It's really availability in a particular  
7 service area.

8           And so I wonder if, as part of our thinking about  
9 more of a continuum further out, we don't really need to  
10 think not just about availability of SNFs in a market,  
11 about availability of IRFs or LTCHs, et cetera, but rather  
12 what is the convergence across some sorts of service areas,  
13 so we understand, you know, the impact of geographical  
14 availability in terms of the ability to match level of need  
15 with level of service. Thanks.

16           DR. CROSSON: One sec, because I actually have a  
17 question, and this may be an appropriate time to build on  
18 what Jon just said. And I apologize because I'm pretty  
19 sure I've asked this before. But IRFs are not available  
20 everywhere. We know that, or I believe we know that where  
21 they are not available, acute care hospitals provide the  
22 same or similar services under the IPPS. Do we have any --

1 I'm sorry?

2 DR. TORAIN: And SNFs.

3 DR. CROSSON: And SNF. Okay. But maybe just for  
4 the moment focusing on hospital based, acute care hospital-  
5 based services, do we have any way of estimating how much  
6 more the Medicare program is paying for XYZ services in an  
7 IRF compared with what it pays in an acute care hospital?

8 MS. KELLEY: It's a really difficult question to  
9 answer, because it's very hard to control for placement  
10 issues and selectivity. It is true that an IRF patient  
11 might stay longer in an acute care hospital if it is, you  
12 know, a true post-acute stay, but the patient also could go  
13 to a SNF in some areas, and it's very difficult for us to  
14 control for that when we do an analysis like this.

15 You know, we might be able to -- what do you  
16 think, Carol? We might be able to do some sort of look at  
17 it, but I don't know. I think we would have to have so  
18 many caveats to an analysis like that, that I don't know  
19 that it would be as useful as you would like it to be.

20 DR. CROSSON: Okay. And I won't say why I'm  
21 asking the question. How's that? Pat.

22 MS. WANG: This might slide into a round two sort



1 of thing but let me just ask the question. I think it's  
2 really significant that, you know, you've repeated and  
3 called out these two recommendations in a response to some  
4 of the other questions. You've noted that there's always a  
5 concern, but it's a little heightened here, because of the  
6 nature of the IRF pie.

7           To what extent is the update recommendation a  
8 blunt instrument to get at this, because this hasn't  
9 happened? If this were in place, do you think the update,  
10 like the margins would look different, and do you think the  
11 update recommendation would be different? And, you know,  
12 full disclosure, I am, what I said before, where the  
13 overall margin is close to 15 percent, but it's 2.5 percent  
14 in not-for-profit, hospital-based, and 10 times that in  
15 freestanding for-profit.

16           The disparity, given the concerns that you raise  
17 here, you know, I'm just -- so I guess the question is,  
18 could you just confirm that you haven't been able to sort  
19 of thread a needle in the update factor recommendation that  
20 all these things have happened and you still, for the  
21 revised margin, feel like a 5 percent cut is appropriate,  
22 or is this kind of in lieu of these other things happening?

1 MS. KELLEY: So I think the thing to do is to  
2 think about this in two sort of different buckets. If we  
3 had -- if we felt that costs were better, or evenly aligned  
4 -- or rather if we felt that payments were evenly aligned  
5 with costs across different types of patients, we would see  
6 higher -- I think we would see higher margins in hospital-  
7 based and nonprofits than we currently do, in the absence  
8 of any behavioral change. But that would be moving money  
9 across patients. In terms of an aggregate, we wouldn't see  
10 any change in the total amount of money in the system. So  
11 the average margin, the aggregate average margin would  
12 still be high. So the update recommendation deals with  
13 that second factor.

14 MS. WANG: Okay. And you're looking at it in the  
15 aggregate, because just assuming that that hasn't happened,  
16 this aggregate update factor is going to affect the sectors  
17 quite differently, given the current state.

18 DR. MATHEWS: Pat, let me see if I can take a  
19 stab at answering your question, just from a slightly  
20 different angle. I agree with everything that Dana just  
21 said, this might be more helpful to you.

22 So in the past, other post-acute care sectors

1 we've looked at have had very high margins, SNF and home  
2 health being case examples. And when we have dug into the  
3 payment systems, we have been able to find specific factors  
4 in the payment systems where certain types of cases were  
5 more profitable than others, and we were able to make  
6 recommendations in the way the payment systems operated  
7 such that we could justify an across-the-board reduction in  
8 payments, 5 percent.

9           Here we see, you know, very stark differential  
10 performance across different types of IRFs, but we have yet  
11 to find the thing embedded in the payment system that  
12 allows us to say here is how to fix the payment system and  
13 that's why you can cut payments by 5 percent.

14           And so in lieu of finding that key, we are using  
15 these kinds of recommendations as safeguards. So, for  
16 example, increasing the outlier pool. This is a very, very  
17 blunt instrument, but it does serve to protect those IRFs  
18 who have legitimately high cost case who might really be  
19 adversely affected by a 5 percent cut.

20           And so I think earlier on Jamila or Dana used the  
21 term, you know, "short term" or "stop gap" or "Band-aid."  
22 That's what these recommendations were designed to do.

1 And, you know, among ourselves, the next task we have  
2 underway -- and by "we" I mean Jamila - is to start digging  
3 into the payment systems the same way we've done for SNF  
4 and home health.

5 Does that help get at what you're....

6 DR. CROSSON: Okay. Seeing no more questions,  
7 we'll move to the discussion phase. And we have the  
8 recommendation on the table, but I guess the amendment, if  
9 you want to call it that, or add-on would be the question  
10 of whether to reiterate the 2016 recommendation. So we'll  
11 take those two issues together, and looking around, I'm  
12 assuming support. So we will then take this in expedited  
13 form for the January meeting. Thank you so much, Jamila.  
14 Excellent work. Thank you, Dana, as well.

15 Okay. Our last presentation and discussion for  
16 today is on the update for long-term care hospitals.  
17 Stephanie and Carolyn are here, and, Carolyn, it looks like  
18 you're going to begin. You have the floor.

19 MS. SAN SOUCIE: Good afternoon. Today we are  
20 here to discuss how payments to long-term care hospitals  
21 should be updated for fiscal year 2021. Using the  
22 established framework, we will evaluate the adequacy of

1 Medicare payments to LTCHs. I'll begin with some  
2 background on LTCHs, the implementation of the dual-payment  
3 rate structure, and the first part of the payment adequacy  
4 framework. Then Stephanie will conclude with the remainder  
5 of the framework as well as the Chairman's draft  
6 recommendation.

7 I will start by summarizing some background  
8 information that was included in your mailing materials.  
9 To qualify as an LTCH under Medicare, a facility must meet  
10 Medicare's conditions of participation for acute-care  
11 hospitals. Additionally, LTCHs must have an average length  
12 of stay for certain Medicare cases of greater than 25 days.

13 As you'll recall, the Pathway for SGR Reform Act  
14 of 2013 changed the way LTCHs are paid, establishing a  
15 dual-payment rate structure. Cases meeting the LTCH PPS  
16 criteria are those that are preceded by an acute-care  
17 hospital discharge and either spent three or more days in  
18 the ICU of the referring acute-care hospital or receive  
19 prolonged mechanical ventilation in the LTCH. These cases  
20 are paid under the LTCH PPS and will be the focus of a lot  
21 of the analysis we will walk through.

22 All other cases, those not meeting the LTCH PPS

1 criteria, are paid a lower site-neutral rate. The policy  
2 began in fiscal year 2016 and is being phased in over four  
3 years. Until fiscal year 2020, cases that did not meet the  
4 LTCH PPS criteria were paid a rate equal to 50 percent of  
5 the site-neutral rate and 50 percent of the much higher  
6 standard LTCH payment rate. Beginning this fiscal year,  
7 these cases are paid the reduced rate.

8 Care provided in LTCHs is expensive. Total  
9 Medicare spending on care furnished in 374 LTCHs was  
10 approximately \$4.2 billion in 2018. This total spending  
11 accounted for payments for just over 100,000 Medicare  
12 cases.

13 The average Medicare payment per case was about  
14 \$40,000 across all cases and approximately \$47,000 across  
15 the cases meeting the LTCH PPS criteria discussed on the  
16 previous slide.

17 I will now turn to the question of how payments  
18 to LTCHs should be updated for fiscal year 2021. To  
19 determine the update recommendation, we review payment  
20 adequacy using our established framework consistent with  
21 what you've seen in other sectors throughout the day.

22 To begin, we'll focus on beneficiaries' access to

1 care.

2           While we apply the framework on the prior slide  
3 in the same manner for LTCHs, we expect substantial changes  
4 from the implementation of the dual-payment rate structure  
5 given the financial disincentive for LTCHs to continue  
6 taking Medicare beneficiaries not meeting the LTCH PPS  
7 criteria. Because of the reduction in payment, the extent  
8 to which LTCHs are able to alter their admission patterns  
9 toward cases meeting the LTCH PPS criteria determines  
10 facilities' financial performance under Medicare. Because  
11 some LTCHs have dramatically altered their admission  
12 patterns in response to the policy consistent with the  
13 goals of the dual-payment rate structure, we isolate some  
14 of our analyses to the LTCHs with more than 85 percent of  
15 their cases meeting the LTCH PPS criteria in 2018.

16           Approximately 38 percent of LTCHs met the 85  
17 percent threshold in 2018. All of their Medicare stays  
18 account for 37 percent of total Medicare stays that year.  
19 Please note that this is a correction from Table 11-8 of  
20 the mailing materials. We will specify when we consider  
21 this subset of providers during the presentation.

22           We find the number of LTCH cases has been

1 declining since 2012. The reduction in volume has not been  
2 consistent across case types over the past six years. The  
3 number of cases meeting the LTCH PPS criteria remained  
4 remarkably stable over time. Most of the attrition of LTCH  
5 use we have seen since 2015 came from a reduction in cases  
6 not meeting the LTCH PPS criteria. As you can see, the  
7 number of these cases declined rapidly from 2016 to 2018.  
8 As a result, the share of LTCH cases meeting the LTCH PPS  
9 criteria has increased since 2012.

10 The number of LTCH facilities has been decreasing  
11 since 2012. There was a 6.4 percent reduction in the  
12 number of LTCHs from 2012 to 2017 and a 5.1 percent  
13 reduction from 2017 to 2018. We also found additional  
14 closures occurring in 2019.

15 In 2018, LTCH occupancy rates averaged around 63  
16 percent, a three-percentage-point drop from 2016. This  
17 suggests that LTCHs had ample capacity in the markets they  
18 served.

19 Medicare marginal profit across all LTCHs was 16  
20 percent in 2018, up from about 14 percent in 2017. The  
21 marginal profit for LTCHs with a high share of Medicare  
22 beneficiaries meeting the LTCH PPS criteria was 18 percent



1 in 2018. Therefore, we contend that LTCHs have a financial  
2 incentive to increase their occupancy rates with Medicare  
3 beneficiaries who meet the LTCH PPS criteria.

4 Now Stephanie will take over the rest of the  
5 payment adequacy framework, starting with quality of care.

6 MS. CAMERON: Not unexpectedly, given differences  
7 in patient severity, unadjusted rates of direct LTCH to  
8 acute-care hospital readmissions, death in the LTCH, and  
9 death within 30 days of discharge from the LTCH varied  
10 depending on whether or not the case met the LTCH PPS  
11 criteria, but were generally stable over time.

12 In 2018, for cases meeting the LTCH PPS criteria,  
13 10 percent were readmitted to the acute-care hospital  
14 directly from the LTCH, 16 percent died in the LTCH, and 13  
15 percent died within 30 days of discharge from the LTCH. By  
16 comparison, cases not meeting the LTCH PPS criteria have  
17 lower rates of readmission and mortality.

18 CMS publishes data for several outcomes measures  
19 including rates of various infections. Publicly available  
20 data for several of these measures spans more than one year  
21 and thus can be used for some analysis. In 2018, the  
22 standardized infection ratios for all four infection types

1 listed on the screen were lower than expected after  
2 adjustments for certain risk factors, consistent with 2017,

3           Moving on, we will now discuss the third piece of  
4 our payment adequacy framework, access to capital. Access  
5 to capital allows LTCHs to maintain and modernize their  
6 facilities; however, given the last decade of policies that  
7 have limited industry growth, including moratoria on new  
8 facilities and the implementation of the dual-payment rate  
9 structure, the availability of capital is limited across  
10 the industry. Major chains have been diversifying their  
11 portfolios and have been strategic in their purchase, sale,  
12 and closure of LTCH facilities in more competitive LTCH  
13 markets. These major industry shifts have reduced the need  
14 for capital. We expect major industry changes to continue  
15 until after the dual-payment rate structure is fully phased  
16 in.

17           LTCHs' access to capital also depends on their  
18 all-payer profitability, which was 2.2 percent in 2018 up  
19 from 0.2 percent in 2017. LTCHs with more than 85 percent  
20 of their Medicare cases meeting the LTCH PPS criteria had  
21 an aggregate all-payer margin of 4.5 percent in 2018.

22           And, lastly, our final factor of the payment

1 adequacy framework is Medicare payments and costs. We  
2 continued to find the difference in cost growth across  
3 LTCHs following the implementation of the dual-payment rate  
4 structure.

5           For example, across all LTCHs we found small  
6 increases from 2015 to 2017; however, cost growth increased  
7 2.7 percent in 2018, likely due to increases in the share  
8 of patients meeting the LTCH PPS criteria.

9           On the other hand, for LTCHs with a high share of  
10 cases meeting the LTCH PPS criteria, larger growth in cost  
11 occurred from 2015 to 2017, averaging 3.6 percent annually.  
12 For these LTCHs, from 2017 through 2018, we saw cost growth  
13 stabilize at 1 percent. These trends are not unexpected  
14 given the large range of admission strategies following the  
15 partial implementation of the dual-payment rate structure.  
16 LTCHs that substantially increased the share of cases  
17 meeting the LTCH PPS criteria had higher cost growth; once  
18 the share of those patients stabilized, cost growth also  
19 stabilized.

20           Even with a 2.7 percent increase in costs, in  
21 2018 the aggregate LTCH margin increased by 1.7 percentage  
22 points to negative 0.5 percent. Consistent with prior

1 years, financial performance in 2018 varied across LTCHs.  
2 For example, for-profit LTCHs had the highest aggregate  
3 Medicare margin at 1.3 percent compared to nonprofit LTCHs  
4 at negative 11.7 percent.

5 LTCHs with a high share of Medicare cases meeting  
6 the LTCH PPS criteria have historically had higher margins,  
7 in part due to the case mix and relatively high  
8 profitability of Medicare cases admitted. In 2018, the  
9 aggregate Medicare margin for these LTCHs was 4.7 percent,  
10 a two-percentage-point increase from 2017.

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 2018 margins  
14 with those in the bottom. More than half of the LTCHs with  
15 the highest Medicare margins in 2018 also had more than 85  
16 percent of their Medicare cases meeting the LTCH PPS  
17 criteria. Therefore, many, although not all, of the  
18 attributes of the highest-margin facilities overlapped with  
19 those LTCHs with a high share of cases meeting the LTCH PPS  
20 criteria.

21 As you can see, high-margin LTCHs tend to be  
22 larger and have higher occupancy rates, so they likely

1 benefit more from economies of scale. Low-margin LTCHs had  
2 standardized costs per discharge that were almost 50  
3 percent higher than high-margin LTCHs. High-margin LTCHs  
4 are more likely to be for-profit.

5 We project that the aggregate Medicare margin for  
6 LTCHs with a high share of cases meeting the LTCH PPS  
7 criteria will increase in 2020. Our projection of the LTCH  
8 margin for fiscal year -- excuse me, decrease in 2020. Our  
9 projection of the LTCH margin for fiscal year 2020 focuses  
10 on these LTCHs which align with the goals of the dual-  
11 payment rate policy -- encouraging LTCHs to admit the most  
12 medically complex cases requiring specialized services. We  
13 expect significant changes in LTCHs' costs as the dual-  
14 payment rate structure is fully implemented and LTCHs  
15 continue to increase their Medicare admissions toward cases  
16 that meet the LTCH PPS criteria.

17 However, once an LTCH has reached a threshold of  
18 Medicare cases that meet the criteria, we expect changes in  
19 cost will become increasingly stable and reflect cost  
20 growth levels consistent with those prior to 2016. Using  
21 historical levels of cost growth, we project a 3.7 percent  
22 Medicare margin for LTCHs with a high share of cases

1 meeting the LTCH PPS criteria in 2020.

2 In sum, occupancy rates across the industry have  
3 decreased slightly. Although growth in the volume of LTCH  
4 services per beneficiary declined, this decline is in large  
5 part from the implementation of the dual-payment rate  
6 structure and LTCHs admitting more patients meeting the  
7 LTCH PPS criteria which aligns with the goals of the  
8 policy.

9 In terms of quality, unadjusted mortality and  
10 readmission rates appear to be stable while the adjusted  
11 infection rates continue to be lower than expected.

12 The effect of fully implementing the dual-payment  
13 rate structure will continue to limit industry growth and  
14 access to capital in the near term. The aggregate margin  
15 for LTCHs with a high share of cases meeting the LTCH PPS  
16 criteria increased to 4.7 percent in 2018. Our projected  
17 margin for these LTCHs in 2020 is 3.7 percent.

18 There is no statutory update for Medicare  
19 payments to LTCHs; however, CMS historically has used the  
20 LTCH market basket as a starting point for establishing the  
21 LTCH update. Therefore, we make our recommendation to the  
22 Secretary.

1           With that, the Chairman's draft recommendation  
2 reads: For 2021, the Secretary should increase the fiscal  
3 year 2020 Medicare base payment rate for long-term care  
4 hospitals by 2 percent.

5           This 2 percent update is expected to reduce  
6 federal program spending relative to the 2.8 percent  
7 expected regulatory update, given current projections of  
8 market basket and productivity.

9           We anticipate that LTCHs can continue to provide  
10 Medicare beneficiaries who meet the LTCH PPS criteria with  
11 access to safe and effective care.

12           And, with that, I turn it back to Jay.

13           DR. CROSSON: Thank you, Stephanie and Carolyn.

14           We're now open for clarifying questions. David  
15 and Jonathan.

16           DR. GRABOWSKI: Thanks for this presentation and  
17 report. I wanted to ask about the dual-payment rate  
18 structure. Reading the chapter and then seeing this  
19 presentation, I think it seems like it's working as  
20 intended. And to the extent that you wanted to criticize,  
21 as you said, beneficiaries' access to care has been  
22 limited, but limited in the ways that the policy was

1 intended to limit that care, and similar with access to  
2 capital.

3           So have there been any unintended consequences of  
4 the dual rate structure? Because this seems very, very  
5 positive.

6           MS. CAMERON: So I think it really frankly  
7 depends on who you speak with. You know, from our  
8 perspective, the policy is working as intended. I think  
9 from the industry perspective, I think for the most part  
10 folks we've talked to -- and you'll recall we did a  
11 mandated report on this last June. We've been to, I think,  
12 over 15 different cities and seen various LTCHs in those  
13 areas. So the people we've talked to have been relatively  
14 on board with kind of the intent of the policy, and I think  
15 in general the criteria seems like it's in the right  
16 direction.

17           I think where there have been concerns it  
18 pertains to wound care, and there was one study -- and we  
19 referenced this I believe in our June chapter -- that did  
20 show an associated increase in readmissions, I believe,  
21 with patients receiving wound care at other non-LTCH  
22 facilities. But that has been the kind of one area, and I



1 think when the Commission originally recommended this back  
2 in 2014 and based on the work that was done long ago in a  
3 kind of PAC-PRD and by, you know, the RTI analysis, wound  
4 care was not something that was included in the  
5 recommendation. But that has been, I would say, like the  
6 one primary concern that we have heard from industry.

7 DR. CASALINO: On this point, Jay. So fewer  
8 patients, fewer non-LTCH patients are going to the long-  
9 term care hospitals. Is there a sense of where they're  
10 going? And wherever that is, if we know, is that a good or  
11 a bad thing?

12 MS. CAMERON: So I think this is a very tricky  
13 question, and, you know, kind of following up on what Dana  
14 said about the difference between the IRF and the PPS, I  
15 think, you know, some of the patients are staying in the  
16 hospital a little bit longer. Their stays may have been  
17 extended a few days, and then they're subsequently  
18 discharged to a different post-acute care setting. Once  
19 they are stable enough and able to go to a SNF, for  
20 example, perhaps they go to that setting.

21 I think something to keep in mind is the volume  
22 of these patients is very low when you compare them to the

1 volume of overall hospital patients and the volume of  
2 patients going to SNFs. So hospitals have close to nine,  
3 ten million patients. We are talking about 100,000. You  
4 think about how many patients go to SNFs. It's a very  
5 small share. And so these patients are very difficult to  
6 track when you think of who would have gone to an LTCH.  
7 But for the most part, you know, our understanding is  
8 they're staying in the acute-care hospital potentially a  
9 little bit longer, and then they're discharged to other  
10 post-acute care settings.

11 DR. CROSSON: Jonathan?

12 DR. JAFFERY: Yeah. So thanks to you both for a  
13 great presentation and a clear chapter.

14 Two questions. The first is just to clarify.  
15 The phasing period from the 50-50 split over four years,  
16 was it progressive or was it 50-50 for four years and now  
17 it will be 100?

18 MS. CAMERON: So it was 50-50 for four years, and  
19 it's moving to 100. But it's on an individual hospital's  
20 cost reporting year. So we haven't really seen many  
21 facilities go to 100 percent yet, even though technically  
22 we're in fiscal 2020.

1 DR. JAFFERY: Okay.

2 MS. CAMERON: It will be later this year.

3 DR. JAFFERY: Yeah. Okay, great. Thanks.

4 Then thinking about the two ways to get the  
5 standard, the new standard LTCH PPS, so the three days in  
6 an ICU and the 96 hours of mechanical ventilation, have you  
7 tried to sort out if there are any differences in those two  
8 patient populations in terms of costs or outcomes or  
9 anything like that? I ask because it strikes me that there  
10 may be a greater degree of heterogeneity in the folks who  
11 had an ICU stay -- ICUs are very different at different  
12 hospitals and whatnot -- versus the mechanical ventilation.

13 MS. CAMERON: We haven't looked at this  
14 specifically.

15 There was a study published last year by folks --  
16 Jeremy Khan was one of the authors -- up in Pittsburgh  
17 looking at the variation in outcomes for ventilator  
18 patients at an LTCH, and the variation was quite wide, and  
19 I think wider than you would expect. And there is going to  
20 be additional research kind of thinking about best  
21 practices that we're hoping is going to be published in the  
22 next year. So, hopefully, next year, we'll have a more

1 satisfying answer, but we haven't looked specifically kind  
2 of at the variation in outcomes for those two populations.

3 DR. JAFFERY: Thank you.

4 DR. CROSSON: Okay. Seeing no further questions,  
5 we'll move on to the discussion phase. We have the  
6 recommendation before you for a 2 percent increase. Any  
7 observations?

8 [No response.]

9 DR. CROSSON: Seeing none, I am interpreting this  
10 is general -- I saw something. Jonathan?

11 DR. JAFFERY: Let me just -- I am in general  
12 support of the recommendations.

13 The only thing I'm -- so I've said this before at  
14 different meetings, but I'm still struggling with where  
15 LTCHs fit in, in this post-acute care spectrum, and is it  
16 really post-acute care? I think about 30 percent of people  
17 actually dying in the stay or 30 days after discharge. I  
18 just continue to struggle with that.

19 So I think the way that I was thinking about  
20 addressing that in the context of our discussion this  
21 afternoon kind of goes back to Paul's comment about maybe a  
22 preamble. if that is something that the staff is able to

1 get to and looking at the different post-acute care  
2 settings as we're going into a unified PAC PPS, maybe  
3 there's some ways we can start to think about how it's  
4 really different maybe from the other settings, and is it  
5 really going to fit in with that, or do we need to think  
6 about something a little bit different about where is  
7 LTCH's role really? So that's my comment.

8 DR. CROSSON: So the patient characteristics that  
9 would fulfill the criteria that are currently used for  
10 LTCH, I think you're saying might not fit in other post-  
11 acute care settings, by and large.

12 DR. JAFFERY: Correct. Yeah.

13 DR. CROSSON: And I think that's right, but some  
14 would.

15 DR. JAFFERY: Yeah. And does it mean that maybe  
16 LTCHs are on a spectrum with actual acute care hospitals  
17 and there's some other way to address how do we take care  
18 of patients who need prolonged mechanical ventilation or  
19 wound care or other things that maybe are through some  
20 other outlier, payments, and can address some other --

21 DR. CROSSON: Right. Or we could see the  
22 evolution of a higher quality or a higher set of

1 capabilities, for example, in skilled nursing facilities as  
2 a consequence of this.

3 I'm sorry. Brian and Amol.

4 DR. DeBUSK: I was going to say to your point, I  
5 think there's some history here, and I'm going to guess  
6 that Kathy and Paul could probably tell us right off the  
7 top of their heads. But we even created LTCHs, I think,  
8 because there were like maybe 40 hospitals that didn't fit  
9 back in 1982, that didn't fit the DRGs. So we created that  
10 separate payment area, but then we went back and acuity-  
11 adjusted the DRGs. I remember reading some history about  
12 that. We added acuity adjustment to the ACH, the acute  
13 hospital DRGs.

14 MS. BUTO: The history I remember is trying to  
15 eliminate LTCHs as a provider type, and then it went into a  
16 moratorium and so on. I think they really do have a niche,  
17 though, with mechanical ventilation and those kinds of  
18 patients. Just like IRFs, they aren't everywhere. There  
19 are some places where there are no LTCHs. It goes back to  
20 the issue of putting this in context because these  
21 patients, there is some overlap, but there is a lot of non-  
22 overlap with some of these patients.

1 DR. DeBUSK: To more specifically answer  
2 Jonathan's point about that, I think it was maybe you and  
3 I. I was asking you at some point, could you just take the  
4 DRGs, the severity-adjusted, the MS-DRGs, just add a couple  
5 of extra levels of acuity or length? I mean, they work off  
6 the same DRG table, anyway. They're just in a different  
7 base. The base rate is just like four times more  
8 expensive.

9 The question is, could you sort of pack those  
10 back into -- this is a little outside the payment update  
11 conversation, but could you pack the LTCH codes back into  
12 the acute care hospital DRG schedule by just adding, say, a  
13 Level 4 and a Level 5 to some of these severity levels in  
14 the DRG?

15 MS. BUTO: We probably could. I don't know,  
16 Brian, but I think the hope is that with the PAC, unified  
17 PAC PPS, that we'll see some of this sort out into the  
18 appropriate settings, or there will be units in a way that  
19 are providing PAC services, maybe within an acute care  
20 hospital. So I think the road we're on toward a unified  
21 PAC is a good way to get to that next stage, whatever it  
22 is.

1 DR. CROSSON: I'm not sure who went first. Amol  
2 and then Jon.

3 DR. NAVATHE: Related to the point, it also sort  
4 of touches on Larry's question. What I was wondering is  
5 would we -- I guess this is a speculation, so I'm curious  
6 to hear your speculation. Would a potential unintended  
7 consequence in some sense be that we see more outlier cases  
8 in short-term acute hospitals, and is that something that  
9 we possibly track in some way or query on to try to better  
10 understand?

11 MS. CAMERON: So it is a potential that you could  
12 see additional outlier cases. Again, I think that when you  
13 just think about the sheer low volume relative to the rest  
14 of acute care hospital cases, it's very difficult to detect  
15 any changes and then attribute it to this policy in  
16 particular.

17 Again, it's 1 percent of PAC cases here. So I  
18 just really caution kind of those types of analyses. It  
19 would be very, very difficult to detect change.

20 DR. CROSSON: Jon?

21 DR. PERLIN: Yeah. I want to come back to this  
22 notion of matching level of care needs with level of



1 service offered. Taken to its fruition, a PAC PPS has an  
2 implication that it really is less related to the  
3 nomenclature around the facility and the capability of what  
4 that facility offers.

5 Jay, you have just pointed out the regional  
6 differences and the availability of IRFs. SNFs adapt.  
7 There are regional difference obviously in LTCH and other  
8 settings evolved as well.

9 Which again points to the data for the sort of  
10 explanation of continuum that Paul pointed out. I just  
11 want to go back from the highest acute to the least acute  
12 on the home health. Ironically -- and this is perhaps from  
13 a provider perspective -- it's in some ways more difficult  
14 to access home health by virtue of the rules around it.

15 I want to go back to an earlier conversation we  
16 had in which -- Kathy, you have just pointed out the fact  
17 that home health has evolved. The original notions of  
18 homebound are pressed. Is this a moment where we really  
19 think about the utility?

20 I think in an earlier discussion, Karen and Sue  
21 pointed out that, gosh, home health has such high utility,  
22 not just post-acute, but really as a preventive service,

1 and if the utility is to keep patients healthiest out of  
2 acute care environments, et cetera, then this may be the  
3 time just as we think about this comprehensively to think  
4 about making sure that we can access those lower levels of  
5 service so the higher levels of service aren't necessary,  
6 notwithstanding the obvious benefit to patient.

7 Thanks.

8 DR. CROSSON: Okay. Thank you, Jon.

9 Seeing no further discussants, I am once again  
10 making the assumption that we have support for the  
11 recommendation. Therefore, in January, we'll bring this  
12 forward through the expedited voting process, without  
13 objection.

14 Carolyn, Stephanie, thank you very much.  
15 Excellent work.

16 We now have an opportunity for a public comment  
17 period. If there are any of our guests who wish to make a  
18 comment about the business before the Commission this  
19 afternoon, please come forward to the microphone.

20 [No response.]

21 DR. CROSSON: Seeing none, we are adjourned until  
22 8:30 tomorrow morning.

1                   [Whereupon, at 3:43 p.m., the meeting was  
2 adjourned, to reconvene at 8:30 a.m., Friday, December 6,  
3 2019.]

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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 6, 2019  
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
PAUL GINSBURG, PhD, Vice Chair  
KATHY BUTO, MPA  
LAWRENCE P. CASALINO, MD, PhD  
BRIAN DeBUSK, PhD  
KAREN B. DeSALVO, MD, MPH, Msc  
MARJORIE E. GINSBURG, BSN, MPH  
DAVID GRABOWSKI, PhD  
JONATHAN B. JAFFERY, MD, MS, MMM  
AMOL S. NAVATHE, MD, PhD  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

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AGENDA	PAGE
Assessing payment adequacy and updating payments: Outpatient dialysis services	
- Nancy Ray, Andy Johnson.....	3
Assessing payment adequacy and updating payments: Hospice services	
- Kim Neuman.....	52
The Medicare Advantage program: status report	
- Andy Johnson, Luis Serna.....	105
Public Comment.....	151

P R O C E E D I N G S

1

2

[8:30 a.m.]

3

4

DR. CROSSON: Okay. I think it's time we can get started.

5

6

7

We apologize for the noise. You're actually not on an airplane. That's some strange noise that apparently is going to be fixed soon. That's the theory, anyway.

8

9

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11

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13

I'd like to welcome everybody to the Friday's session of our December MedPAC meeting. This morning, we have a continuation of yesterday's work, which is our annual work on payment updates, and we have two presentations. And then we will do our annual status update on the Medicare Advantage program.

14

15

16

So the first presentation is on outpatient dialysis service. Nancy and Andy are here, and Nancy looks like she's going to begin. You have the floor.

17

18

19

MS. RAY: Good morning. Today we are going to talk about the outpatient dialysis payment update for calendar year 2021.

20

21

22

First, I'll discuss some background on this payment system. Then we'll walk through the payment adequacy analysis, and we'll end with the Chairman's draft

1 recommendation

2           Outpatient dialysis services are used to treat  
3 most patients with end-stage renal disease. In 2018, there  
4 was roughly 395,000 Medicare fee-for-service dialysis  
5 beneficiaries treated at 7,400 facilities. Total Medicare  
6 fee-for-service spending was about \$12.7 billion for  
7 dialysis services.

8           This slide highlights the recent changes to the  
9 ESRD prospective payment system, PPS, and the payment for  
10 certain drugs, equipment, and supplies outside the payment  
11 bundle.

12           Beginning in 2018, calcimimetics have been paid  
13 outside the bundle under a transitional drug add-on payment  
14 policy, a TDAPA. Later in the presentation I'll come back  
15 to the effect of the TDAPA on Medicare spending and cost.

16           In 2020, the add-on payment for drugs, the TDAPA,  
17 will be expanded, and a new add-on payment policy for ESRD  
18 equipment and supplies will begin.

19           So let's move to our payment adequacy analysis.  
20 As you have seen, we look at the factors listed on this  
21 slide, which include examining beneficiaries' access to  
22 care, changes in the quality of care, providers' access to

1 capital, and an analysis of Medicare's payments and  
2 providers' costs.

3 We look at beneficiaries' access to care by  
4 examining industry's capacity to furnish care as measured  
5 by the growth in dialysis treatment stations. Between 2017  
6 and 2018, growth in dialysis treatment stations grew faster  
7 than fee-for-service beneficiary growth.

8 Between 2017 and 2018, more facilities opened  
9 than closed. There was a net increase of roughly 320  
10 facilities. Few facilities closed in 2017. There was a net  
11 increase in for-profit, freestanding facilities, as well as  
12 facilities located in rural and urban areas. The roughly  
13 70 facilities that closed were more likely to be hospital-  
14 based and nonprofit, compared to all other facilities.

15 Few patients, about 0.4 percent, were affected by  
16 these closures. Our analysis suggests that affected  
17 patients were able to obtain care elsewhere.

18 Another indicator of access to care is the growth  
19 in the volume of services, trends in the number of dialysis  
20 fee-for-service covered treatments, and fee-for-service  
21 dialysis beneficiaries.

22 Between 2017 and 2018, both grew at similar rates



1 of less than 1 percent, and average treatments per  
2 beneficiary remained steady in both years. The 18 percent  
3 marginal profit suggests that providers have a financial  
4 incentive to continue to serve Medicare beneficiaries.

5 Each year, we also look at volume changes by  
6 measuring growth in the volume of dialysis drugs included  
7 in the PPS payment bundle. Since the PPS was implemented  
8 in 2011 and these drugs were included in the payment  
9 bundle, providers' incentive to furnish them, particularly  
10 the erythropoietin stimulating agents, ESAs, has changed.

11 Between 2010 and 2018, use of ESAs has declined  
12 by nearly 60 percent in aggregate, with some positive  
13 changes to beneficiaries' health status.

14 Expanding the payment bundle in 2011 is an  
15 example of the how Medicare used payment policy to decrease  
16 spending and improve health outcomes.

17 In more recent years, since 2015 and 2016, we see  
18 substitution among the ESAs for the lower-cost product,  
19 which is consistent with the goals of the PPS.

20 Now we look at quality by examining changes  
21 between 2013 and 2018. One indicator that measures how  
22 well the dialysis treatment removes waste from the blood,

1 dialysis adequacy, remains high. The percent of dialysis  
2 beneficiaries using home dialysis, which is associated with  
3 improved quality of life and patient satisfaction,  
4 increased from 10 percent to 12 percent in this five-year  
5 period.

6 Hospital admissions has modestly declined, and  
7 mortality and the percent of hospitalized beneficiaries  
8 with a readmission have held steady. These are all good  
9 trends.

10 On the other hand, the percent of dialysis  
11 beneficiaries with at least one emergency department visit  
12 increased.

13 Regarding access to capital, indicators suggest  
14 it is positive. An increasing number of facilities are  
15 for-profit and freestanding. Private capital appears to be  
16 available to the large and smaller-sized dialysis  
17 organizations.

18 Since the start of the dialysis PPS, the two  
19 largest dialysis organizations have had sufficient access  
20 to capital to each purchase mid-sized dialysis  
21 organizations. There are new entrants to the dialysis  
22 sector in recent years, including CVS Health that is

1 currently running clinical trial for a home hemodialysis  
2 machine. The 2018 all-payer margin was 20 percent.

3 So now let's talk about providers' financial  
4 performance under Medicare. This slide shows the Medicare  
5 margin under the ESRD PPS since 2011.

6 In the early years, the increase in the margin is  
7 chiefly a result of the decline in drug use. The decrease  
8 in the margin between 2013 and 2017 was due to the rebasing  
9 of the base PPS rate to account for the decline in drug  
10 use, as I showed you on slide 7.

11 The increase in the Medicare margin between 2017  
12 and 2018 is a result of the TDAPA for calcimimetics that  
13 began in 2018, and in 2020, the TDAPA will expand and there  
14 will be a new add-on payment for equipment and supplies.

15 So, in 2018, the Medicare margin was 2.1 percent.

16 Between 2017 and '8, the TDAPA has increased the  
17 Medicare margin across all of the facility types listed on  
18 this slide by 2 to 3 points.

19 Even with the TDAPA effect, we still see the  
20 difference in the margins between rural and urban  
21 facilities. In 2018, the aggregate Medicare margin for  
22 rural facilities, which account for 17 percent of

1 facilities, was negative 2.8 percent.

2           The lower Medicare margin for rural facilities is  
3 related to their capacity and treatment volume. Rural  
4 facilities are on average smaller than urban ones. They  
5 have fewer treatment stations and provide fewer treatments,  
6 and smaller facilities have substantially higher cost per  
7 treatment than larger facilities, particularly overhead and  
8 capital costs.

9           I would like to point out that in 2018, however,  
10 the majority of treatment volume was furnished at positive-  
11 margin facilities.

12           So let's review the factors that the 2020  
13 projection accounts for. It accounts for the increase in  
14 revenues based on the net payment updates in 2019 and 2020.

15           It also accounts for the increase in payments due  
16 to regulatory changes made by CMS to the outlier payment  
17 policy in both years.

18           It also accounts for the decrease in payments  
19 from the reduction of the TDAPA payment in 2020 from 106  
20 percent of ASP to 100 percent of ASP.

21           And, lastly, to accounts for the small estimated  
22 reduction in total payments due to the ESRD Quality

1 Incentive Program.

2           The projection does not account for the expanded  
3 TDAPA or the new equipment add-on payment that will begin  
4 in 2020, which might improve providers' financial  
5 performance.

6           The 2020 projected Medicare margins is 2.4  
7 percent, a small increase from the 2018 margin.

8           So here is a quick summary of the payment  
9 adequacy findings. Access to care indicators are generally  
10 favorable. Quality is improving for some measures. The  
11 2020 Medicare margin is projected at 2.4 percent.

12           So now we come to the Chairman's draft  
13 recommendation, which reads for calendar year 2021, "The  
14 Congress should update the calendar year 2020 Medicare end-  
15 stage renal disease prospective payment system base rate by  
16 the amount determined in current law."

17           This draft recommendation has no effect on  
18 spending relative to current law. We expect beneficiaries  
19 to continue to have good access to outpatient dialysis  
20 care, and we expect continued provider willingness and  
21 ability to care for Medicare beneficiaries.

22           Thank you.

1 DR. CROSSON: Okay. Thank you, Nancy.

2 We'll now take clarifying questions for the  
3 presentation.

4 Brian?

5 DR. DeBUSK: First of all, thank you for a great  
6 report, well written. It was a good read.

7 I had a question, though, about page -- and this  
8 is TDAPA, basically on TDAPA. On page 39 of the mailing  
9 materials, you talk about the calcimimetics basically  
10 reversing the Medicare margin from what would have been  
11 minus 2 percent to 2.1 percent, so about a 4-point swing,  
12 correct?

13 MS. RAY: It's about a 2- to 3-point swing,  
14 depending upon --

15 DR. DeBUSK: Okay.

16 MS. RAY: -- the facility type.

17 DR. DeBUSK: Okay. Yeah. So I was looking at  
18 2.1 and without it, okay, minus 2.

19 But then I noticed on page 36, you were talking  
20 about that the calcimimetics was about 6 percent of cost  
21 per treatment.

22 MS. RAY: Right. So what happened with the

1 calcimimetic -- now, the calcimimetic increased Medicare  
2 payment by \$26 per treatment on average. It increased  
3 providers' cost roughly by \$19 per treatment -- I'm sorry.  
4 Total cost per treatment increased by \$19 per treatment.

5 I don't know specifically the -- using cost  
6 reports, I can't identify specific calcimimetics cost  
7 because it's included in a bigger category.

8 If I do a rough estimate, however, because that  
9 category has been declining since 2014, I would roughly  
10 estimate the calcimimetics increased providers' cost by \$15  
11 per treatment. So you're looking at -- and, again, that's  
12 a really rough estimate of \$15 in cost for calcimimetics  
13 compared to \$26 in treatment.

14 DR. DeBUSK: Okay. I was just --

15 MS. RAY: In payment.

16 DR. DeBUSK: I was just curious, and again, the  
17 analysis is excellent. I was just curious about how a 6  
18 percent cost, source of cost, could swing margin a full 4  
19 percent unless you were shedding something completely.  
20 Maybe there was another drug they weren't using and still  
21 being paid in the prospective bundle for.

22 Is the TDAPA payment -- I mean, it's a separate

1 ASP plus 6 payment on top.

2 MS. RAY: In 2018 and 2019, it's 106 percent of  
3 ASP.

4 DR. DeBUSK: Okay. And then it goes to 100  
5 percent.

6 But I'm back to -- and, again, I'm trying to make  
7 the numbers tie because it seems like we have a scheme  
8 setup here where -- a systems setup here where anytime a  
9 new TDAPA drug is introduced, if it's a substitute for  
10 anything that could possibly be in the bundle, it would be  
11 economically unwise not to adopt the new drug, whether it's  
12 better or not.

13 MS. RAY: Right. So there is no calcimimetic  
14 already in the bundle.

15 DR. DeBUSK: Okay.

16 MS. RAY: When it goes into the bundle, these two  
17 drugs will be the first two calcimimetics -- the oral and  
18 the injectable.

19 I am not a clinician. The only thing I can say  
20 is when you look at page 20, table 4, the percent change,  
21 they will be included in the category, in the therapeutic  
22 class that includes vitamin D agents.



1 DR. DeBUSK: Okay.

2 MS. RAY: And those three vitamin D agents  
3 declined between 2017 and 2018. That's not totally unusual  
4 because dialysis drugs under the PPS have been declining.

5 DR. DeBUSK: So it's unclear how much the effect  
6 of bundling, the ongoing bundling of drugs and the ongoing  
7 decline, how much of that decrease is coming from that and  
8 how much of that is there possibly a calcimimetic that's  
9 pushing another drug out of this bundle or into lower use.

10 MS. RAY: Again, I don't know if calcimimetics  
11 substituted for vitamin D, and 2018 is the first year for  
12 calcimimetics paid under the TDAPA.

13 DR. DeBUSK: Okay. Again -- and I'll leave it at  
14 that -- I'm just a little confused that 6 percent of your  
15 cost could swing 4 percent of your margin unless you're  
16 getting something for free.

17 MS. RAY: I mean, it also increased Medicare  
18 spending by 11 percent between 2017 and 2018.

19 DR. DeBUSK: Okay. Well, thank you, and again,  
20 great report.

21 DR. CROSSON: Yeah. On this point? And you're  
22 next, anyway.

1 MS. BUTO: Yeah. Nancy, I thought I read in the  
2 mailing materials that a drug in the bundle, if a new drug  
3 came along, would not be eligible for the add-on payment,  
4 that there was something already in the bundle, and I  
5 wondered if that applied to oral forms of drugs that are in  
6 the bundle that are not oral, for example. But isn't that  
7 right that if there's something in the bundle, there's an  
8 add-on, even if it's the next generation of the drug in the  
9 bundle?

10 I'm watching your body language, but I'm not  
11 getting an answer.

12 [Laughter.]

13 DR. JOHNSON: I am having trouble with the  
14 microphone.

15 So the first version of the TDAPA policy was just  
16 for drugs that were outside of the bundle currently.

17 MS. BUTO: Right.

18 DR. JOHNSON: Then there was a revision to the  
19 policy that included TDAPA payments for drugs that were  
20 already included in the bundle for two years. There was a  
21 slight difference as to how much the -- the effect on the  
22 base rate. So if a drug outside the bundle was included

1 through the TDAPA, the base rate will ultimately be updated  
2 at the end of the TDAPA period, but --

3 MS. BUTO: Updated meaning reduced to account for  
4 the new?

5 DR. JOHNSON: Likely increased, but it would  
6 account for the new mix of drugs that are now in the  
7 bundle, a set of services and drugs in the bundle. Now  
8 there's a new one. So it's going to be updated to reflect  
9 that new set.

10 For drugs or categories that are already in the  
11 bundle, the drug would just be included in, and the bundle  
12 would not need to be updated because it's already one of  
13 the categories included.

14 DR. DeBUSK: On that point, that's sort of what I  
15 got from the updated TDAPA rules. This is a question, I  
16 promise, but if you'll walk me through this, just to make  
17 sure I understand.

18 Let's say there's an oral drug in the bundle  
19 that's \$10 and an injectable version comes out that's \$25.  
20 During the TDAPA period, I enjoy the benefit of that \$10  
21 drug's cost being integrated into the bundle, but I get the  
22 ASP payment, now ASP plus 100 going forward, for the \$25.

1 But then when they go to rebase the bundle, they're going  
2 to say, "Oh, the net spending change was \$15. Let's update  
3 the bundle \$15."

4 DR. JOHNSON: A couple points. If a drug is  
5 getting a TDAPA payment, it is correct that the base rate  
6 is now lowered, even if that drug is in the category that's  
7 already included in the bundle.

8 Your specific example about an oral drug, there's  
9 a special rule that the law says that oral-only drugs would  
10 not be included into the bundle until 2025. So it would be  
11 an addition of an injectable that would trigger that drug  
12 no longer being oral only to be included in the bundle.

13 And your last point was about cost.

14 DR. DeBUSK: Well, so my thought was during the  
15 TDAPA period, I would enjoy the, say, \$10 that was built  
16 into the bundle for the drug, even though I'm no longer  
17 buying the drug.

18 DR. JOHNSON: That's correct.

19 DR. DeBUSK: But I would receive the TDAPA  
20 payment for the \$25 drug.

21 DR. JOHNSON: That's correct.

22 DR. DeBUSK: Now, again, at the end of the TDAPA

1 period, they're going to look at the cost report, and  
2 they're going to adjust the net, or are they just going to  
3 add the \$25? Would they add \$25 or \$15 at the end of the  
4 period?

5 DR. JOHNSON: If the drug is in one of the  
6 functional categories that's already included in the  
7 bundle, there would be no update to the base rate. It  
8 would just be included in the set of drugs, and the base  
9 payment rate would stay the same.

10 DR. DeBUSK: Oh. So they would have to start  
11 eating the cost of that \$25 drug?

12 DR. JOHNSON: Unless the cost of the drug changed  
13 to the provider, meaning manufacturers lower their cost,  
14 prices.

15 DR. CROSSON: Well --

16 MS. BUTO: Are you finished?

17 DR. CROSSON: Brian, are you -- so you're  
18 finished for the moment. Kathy, do you want to comment on  
19 this?

20 MS. BUTO: No. I want to actually ask a quick  
21 question.

22 DR. CROSSON: You're on the list, yeah.

1 MS. BUTO: I actually have another question.

2 DR. CROSSON: Okay. So -- but Brian still  
3 doesn't have an answer, I think, to his question.

4 MS. BUTO: Right. Clearly an area that requires  
5 us to better understand what's going on, I think.

6 DR. CROSSON: Go ahead.

7 MS. RAY: So I have a secret slide.

8 MS. BUTO: A secret slide.

9 [Laughter.]

10 DR. CROSSON: You have to know the magic word.

11 MS. RAY: Yeah. So maybe this will help clear up  
12 some of the questions about the TDAPA. So I'm going to say  
13 that there's like three different kinds of TDAPA for a  
14 drug. There is the TDAPA for the oral-only drugs that's  
15 just calcimimetics and phosphate binders, and according to  
16 the statute, they stay covered under Part D until 2025, but  
17 they will be put into the PPS earlier if an injectable form  
18 is approved by the FDA. That is what happened with the  
19 calcimimetics. So that's why the calcimimetics are in the  
20 bundle. They are paid 106 percent in 2018 and 2019, and  
21 ASP thereafter.

22 MS. BUTO: And Nancy, once it's in the bundle, no

1 additional --

2 MS. RAY: For calcimimetics and phosphate  
3 binders, there will be an additional payment. CMS said  
4 that in the final rule, I think, in 2011, because they did  
5 not account for those dollars in 2011. So that's the  
6 second column.

7 Now the second TDAPA, that's given for -- and  
8 that began in 2016, so that could have happened since 2016,  
9 but it hasn't -- it's for a drug that doesn't fit into one  
10 of the 11 functional categories, what we call therapeutic  
11 classes, of drugs already in the PPS payment bundle. If a  
12 drug in a new functional category was approved by the FDA,  
13 it would be paid at ASP. CMS would pay it for at least two  
14 years, and then they would reevaluate the base rate, again,  
15 because it's for a new functional category. It's not  
16 already in the bundle.

17 The third category of TDAPA, that begins in 2020,  
18 and that's for drugs that fit into an existing functional  
19 category. It's essentially any new drug, except for  
20 generics and a couple of other kinds of drugs that I listed  
21 in your mailing materials. So this could be a biosimilar,  
22 let's say, for EPO. That would get a TDAPA for two years.

1 It would be paid at 100 percent of ASP. But after the two-  
2 year period, it would be folded into the PPS without a  
3 change in the base rate.

4 Now the last column is the add-on payment for  
5 equipment and supplies, and I'm not going to try to say the  
6 name of the acronym because I'm just not. Payment is based  
7 on manufacturer's invoices, 65 percent of invoices. The  
8 add-on for equipment and supplies does have a requirement  
9 that it has to be substantially better than what's already  
10 in the bundle, so it uses the substantial criteria from the  
11 inpatient PPS.

12 MS. BUTO: So the one where it fits into an  
13 existing functional category that has the two-year external  
14 ASP --

15 MS. RAY: That's the TDAPA, yeah.

16 MS. BUTO: Right, and gets folded in at no  
17 additional adjustment to the bundle.

18 MS. RAY: Right.

19 MS. BUTO: But during that two years --

20 MS. RAY: There is no offset to the base rate.

21 MS. BUTO: That was the question. Okay. That's  
22 the question I think you were trying to get at.



1 DR. DeBUSK: That's what I was trying to clarify.  
2 So again, you used EPO as an example. I mean, in theory,  
3 if a biosimilar comes out for at least two years, you're  
4 going to get double-paid simply by adopting that new -- I  
5 mean, even if it's more expensive, I mean you could launch  
6 the biosimilar at higher than the reference biologic, enjoy  
7 the two years of payment, and similarly, if it were at less  
8 than the reference biologic, at the end of the TDAPA period  
9 you're still going to enjoy the differential of the lower  
10 rate. I mean, we sort of created a process where it would  
11 be foolish not to adopt a TDAPA drug, whether it worked or  
12 not.

13 MS. RAY: Well, according to providers, though,  
14 particularly for drugs that fit into an existing functional  
15 category -- and I'm just going to tell you what I have  
16 heard from providers -- again, you would have to -- you  
17 know, if the manufacturer does not -- if it would be  
18 necessary -- it might be necessary to have to switch a  
19 patient back to a product that's already in the bundle if  
20 the price that the manufacturer set was not changed, once  
21 it went into the bundle, let's say. And, you know, that is  
22 a clinical decision and that might affect providers'

1 willingness to put a patient on a new product, if they  
2 know, down the road, they may have to switch the patient.

3 DR. DeBUSK: Thank you.

4 DR. CROSSON: And/or, I mean, it seems to me that  
5 the combination of these two mechanisms, what Brian  
6 described, which is, let's say, excess margin for a period  
7 of time, and then potentially, assuming that this drug,  
8 which is now in the bundle, is really effective and the  
9 patients need to take it but they can't negotiate the price  
10 down, then we're going to see perhaps more variability in  
11 margin over a period of years than we might expect or want.

12 MS. RAY: That might be the case, although  
13 manufacturers do have an ability to react to changes in  
14 Medicare payment policy, as we have seen.

15 DR. CROSSON: Paul. Sorry.

16 MS. BUTO: So I think, if I'm understanding,  
17 there are two effects that happen. One is there is little  
18 price competition between the biosimilar and the drug  
19 that's already in the bundle, that why should there be,  
20 really, when they are essentially getting the payment in  
21 the bundle, and then the add-on. The other thing that  
22 happens, it strikes me, is that, I don't know if it was

1 designed this way, favors using the biosimilar, at least  
2 initially, right? Because once they're available --

3 MS. RAY: The TDAPA for drugs that fit into an  
4 existing functional category, now that applies to both  
5 drugs and biologics. So it would incentivize, all other  
6 things being equal, that drug being paid under the TDAPA,  
7 yeah.

8 MS. BUTO: Yeah.

9 MS. RAY: It doesn't necessarily have to be a  
10 biosimilar. That was just my example.

11 MS. BUTO: Right. No, but I'm just thinking  
12 about our general -- there are two conflicting things going  
13 on here, I think.

14 DR. CROSSON: Kathy, forgive me. I know you have  
15 another point, but Paul wanted to --

16 DR. PAUL GINSBURG: Yeah. I just wanted to say,  
17 this seems like actually a very effective way of favoring  
18 biosimilars. To the degree that a biosimilar comes in with  
19 a lower price, the provider gets a bonus for two years for  
20 using it and then they're already set when it becomes part  
21 of the bundle.

22 MS. BUTO: They don't even need to come in with a

1 lower price.

2 DR. PAUL GINSBURG: But if there's not a lower  
3 price then they couldn't use it as part of the bundle.

4 MS. RAY: But I'd just like to point out that in  
5 either late 2015 or early 2016, a new EPO biologic, EPO  
6 Beta, was approved. At that time it was put right into the  
7 bundle, and we saw provider movement towards that lower-  
8 cost new biologic. So the PPS, I mean, that's an example  
9 of the PPS working to incentivize the use of a new product  
10 that came in at a very competitive price.

11 DR. CROSSON: Yeah, I'm sorry, Kathy. One more  
12 time. Jonathan wanted to come in on this point.

13 DR. JAFFERY: Yeah. So first of all, in general,  
14 I think, Nancy, your last point was an important one, is  
15 that to the extent that these are -- first of all, they're  
16 often not biologics. We're talking about lots of less  
17 commonly biologics or biosimilars. But to the extent that  
18 we're talking about drugs that, for the most part, are  
19 equivalent in their effectiveness, the PPS system  
20 inherently incents providers to do that.

21 The other thing I would just point to, if we  
22 think about the injectables, in particular, and you think

1 about maybe a large dialysis unit deciding to switch every  
2 year, every two years, based on payment policy, you know,  
3 that's not very dissimilar than just switching a formulary.  
4 And I think that in some ways, you know, assuming that  
5 providers believe that this IV vitamin D is just as  
6 effective as this IV vitamin D, for example, the ability to  
7 switch patients may be easier in that setting than if  
8 you're writing a new prescription, because these are given  
9 three times a week on dialysis and patients don't actually  
10 have to physically take them. It's a nurse or a tech comes  
11 up and injects it during the dialysis treatment, and they  
12 don't know if it's necessarily EPO A or EPO B.

13 DR. CROSSON: Okay. Thank you.

14 DR. DeBUSK: On that one point, I mean, it does  
15 appear that we've created an incubator for biologics and  
16 new drugs, but we've also given them a dominant strategy of  
17 launch at the highest possible price you can, enjoy the  
18 cost plus TDAPA period, and the moment that you're about to  
19 get integrated back into the bundle, bring your price down  
20 to parity, certainly not below, because they've already  
21 switched to you because they've been receiving a premium.  
22 So it seems like that would be the dominant strategy a

1 manufacturer would use.

2 DR. CROSSON: Okay.

3 MR. PYENSON: And Nancy, if I'm reading this  
4 right, as me-too brands come out, each successive brand  
5 would be eligible for TDAPA. Is that correct?

6 MS. RAY: Yes. As long as it's not a generic or  
7 one of the other kinds of approvals that I included in a  
8 footnote. But yeah, if a new vitamin D agent came on the  
9 market, yes, it would get the TDAPA for two years, and then  
10 it gets into the base rate, and no change to the base rate.  
11 And then if another new vitamin D comes along, the same  
12 thing will happen. According to the -- when CMS expanded  
13 the TDAPA, their rationale was to incentivize the  
14 development of new technology.

15 DR. CROSSON: Okay. Kathy, finally it's your  
16 turn.

17 MS. BUTO: So back to Slide 4, or any of the  
18 slides that deal with quality parameters, we have dialysis  
19 under quality, dialysis adequacy and anemia management,  
20 home dialysis use and mortality. I'm wondering whether we  
21 have any information or data on adverse outcomes, or even  
22 sort of -- you mentioned the use of ER visits going up.

1 What do we know about those? I think of those as sort of  
2 the equivalent of ambulatory sensitive conditions. Do we  
3 know anything about that or of the principal reasons why  
4 people on dialysis go into inpatient care?

5 MS. RAY: Right.

6 MS. BUTO: I mean, in order to really evaluate  
7 quality, just looking at the use of home dialysis, doesn't  
8 strike me as one thing that really helps us determine what  
9 the quality is.

10 MS. RAY: Sure. I understand.

11 MS. BUTO: That's the reason behind my question.

12 MS. RAY: I don't know the reason for the ED  
13 visits. What I can tell you is that hospitalizations, a  
14 good chunk of, and for January I can give you a little bit  
15 more precise than a big chunk of them, is due to  
16 cardiovascular reasons and infections.

17 DR. JAFFERY: And that's been true for decades.

18 MS. BUTO: Mortality has really not changed over  
19 the last 10 years or so?

20 MS. RAY: Yeah. Yeah. There was a little bit of  
21 decline in the early part of this decade, but it's sort of  
22 steadied out in the last five years.

1 DR. JAFFERY: It hadn't really budged at all for  
2 many, many decades, and then it came down a little bit.

3 DR. CROSSON: Paul.

4 DR. PAUL GINSBURG: Yeah. I've got two  
5 questions. One, which Jonathan might be the best one to  
6 answer it, would be, you know, it's interesting how we've  
7 put in different incentives on facilities that affect drug  
8 choice, but you'd think physicians would be prescribing  
9 these drugs but physician payment is separate. And could  
10 you give me a sense if there are a lot of these decisions  
11 just made by the facility rather than a physician, or how  
12 many of them are customized to a patients and the physician  
13 makes?

14 DR. JAFFERY: Yeah, great question, and, I mean,  
15 I do think that the incentives aren't there for the  
16 providers in this setting. It doesn't matter either way.  
17 So that sort of gets back to my formulary comment, I think  
18 to the extent that there are certain particularly  
19 injectables, or actually exclusively injectables, because  
20 otherwise you're writing a prescription that they wouldn't  
21 get filled in the dialysis unit. But if they're  
22 injectables, the dialysis unit, the facility may decide



1 that we're going to go with this vitamin D or this  
2 calcimimetic.

3 DR. PAUL GINSBURG: I see. Thank you. Same  
4 question is do we have any information on what rates are  
5 used by MA plans when they pay for dialysis?

6 DR. JOHNSON: We've looked into that a little  
7 bit. We could do a more comprehensive look. It seems like  
8 this question has come up a few times. In general, I think  
9 the MA plans pay a little bit more than fee-for-service.  
10 We've looked at the range of payments that the fee-for-  
11 service PPS would make and many of the MA rates are within  
12 that range. A few are quite a bit higher. But it still  
13 could be that within that range the MA payments are higher  
14 than fee-for-service. But it is not nearly as high as the  
15 commercial rates.

16 DR. CROSSON: Okay. I have Dana and Amol.

17 DR. SAFRAN: Thanks. I have a couple of  
18 questions, all quality related. So I was under the  
19 impression -- but I'm not sure I'm right so that's why I'm  
20 asking -- that dialysis facilities were routinely  
21 collecting quality-of-life data from patients, so  
22 systematically tracking something like SF12 or SF36. Is

1 that correct?

2 MS. RAY: Patients fill out a CAHPS.

3 DR. SAFRAN: So patient experience --

4 MS. RAY: Yes.

5 DR. SAFRAN: -- but not their functional -- like  
6 not functional health status and well-being.

7 MS. RAY: To my knowledge it's not required by  
8 Medicare. Now if they are doing it, it could be that  
9 they're just doing it on their own.

10 DR. SAFRAN: Okay. Thanks. Second question is,  
11 do we have any -- understanding that there are differences  
12 in the underlying clinical status of patients who are  
13 candidates for home dialysis, I'm curious what we know  
14 about differences in some of the quality measures that  
15 you've reported here, like, you know, emergency room,  
16 hospital, et cetera, to the extent that we can adjust for  
17 case mix differences.

18 MS. RAY: I'd have to get back to you on that. I  
19 mean, an important caveat to that is that home dialysis  
20 patients -- there are real differences in the demographics  
21 of home dialysis patients versus in-center patients.

22 DR. SAFRAN: Yeah.

1 MS. RAY: They tend to be younger. They tend to  
2 be white. But I can try to get back to you with some  
3 information in January.

4 DR. SAFRAN: Thank you. And my last question is,  
5 has the program ever contemplated a quality component of  
6 payment for dialysis?

7 MS. RAY: There is the ESRD quality incentive  
8 program, the QIP, and that subtracts up to 2 percent off of  
9 the base rate for facilities that don't achieve the  
10 necessary score. So that has been in place since 2012.

11 DR. SAFRAN: Great. I'd love to learn more about  
12 that program, so thanks.

13 DR. CROSSON: Amol.

14 DR. NAVATHE: I just wanted to pick up on the  
15 home dialysis thread of questions. So a couple of  
16 questions in that regard. One is, do we have a sense of  
17 rates of home dialysis in other settings, so MA, VA also,  
18 for example, as a reference benchmark?

19 DR. JOHNSON: Not offhand, but that's something  
20 we can look to in the MA sector.

21 DR. NAVATHE: Okay. Thanks.

22 MS. RAY: What we could easily bring to you is a

1 national rate of home dialysis. That data is available  
2 from U.S. Renal Data System. We'd have to look into it,  
3 you know, sector by sector, though.

4 DR. CROSSON: I believe I recently saw, for one  
5 large integrated delivery system located in the state of  
6 California the number was 30 percent.

7 MS. RAY: Yes, it was.

8 DR. NAVATHE: Jon, do you have a sense of what it  
9 has been historically in the VA?

10 DR. PERLIN: This is really an interesting  
11 question because obviously the technology is changing, and  
12 I refer to our nephrologist on the team over here. But I'm  
13 not sure what the numbers are specifically for  
14 hemodialysis, not peritoneal dialysis. Historically,  
15 obviously, a lot of home dialysis has been the peritoneal.

16 But what's changing the dynamic, in, ironically,  
17 both in-hospitals and dialysis centers and at home, are  
18 these new low-volume dialysate processes, that don't  
19 require the large volumes of water, et cetera. And so this  
20 is something where I think Nancy referred to the entrance  
21 of CVS into the dialysis arena. I think these new  
22 technologies are going to change the locations of dialysis

1 to potentially make the smaller centers more effective, and  
2 the smallest center, obviously, one that is potentially  
3 best for patients is home, when possible.

4 DR. NAVATHE: Yeah. That makes total sense, and  
5 that's, I guess, the spirit of my thought and line of  
6 questioning here.

7 Another question is just relating to the cost.  
8 Do we get any specific information? Do we have a sense of  
9 the underlying cost differences? Obviously, it's cheaper  
10 to provide home dialysis or peritoneal dialysis, but do we  
11 have a sense of the cost difference of doing that?

12 DR. JOHNSON: A few studies have suggested that  
13 the peritoneal dialysis is cheaper than in-center  
14 hemodialysis, and home hemodialysis is maybe slightly  
15 cheaper but roughly the same.

16 I think the two next discussions that happen is  
17 how are the costs being allocated. Usually, that analysis  
18 is done via cost reports, and there's a lot of questions as  
19 to whether or not all of the costs associated with home are  
20 correctly allocated to the right categories.

21 The other trend that seems to be happening is  
22 that some of the machines and equipment are becoming more

1 advanced and also more expensive, so it's unclear that if  
2 there has been -- if home dialysis has been cheaper,  
3 whether or not that will continue to be the case.

4 DR. NAVATHE: So last question is I think part of  
5 the reason that I'm interested in getting more information,  
6 if we could either collect more information or make a  
7 recommendation to collect some of this information, is  
8 related to Jon's point, which is home dialysis is changing.  
9 There's a lot of evidence, one, in other countries, it's  
10 certainly much higher in terms of the proportion of  
11 dialysis on average has tended to be cheaper. It's higher  
12 quality of life and a lot or at least more independent-  
13 supporting, in some sense, and could change the dynamic of  
14 how ESRD patients live and interact with the community and  
15 their potential for work, et cetera.

16 And so if I think about it from a marginal -- if  
17 I channel my inner Brian and think about it from the  
18 operator's marginal incentive, it seems like the marginal  
19 incentive is to try to get people under PPS into the home  
20 dialysis, but we're seeing some increases in those rates  
21 but certainly not rapid. And if we can better understand  
22 some of the cost structures and get more information on

1 this, maybe we can understand some of the frictions. Some  
2 of them may be cultural, and Jonathan could tell us about  
3 that.

4 But I think it would be helpful to be looking a  
5 little bit down the road and, therefore, collect  
6 information so we can kind of arm ourselves in that regard.

7 DR. CROSSON: Kathy? On that question?

8 MS. BUTO: On the same point -- I'm sorry?

9 DR. CROSSON: Go ahead. I'm sorry. I think I  
10 missed, Larry, but go ahead.

11 MS. BUTO: Oh, it's on the same point. I  
12 wondered whether we have any information on the factors  
13 that lead to success or that are critical for home dialysis  
14 to be successful.

15 So I assume that at least one of them might be  
16 the availability of a caregiver or partner to help with  
17 that, with the process.

18 I mean, I think cost isn't the only thing that's  
19 important here in understanding it. So if there are any  
20 data or an assessment of factors that make home dialysis a  
21 more successful approach, I think that would be helpful.

22 DR. JOHNSON: I think Nancy has put together some

1 of that before. We can bring that and maybe update to the  
2 extent that it's needed.

3 DR. CROSSON: Larry?

4 DR. CASALINO: Going back to Dana's line of  
5 questioning, quality of life is a big deal for everybody  
6 but especially for dialysis patients, I think, and I'm just  
7 curious about why we don't -- is the data not available to  
8 look at patient experience measures as one of the quality  
9 things that we've had that we look at in these annual  
10 reports.

11 MS. RAY: We can certainly look into analyzing  
12 the CAHPS data and bringing that for you.

13 DR. CASALINO: I think that would be good because  
14 really it can vary so much, and it's really huge.

15 DR. CROSSON: On this?

16 DR. JAFFERY: Yeah, maybe to the last couple  
17 points, a few things.

18 Can you bring up my secret slide? No, I'm just  
19 kidding.

20 [Laughter.]

21 DR. JAFFERY: So there is a Kidney Disease  
22 Quality of Life survey that's specific to --



1 MS. RAY: Yeah.

2 DR. JAFFERY: It's called the KDQOL or whatever.

3 MS. RAY: Yeah.

4 DR. JAFFERY: And I thought that it was mandated,  
5 so we can check into that.

6 MS. RAY: It could be. I will check into it.

7 DR. JAFFERY: So we maybe have some quality of  
8 life, and I don't know how long it would have been  
9 administered.

10 Just to the home dialysis question, I agree this  
11 is a bit of a moving target in a couple ways. There's the  
12 technology that's just been advancing, including places  
13 like CVS really digging into it.

14 You know, PD has been around a long time, and  
15 there's lots of cultural reasons why it hasn't -- it used  
16 to be more popular. It's not. There's a lot of training  
17 issues in terms of nephrology fellows learning about how to  
18 do the technology, in terms of a caregiver. PD, really you  
19 can do it yourself. Home dialysis, you need somebody. So  
20 there's differences there.

21 And I guess the final contextual point would be  
22 that administration has come up with a whole bunch of CKD

1 and ESRD initiatives, including some things to try and  
2 incent additional use of home dialysis. So we're starting  
3 to see people get prepared for that, including financial  
4 incentives. It's hard to imagine that we won't see some  
5 movement based on that, so just a couple other thoughts.

6 DR. CROSSON: Okay. Let's see.

7 DR. CASALINO: If I may just on this topic?

8 DR. CROSSON: Yeah.

9 DR. CASALINO: It's tricky because, on average, I  
10 think one wants to incent more, incentivize more home  
11 hemodialysis, but it really isn't for everybody. It's kind  
12 of like giving all physicians incentive to get every  
13 patient's blood pressure down to below X when that really  
14 might not be the right thing for some patients, and  
15 certainly for home dialysis, that's true as well.

16 I think a lot of dialysis -- this is a smaller  
17 point, but I think a lot of dialysis patients are actually  
18 fairly socially isolated, and the opportunity to actually  
19 go somewhere three times a week is not trivial. So this  
20 is, again, a reason why patients' experience measures could  
21 be important. The lesson we want is physicians or dialysis  
22 centers really pushing people into home dialysis who it

1 might not really be appropriate for. On the other hand,  
2 probably it's underused now, I agree.

3 DR. CROSSON: Okay. Bruce and then Warner.

4 MR. PYENSON: Nancy, on the reading materials, on  
5 the bottom of page 37, you report that administrative costs  
6 from the Medicare cost report are, I think, 24 percent of  
7 the total cost of running the dialysis program, and that  
8 strikes me as high, though I don't have much of a context  
9 for that. And I think that probably is a relevant issue as  
10 we think of smaller-scale operations, like Amol's example  
11 of moving to smaller-scale programs or smaller-scale  
12 operations.

13 I wonder if you could give a sense of the context  
14 for the 24 percent. Of course, I think of administrative  
15 costs from the standpoint of a payer, 24 percent would be  
16 very high for a payer, but how do you think of that?

17 MS. RAY: So the cost reports don't allow me to  
18 dig into that category any deeper than administrative  
19 costs. I'm thinking based on discussions with providers,  
20 it could range from insurance to the home office cost, to  
21 their corporate -- you know, if it's a large organization,  
22 their home office.

1           Back in 2014, the Commission recommended that CMS  
2   audit dialysis cost reports, and Congress took up our  
3   recommendation, appropriated money to CMS. And one of the  
4   reasons why we recommended that back in the day was to find  
5   out these kinds of questions, and CMS has said that the  
6   audit results are completed. But they have not announced  
7   them yet.

8           MR. PYENSON: Just a question on 24 percent, was  
9   that allocated to Medicare beneficiaries, or is that across  
10  the entire organization?

11          MS. RAY: That's an across-the-entire-  
12  organization number.

13          DR. CROSSON: Warner?

14          MR. THOMAS: I had a different question. In the  
15  reading, it's mentioned that there's basically two large  
16  dialysis organizations that account for about 75 percent of  
17  the care. Do you have any thoughts about any impact that  
18  has, one way or another, on the data or on the industry  
19  overall?

20          MS. RAY: Well, I mean, on the data, clearly the  
21  two large dialysis organizations have a large impact on --  
22  well, they have a large impact on everything we see here,

1 ranging from access to care to quality to the providers'  
2 financial performance. Yeah.

3 DR. CROSSON: Warner, was your question how  
4 effective is the competition between the two? I'm not  
5 sure.

6 MR. THOMAS: I think it was really more just -- I  
7 mean, we've looked at consolidation and other facets, and  
8 this is one that's pretty consolidated. I just didn't know  
9 if there was any takeaways as you guys analyzed the data or  
10 looked at it, one way or the other. I mean, are there  
11 trends there? Do you see differences? I don't know. It's  
12 just a very unique situation, and as you mentioned, most of  
13 the centers that are closing are smaller, hospital-based.  
14 It was just more of a -- and, I guess, are you seeing any  
15 new entrants as well? Given that there's so much  
16 significance from these two entities, do you see new  
17 entrants trying to get back into this world? I mean, I  
18 don't know if you had any thoughts or takeaway from it.

19 MS. RAY: I mean, over the last 10 years, we have  
20 seen some new entrants, but by comparison to the two large  
21 dialysis organizations, I mean, they are relatively small.

22 I think the third biggest chain has facilities in

1 the hundreds by comparison to Fresenius and DaVita, which  
2 is each over a thousand.

3 DR. CROSSON: On this point?

4 DR. CASALINO: Yes.

5 I think on other sectors, we have spent a certain  
6 amount of time -- and the presentation sometimes included  
7 that information -- on what effect Medicare policies have  
8 had, if any effect, on consolidation. So this is an area I  
9 really don't know about, but it would be interesting in the  
10 future or if you have anything to say about it today to  
11 know more about whether there are Medicare policies that  
12 have fostered and/or continue to foster this kind of  
13 consolidation.

14 DR. JOHNSON: I think that's something we'll have  
15 to look into.

16 DR. CROSSON: Okay. Jonathan and David, I think  
17 you're both on this point, and then I think we have to move  
18 on.

19 DR. JAFFERY: Yes. This is related. I mean, I  
20 certainly agree with Warner. This is a unique situation  
21 where we've got this level, degree of consolidation.

22 There's also something else unique about it in

1 that these organizations are very vertically integrated. I  
2 don't know that we have other sectors. They make the  
3 machines. They make the filters and so forth. I think you  
4 mentioned some of that in the reading.

5 So my question is when we're looking at margins,  
6 does any of that factor into it for these organizations, or  
7 are we just looking at the dialysis book of business for  
8 them, the dialysis delivery?

9 MS. RAY: Oh. Well, the Medicare margin is just  
10 dialysis, and the total margin is just dialysis. The  
11 access to capital gives you the other factors going on.

12 In terms of the vertically integrated company  
13 selling equipment and supplies, so for their own cost  
14 report, I believe that they have to report a cost that's  
15 similar to the payment level that they're getting in the  
16 open market.

17 DR. JAFFERY: So for that part, they actually  
18 have better margins? Because they're not paying that much  
19 money for -- presumably.

20 MS. RAY: I mean, they have to charge themselves  
21 at the market rate for a dialyzer or a machine, for  
22 example. I can add that to the paper.

1 DR. GRABOWSKI: Okay. Yeah. Great.

2 I'm so happy, Warner, you raised this issue.

3 This has bothered me about this sector, just how  
4 concentrated it is, and there is as fair amount of economic  
5 research focusing on just the implications of this  
6 concentration. So, to your point, Larry, we should really  
7 bring that in and think about that here.

8 I also wonder if there's anything we might  
9 analyze around entrance or exits and sort of market-to-  
10 market, are some more competitive than others, and what  
11 that might tell us about behavior here of the different  
12 centers.

13 MR. THOMAS: Great. One of the things I'm just  
14 sitting here wondering is that if we were -- I mean, we've  
15 had discussions on other sectors in the industry. If you  
16 look at whether it would be IRFs or hospitals or physicians  
17 and you said what consolidation would take place in order  
18 to get to providers that were 75 percent of the market, I  
19 think we'd go, "Wow. That's pretty significant."

20 [Laughter.]

21 MR. THOMAS: So, I mean, it's just something that  
22 we ought to just be mindful of, I guess, especially as we



1 look at other sectors as well.

2 MS. BUTO: The other thing is that this is a  
3 Medicare market almost entirely.

4 DR. CROSSON: Yes.

5 MS. BUTO: I mean, that's another aspect. So  
6 it's highly concentrated from a provider perspective and  
7 highly concentrated from a beneficiary.

8 DR. CROSSON: And it has a different level of  
9 pricing power than perhaps some other parts of the  
10 industry.

11 Okay. So let's see the recommendation, which has  
12 come current law. Any discussion, support, lack of support  
13 for the recommendation?

14 MS. BUTO: I am wondering whether we should try  
15 to address the drug issue in some way. I think we all were  
16 talking around -- you know, realizing that it's legislated  
17 and fairly recently, to be silent on it when it creates  
18 these distortions, I think we ought to -- I guess I would  
19 vote for bringing it back in January with an option to  
20 address the -- whatever we call it. TDAPA?

21 MS. RAY: TDAPA.

22 MS. BUTO: TDAPA issue.

1 Jim, I don't know what you think, but --

2 DR. MATHEWS: Can you say a little bit more about  
3 what --

4 MS. BUTO: What it would look like?

5 DR. MATHEWS: Yeah. Because in the past, we  
6 have, in comment letters, addressed concerns about the  
7 application of the TDAPA process, and we could contemplate  
8 a formal recommendation, but can you say a little bit more  
9 about the shape or form?

10 MS. BUTO: To me, the obvious one is something  
11 coming along in the same category that's already in the  
12 bundle, giving it a two-year, in a sense, pass-through.  
13 That strikes me as one we could recommend the bundle back  
14 in immediately or that it not be provided that kind of  
15 TDAPA. That just seems pretty obvious.

16 Anything really new, yeah, there might be an  
17 argument, but, anyway, I'd look at that because that seems  
18 -- I think several of us picked up on that.

19 DR. MATHEWS: Yeah. Well, when we head back,  
20 we'll see what we can do and consult with Jay and Paul, and  
21 we'll see if we can act on this for the January meeting.

22 DR. CROSSON: Yeah. Bruce?

1 MR. PYENSON: There's an issue that I probably  
2 should have raised in the first round, but it overlaps  
3 dialysis and Medicare Advantage, which we alluded to the  
4 higher reimbursement from commercial, which includes  
5 Medicare Advantage.

6 Starting in 2021, Medicare Advantage  
7 beneficiaries who have end-stage renal disease will be able  
8 to choose a Medicare Advantage plan, and it turns out like  
9 everything else in Medicare, the benchmarks are set on a  
10 fee-for-service basis. But the cost of the market  
11 domination of the LDOs -- reimbursement for Medicare  
12 Advantage is higher. The reimbursement rates from Medicare  
13 Advantage are higher. This gets involved with network  
14 adequacy rules and things of that sort.

15 So I don't know whether to raise this issue in  
16 the dialysis discussion or in the Medicare Advantage  
17 discussion, but I suspect the impact is pretty significant  
18 in both areas.

19 As with Kathy's comment on TDAPA, I think this is  
20 something to note. I know we don't have time to do a lot  
21 of work in it. What would you suggest?

22 DR. CROSSON: Well, I'd probably say, "What would

1 you suggest?"

2 I think if we're going to -- why don't we do  
3 this. I think we are going to talk about Medicare  
4 Advantage a little bit later, but one of the things I was  
5 going to say when we start that is that this is not our  
6 only bite of the apple, that we're going to come back on a  
7 range of Medicare Advantage issues in the spring, and so I  
8 think what I'm going to suggest is we leave this to Jim and  
9 the staff to determine whether or not we add this in to the  
10 discussion that we're going to have in January or we pick  
11 it up later, if that's okay.

12 DR. PAUL GINSBURG: Can I give a follow-up?

13 DR. CROSSON: Yeah.

14 DR. PAUL GINSBURG: Yeah, I think while Jim and  
15 the staff are thinking about this, the question I should  
16 have followed up with in Round 1 is, you know, with the  
17 sometimes higher payment rates than fee-for-service  
18 Medicare, to what degree is there a different regulatory  
19 structure for dialysis than we find in physicians and  
20 hospitals that might be the cause of this, or is it  
21 strictly the consolidation that creates a very different  
22 situation than we encounter elsewhere? Because I'm not

1 aware of any other service where Medicare Advantage is  
2 paying more, in any appreciable way.

3 DR. CROSSON: That sort of gets back to the  
4 question of, you know, whether with two dominant plays you  
5 are adequate competition or not.

6 Okay, so --

7 MR. THOMAS: Perhaps one of the things we could  
8 think about is, especially with ACOs growing or whatnot,  
9 could there be some incentive that ACOs, you know, get into  
10 this world? You know, and it's just an idea that I'm  
11 throwing out there, but, you know, most of them, whether it  
12 be physician owned, or probably are more significant and  
13 maybe could, you know, they're controlling populations of  
14 patients and maybe they should -- we could try to figure  
15 out a way, is there a way we could, through payment policy,  
16 help incent folks to get back into this world in a bigger  
17 way?

18 DR. CROSSON: Okay. Pat.

19 MS. WANG: Just my totally non-empirical response  
20 to Paul's question -- which one is it? It's the latter.  
21 It's market power. It's unusual but it's absolutely out  
22 there.

1           And I think Warner's question, I'm intrigued by  
2 any results from the ESCO demonstrations, the pilots, and  
3 whether -- it's a bundled payment for ESRD patients,  
4 whether there's any promising sort of lessons to be learned  
5 there that might lead to, you know, future payment policy.

6           DR. CROSSON: So it strikes me -- this has been a  
7 good conversation. It strikes me that some of the issues  
8 that have been brought up we'll be able to address in  
9 January. Others, once again, may require some further work  
10 and enter into the workflow a little bit later on.

11          DR. MATHEWS: And just a reminder on that point.  
12 We do have additional work on the dialysis facility PPS on  
13 top for our spring meetings, so there will be ample  
14 opportunity to come back to questions that we aren't able  
15 to address by January.

16          DR. CROSSON: Okay. Good. So seeing no further  
17 comments we will come back to this issue in January.  
18 Presumably we will have the same update recommendation  
19 perhaps? But the question of additional recommendations is  
20 on the table.

21          Okay, Nancy, thank you. Andy, thank you very  
22 much. We will move on.

1 [Pause.]

2 DR. CROSSON: Okay. Our final update discussion  
3 for the December meeting is going to be on hospice,  
4 adequacy of payment and recommended update. Kim is here,  
5 and you're on.

6 MS. NEUMAN: Good morning. So today we are going  
7 to talk about the hospice payment update for fiscal year  
8 2021 and a policy option to modify the hospice aggregate  
9 cap. First I'll discuss some background on hospice, and  
10 then we'll go through the payment adequacy analysis. And  
11 then we'll switch gears a bit and talk about the hospice  
12 aggregate cap, and then finally we'll conclude with the  
13 Chairman's draft recommendation.

14 So, first a reminder about the hospice benefit.  
15 Hospice provides palliative care to terminally ill Medicare  
16 beneficiaries who have a life expectancy of six months of  
17 less, and who choose to enroll in the benefit. There is no  
18 limit on how long a beneficiary can be in hospice as long  
19 as a physician certifies that the beneficiary meets the  
20 life expectancy criteria.

21 So now some background on the hospice payment  
22 system. Medicare pays hospice providers a daily rate, and

1 this daily rate structure, as we've discussed before, has  
2 made long stays in hospice quite profitable.

3 Medicare's payments to hospital providers are  
4 wage adjusted, and then there is also an aggregate cap that  
5 limits the total payments a provider can receive in a year,  
6 and we will discuss that cap more later.

7 There are four levels of hospice care. Routine  
8 home care is the most common level, accounting for 98  
9 percent of days. There are three other levels of care that  
10 offer more intensive services to manage a crisis or special  
11 situations.

12 In recent years, CMS has made changes to the  
13 hospice payment system to try to better align payments and  
14 costs. First in 2016, CMS modified the routine home care  
15 payment rates so that instead of a flat daily rate,  
16 Medicare pays a higher daily rate for the first 60 days and  
17 a lower rate for days 61 and beyond. One motivation of  
18 this change was to address the high profitability of longer  
19 stays, and this change did have some effect but it was  
20 modest.

21 Second, in fiscal year 2020, CMS rebased the  
22 payment rates by level of care. Payment rates for the



1 three more intensive levels of care have increased  
2 substantially to better match their costs. To make that  
3 payment change budget neutral, CMS decreased the routine  
4 home care payment rates slightly.

5 So a few key facts on hospice in 2018. In 2018,  
6 over 1.5 million Medicare beneficiaries used hospice  
7 services, including more than half of decedents. Medicare  
8 paid \$19.2 billion to over 4,600 hospice providers.

9 And so we will now walk through our payment  
10 adequacy analysis using the same framework that you've seen  
11 in the other sectors.

12 First, we have provider supply. The total number  
13 of hospice providers has been increasing for many years, as  
14 you can see by the orange line in the chart. In 2018, the  
15 total number of providers continued to grow, up 3.4 percent  
16 from the prior year.

17 The other three lines show the number of  
18 providers by type of ownership, and growth in for-profit  
19 providers account almost entirely for the growth in  
20 provider supply.

21 Hospice use continues to grow. Both the share  
22 of beneficiaries who use hospice before death and their

1 average length of stay grew in 2018. The share of  
2 decedents using hospice reached 50.7 percent in 2018,  
3 increasing by a little less than 1 percentage point from  
4 the prior year. Average length of stay among decedents  
5 increased about 1.5 days between 2017 and 2018, reaching  
6 nearly 90 days.

7           Underneath the average length of stay is  
8 substantial variation across beneficiaries. Many  
9 beneficiaries have short stays, and some beneficiaries have  
10 very long stays, and beneficiaries with long stays account  
11 for the majority of hospice spending.

12           Long stays in hospice likely reflect several  
13 factors. It's partly a reflection of the uncertainty in  
14 predicting life expectancy, particularly for some  
15 conditions. It is also likely, in some cases, a reflection  
16 of the profitability associated with very long hospice  
17 stays.

18           Another indicator of access to care is marginal  
19 profit, and different from other sectors, we have marginal  
20 profit data through 2017, because the 2018 margin data is  
21 incomplete. In 2017, marginal profit, the rate at which  
22 Medicare payments exceed providers' marginal cost, was 16

1 percent, and this is a positive indicator of access.

2           Next we have a little bit more detail on how  
3 length of stay varies by beneficiary and provider  
4 characteristics. Because longer stays are more profitable,  
5 this information helps to explain some of the margins that  
6 you are going to see later in the presentation.

7           Length of stay varies by observable patient  
8 characteristics like diagnosis. So, for example,  
9 neurological patients have an average length of stay that's  
10 about triple cancer patients. And the difference in length  
11 of stay by diagnosis means that providers that wish to do  
12 so can focus on patients with longer more profitable stays.  
13 And we do see that for-profits have a longer stays than  
14 nonprofits, on average 110 days versus 68 days in 2018.

15           Two things explain this difference. For-profits  
16 enroll more patients with diagnoses that are more likely to  
17 have long stays, and for any given diagnosis for-profits  
18 have longer stays than nonprofits.

19           Next, quality. Hospice has a limited set of  
20 quality measures. There are seven process measures that  
21 gauge whether hospices appropriately performed certain  
22 activities at admission. So this is things like

1 documenting treatment preferences, screening and assessing  
2 patients for pain. Performance on those measures is very  
3 high and improved slightly in the most recent year. But  
4 there is concern these measures are mostly topped out.

5 A new process measure about whether a patient  
6 received at least one visit from a physician, nurse, nurse  
7 practitioner, or a physician assistant in the last three  
8 days of life has also recently become available.

9 And the hospice CAHPS survey, which surveys  
10 bereaved family members about the care that their family  
11 member received in hospice, showed stable performance in  
12 the most recent data.

13 So next, access to capital. Hospice is less  
14 capital intensive than some other Medicare sectors.  
15 Overall access to capital appears strong. We continue to  
16 see growth in the number of for-profit providers, which  
17 increased about 4 percent in 2018, suggesting that capital  
18 is accessible to these providers. Reports from publicly  
19 traded companies and private equity analysts also suggest  
20 that the hospice sector is viewed favorably by the  
21 investment community.

22 We have less information on access to capital for

1 nonprofit freestanding providers, which may have more  
2 limited access. Provider-based hospices have access to  
3 capital through their parent providers.

4           Next we have margins, and as I said earlier, in  
5 the hospice sector we have margins through 2018.

6           The aggregate Medicare margin in 2017 was 12.6  
7 percent, up from 10.9 percent in 2016. Margins vary by  
8 type of hospice. Freestanding hospices had a strong  
9 margin, at 15 percent. Home health-based hospices had 8  
10 percent margin, and hospital-based hospices had a -14  
11 percent margin.

12           Margins also vary by ownership. For-profits had  
13 about a 20 percent margin, and nonprofits had a margin of  
14 about 2.5 percent. Both urban and rural providers had  
15 strong margins at about 13 percent and 9 percent,  
16 respectively.

17           And then looking at hospices by whether or not  
18 they exceed the aggregate cap, we see that the margins of  
19 above-cap hospices would have been about 21 percent without  
20 the cap, and were about 13 percent after the cap. That  
21 margin is slightly higher than the margin of below-cap  
22 hospices, which was 12.5 percent in 2017.

1           Next we have a chart that shows margins by length  
2 of stay, and what we see in this chart is sort of the  
3 confirmation of the relationship that as length of stay  
4 increases, as you go from left to right on this chart,  
5 providers' margins increase.

6           This brings us to our 2020 margin projection, and  
7 we start with the 2017 margin, and then we take into  
8 account the payment updates that are occurring in 2018,  
9 2019, and 2020. And then we make assumptions about  
10 increases in cost at rates similar to historic trends, and  
11 with those assumptions we have a margin estimate or margin  
12 projection for 2020 that is 12.6 percent, about the same as  
13 the 2017 margin.

14           So to summarize, indicators of payment adequacy  
15 are favorable. In terms of access to care, the supply of  
16 providers continues to grow. Hospice use rates and average  
17 length of stay increased. Quality data are generally  
18 favorable, although the measures are limited. Access to  
19 capital appears strong. The 2017 aggregate margin and the  
20 2020 projected margin are 12.6 percent.

21           Overall, this analysis suggests that the hospice  
22 payment rates may be higher than needed to ensure

1 appropriate access to care.

2           Before we move to the Chairman's draft  
3 recommendation, we are going to shift gears for a moment  
4 and talk about a policy option related to the hospice  
5 aggregate cap. This policy option could be paired with the  
6 Commission's update recommendation as a way to address  
7 concerns about excess payments.

8           When the hospice benefit was first established,  
9 Congress included an aggregate cap to ensure that the  
10 legislation creating the new benefit saved money. The cap  
11 limits total payments a hospice provider can receive in  
12 year. The cap is an aggregate limit, not a patient-level  
13 limit.

14           If a provider's total payments exceed the number  
15 of patients served, multiplied by the cap amount, the  
16 provider must repay the excess to the Medicare program.

17           Currently, as of fiscal year 2020, the cap is  
18 about \$29,965, and it is not wage adjusted.

19           When we look at experience with the hospice  
20 aggregate cap, what we see is that the cap essentially  
21 functions as a mechanism that reduces payments to hospices  
22 with long stays and high margins. In 2017, we estimate

1 that about 14 percent of hospices exceeded the cap, and as  
2 we've discussed, above-cap hospices would have had high  
3 margins without the cap, but the cap lowers there margin  
4 somewhat.

5 Patients treated by above-cap hospices high  
6 average lengths of stay, 276 days thru the end of 2017.

7 In terms of other characteristics, these hospices  
8 were disproportionately for-profit, freestanding, urban,  
9 small, and newer entrants into the Medicare program. They  
10 also had higher live discharge rates than other hospices.

11 Because the cap is not wage adjusted, the cap is  
12 stricter in high-wage index areas than low-wage index  
13 areas. This results in hospices treating patients in  
14 high-wage index areas being more likely to exceed the cap  
15 than in low-wage index areas, 25 percent versus 9 percent  
16 in 2017.

17 So the Commission could consider a policy option  
18 to wage-adjust the cap and reduce it by 20 percent. Wage  
19 adjustment would improve the equity of the cap across  
20 providers. Reducing the cap would generate savings for  
21 taxpayers and the Part A trust fund. And reducing the cap  
22 and wage-adjusting the cap would improve payment accuracy



1 by focusing payment reductions on providers with  
2 disproportionately long stays and high margins.

3 To illustrate potential effects of this policy  
4 option, we have done a simulation using 2017 historical  
5 data, and assuming no utilization changes. Since CMS'  
6 fiscal year 2020 rebasing is not reflected in the 2017  
7 data, we simulated the effect of the rebasing before  
8 simulating the cap policy option.

9 Under the policy option, the share of hospices  
10 exceeding the cap would increase from about 14 percent  
11 currently to 26 percent under the policy option, and we can  
12 see this in the chart.

13 The green bars on the far right are hospices that  
14 are already over the existing cap, and the yellow bar, in  
15 the middle, are the additional hospices that would be over  
16 the cap under the policy option in our simulation. These  
17 new above-cap hospices have similar characteristics to  
18 existing above-cap hospices. They are largely freestanding  
19 and for-profit providers, with an average length of stay of  
20 254 days and an aggregate margin of 22 percent in 2017.

21 Although more hospices would exceed the cap under  
22 the policy option, many would remain substantially below

1 the cap, and that is shown in the blue bars on the left.

2 So, we have also simulated the effect of the cap  
3 policy option on payments to providers in 2017, and as I  
4 noted before, and I'm going to stress again, the simulation  
5 is based on historical data only.

6 Overall, our simulation estimates that total  
7 payments would be 2.8 percent less in 2017 under the policy  
8 option. And as you can see in this chart, the reduction to  
9 payments occurs among hospices with the longest stays, the  
10 last two lines in the chart.

11 So to talk a little bit more about the effects of  
12 the policy option, most hospices would not be affected by  
13 the cap policy option. Those hospices that would be  
14 affected are those with long stays and high margins, mostly  
15 freestanding and for-profit providers. We find little  
16 effect on nonprofits and hospital-based hospices, provider  
17 categories with the lowest margins.

18 The policy option would improve the equity of the  
19 cap across providers in geographic areas, with the share of  
20 hospices exceeding the cap in high-wage index and low-wage  
21 index areas being much more similar.

22 Under the policy option, we expect that

1 beneficiaries would continue to have good access to hospice  
2 care, as many providers would remain substantially below  
3 the cap. Nonetheless, CMS should monitor utilization  
4 patterns, and in particular live discharge rates. CMS has  
5 experience monitoring utilization patterns, with payment  
6 changes in the hospice sector and other sectors.

7           So now turning to the Chairman's draft  
8 recommendation.

9           Given the strong indicators of payment adequacy  
10 in the hospice sector that we reviewed earlier in the  
11 presentation, the Chairman has the following draft  
12 recommendation on the hospice payment update and the  
13 hospice cap.

14           It reads: For fiscal year 2021, eliminate the  
15 update to the fiscal year 2020 Medicare base payment rates  
16 for hospice, and wage-adjust and reduce the hospice  
17 aggregate cap by 20 percent.

18           This two-part draft recommendation would keep  
19 payment rates unchanged in 2021 at their same 2020 levels,  
20 while modifying the aggregate cap to focus payment  
21 reductions on providers with longer stays and higher  
22 margins.

1           In terms of implications, the recommendation  
2 would decrease spending relative to the statutory update,  
3 and in terms of beneficiaries and providers, we expect that  
4 beneficiaries would continue to have good access to hospice  
5 care and that providers would continue to be willing and  
6 able to provide appropriate care to Medicare beneficiaries.

7           And that concludes my presentation and I turn it  
8 back to the chair.

9           DR. PAUL GINSBURG: Thank you very much, Kim.  
10 Very clear, excellent presentation.

11           Open for clarifying questions. Actually, let me  
12 go on this end. Larry, Karen, Bruce, Marge, Dana, Brian,  
13 Jonathan, and Jaewon.

14           DR. CASALINO: I agree, Kim. It was a very clear  
15 presentation. Thank you. It was very interesting about  
16 the cap.

17           I have a couple of questions. Do you have a  
18 sense of why there's no wage adjustment at the moment?

19           MS. NEUMAN: The cap was written into statute,  
20 and the statute does not have any mention of wage  
21 adjustment of the cap.

22           DR. CASALINO: But you're not aware of a

1 rationale for not having a wage adjustment?

2 MS. NEUMAN: No, I'm not aware of a rationale.

3 DR. CASALINO: Okay.

4 And the second is kind of a broad question and a  
5 comment. We see on Slide 11 about at least an eight-fold  
6 difference in profit margin between for-profit and non-  
7 profit facilities. This is bigger than we often see, but  
8 we see this kind of thing fairly frequently that one type  
9 of provider has much higher margins than others.

10 I would love it if the staff, which is so  
11 familiar in qualitative, not just in the numbers, but in  
12 qualitative ways with the sector, could try to give us more  
13 information on why some sectors are more profitable than  
14 others for this area, but I'm making it as more of a  
15 general comment.

16 This is a question, but just to finish off the  
17 frame of the question, I think that one can look at the  
18 report and say, "Oh, they're more profitable because they  
19 have a longer length of stay or they're more profitable  
20 because they select for neurologic diseases rather than  
21 cancers or whatever," but that's not really an explanation  
22 on how do they get a longer length of stay, how do they

1 select patients.

2 I would really love to see that in general in  
3 presentations, a little bit more information on when we see  
4 large differences, where they seem to come from. I realize  
5 that staff does not want to speculate too much, but if you  
6 do have specific knowledge, it would be nice for the  
7 Commission to benefit from that.

8 So, in this case, how do they get longer length  
9 of stay with the for-profit facilities? How do they select  
10 by diagnosis?

11 MS. NEUMAN: That's a difficult question to  
12 answer. I think right now what I can sort of point to is  
13 the data that we have, and the data that we have show that  
14 for-profits have a higher proportion of patients with  
15 certain non-cancer diagnoses. And then when we look at  
16 those particular diagnoses and compare similar patients,  
17 for-profit, non-profit, they have longer stays as well.

18 It's hard for me to speculate the sort of  
19 dynamics that are going on there at this point, and we can  
20 think about if there's things we can add. But I sort of  
21 fall back to the data.

22 DR. PAUL GINSBURG: Put the mic on, Jim.

1 DR. MATHEWS: In some instances, we can point to  
2 more direct factors that influence length of stay. So, for  
3 example, a patient who is referred to hospice during an  
4 acute care hospital stay at the end of life is likely going  
5 to have a shorter stay relative to someone who is referred  
6 from the community. I think in those instances, the  
7 proximal cause is a little clearer.

8 In other instances, as Kim said, it is --  
9 "speculative" may be too strong a word, but less  
10 definitive, and you start getting into questions about how  
11 patients are referred to hospices and the role of hospices  
12 going out into the communities and soliciting those  
13 referrals. So it's much less definitive in terms of being  
14 able to say here is this patient, here are the factors that  
15 resulted in a longer or shorter length of stay.

16 DR. CASALINO: I guess I would just add that it's  
17 not, I think, simply an idle question or a political  
18 question. It may not be so relevant to the recommendations  
19 for payment updates, but if I were paying the gas company  
20 or electric -- if I had a choice of paying one eight times  
21 more than another, I would want to know -- or giving one  
22 eight times higher margins than another, I should say, is

1 it really eight times more efficient, or what is their  
2 reason?

3           So I think the Commission's more broad role of  
4 making recommendations about policy, I think we do need  
5 that kind of information about how margins can differ so  
6 much.

7           Just the last thing I'll have to say, because  
8 I've been at it long enough, this is -- I said this  
9 yesterday, and I'll say it again. The fact that things are  
10 stable to me are not necessarily an indication that things  
11 are okay. So when you see for hospice that only 75  
12 percent, for example, report that they got care in a timely  
13 way -- I think this is on Slide 4 or whatever -- 72 percent  
14 had adequate pain measures, something like those numbers, I  
15 mean, this is hospice. They're supposed to be relieving  
16 pain. They're supposed to be there when people need them.  
17 So, although those numbers are stable, I'm not sure that I  
18 would think those numbers are good.

19           So I would, again, just appreciate more comments  
20 from staff. If things are stable, is your assessment that  
21 they're stable and good enough or stable and still not good  
22 enough?



1 MS. NEUMAN: I think on the CAHPS survey, it's  
2 hard to know what the right benchmark is. Clearly, a  
3 family member's perception of the care that their loved one  
4 received will not be 100 percent for all patients. The  
5 question is how close it should be to 100 percent, and we  
6 at this point don't have a good way to gage that. But it's  
7 something we could think about what others in the  
8 environment think the right number should be, to provide  
9 more context, longer.

10 DR. PAUL GINSBURG: Actually, before we go on to  
11 Karen, your first point about the fact that the statute  
12 does not have a wage adjustment, I think it's pretty normal  
13 in policy process that someone comes up with an idea, an  
14 aggregate per-patient cap, and it's enacted. And then  
15 people start realizing there are some inequities, and they  
16 refine the policy. I guess that's the stage we're in now.

17 DR. DeSALVO: So, Kim, thank you very much for  
18 all this great work. I'm going to pick up on the CAHPS  
19 line of questioning because, as you note in the chapter,  
20 there is a lot of opportunity to improve the way we're  
21 measuring quality in this space.

22 I first want to -- I was going to ask some

1 similar questions about what's the right number and are we  
2 really topped out, but I wanted to get a little bit better  
3 sense from you about the response rate for the CAHPS survey  
4 and how much of a voice of family we're actually getting.

5 MS. NEUMAN: So I think CAHPS response rates are  
6 on the lower side, and I'm looking for Ledia here. We  
7 could get back to you on what the rate is for hospice.

8 In hospice, it's going to be sort of an extra  
9 challenge in the sense that there is a waiting period  
10 between the time when a patient passes and when they survey  
11 the family.

12 DR. DeSALVO: Correct.

13 MS. NEUMAN: So there are even extra dynamics  
14 that go on in hospice that makes these kinds of surveys  
15 hard but important.

16 DR. DeSALVO: Yeah. I mean, there's as much  
17 psychology involved in the recall of the experience and the  
18 grieving at the same time, so worthy of at least  
19 understanding of how much a voice there is and if there's a  
20 way to improve that, but also what are the other  
21 opportunities for understanding quality?

22 As I understand it -- and maybe I missed this in

1 the chapter -- the Office of Inspector General last year  
2 did some work looking at hospices, following up on  
3 complaints, so sort of the negative view of where there may  
4 be problems. So, clearly, there's some opportunity.

5 I had just one more question about the discharge  
6 from hospice that you mentioned in the slides and that you  
7 have this table. I have to say, clinically, I was really  
8 struck by it, by the high rate of live discharge in that  
9 top decile, and just a clarifying question. You give it a  
10 nice treatment in the paper, but I don't remember if you  
11 said whether or not we can track if those people were  
12 readmitted to hospice.

13 So say the reason for discharge was they  
14 relocated or they chose to disenroll. Can we track whether  
15 those individuals actually reenrolled in hospice?

16 MS. NEUMAN: We can, and we have done that in  
17 prior years. So we could bring back some of the prior-year  
18 analysis, and longer run, it's possible to do that kind of  
19 analysis more currently.

20 DR. DeSALVO: Thanks. It begs the question about  
21 program integrity, and it would be helpful to know if this  
22 is just really truly people making changes or if it's

1 something else going on in terms of a benefit need that  
2 we're not meeting.

3 DR. CROSSON: Yeah. Amol?

4 DR. NAVATHE: Just to add to that, I really like  
5 that idea, Karen, and I would say you did, in the mailings,  
6 highlight the reasons for live discharge, and to look at  
7 that by reason for live discharge would actually be really  
8 meaningful, particularly from a program integrity kind of  
9 perspective, individuals who effectively go on to switch  
10 hospices, even if they didn't move, for example.

11 DR. CROSSON: I have one. Kim, in terms of the  
12 CAHPS survey, is that generally administered as part of the  
13 mandatory bereavement services?

14 MS. NEUMAN: It's part of the Hospice Quality  
15 Reporting Program, and if the hospice -- there's like small  
16 providers are exempted, but everyone else in order to get  
17 their regular update needs to send the Bereaved Family  
18 Member Survey to their patient populations, families, who  
19 have passed.

20 DR. CROSSON: Okay. Bruce?

21 MR. PYENSON: Thank you very much, Kim. This is  
22 a terrific chapter, as others have said.

1 I've got two questions. One is on the  
2 recommendation. I think the existing law is at 2.8 percent  
3 increase, and the recommendation is zero percent combined  
4 with the cap, reducing the cap by 20 percent and wage  
5 adjusting. Do you have a secret slide that --

6 [Laughter.]

7 MR. PYENSON: That shows perhaps some scenarios,  
8 what if the cap were reduced by 30 percent or 40 percent,  
9 sort of the tradeoff of cap and savings from the cap? The  
10 20 percent sounds like a great number, but it seemed like,  
11 if anything, we could be more aggressive about the cap.

12 MS. NEUMAN: So I don't have a secret slide.

13 [Laughter.]

14 MS. NEUMAN: What you're saying, I mean, that  
15 kind of math is possible.

16 What I would also say, however, is that what I  
17 have done here with the 20 percent is a simulation based on  
18 historical data, assuming no utilization changes. That's a  
19 very different thing from what an organization like CBO  
20 would do to say what the budget effect would be, and so we  
21 ourselves can't tell you that second bucket.

22 DR. MATHEWS: If I could also just augment Kim's

1 response, as Kim mentioned in the presentation, financial  
2 performance in 2018 has improved relative to what we  
3 reported out last year. Last year, we made a  
4 recommendation of a minus 2 percent update, and this year,  
5 given the improvement in financial performance and the  
6 stability of other measures, we might have been in  
7 consultation with the Chairman, talking about a minus 3  
8 percent across-the-board update this year.

9           But, as it happens -- and here, I am going to say  
10 things that may or may not be correct, and Kim will correct  
11 me, as Warren did, but the effect of a zero update and  
12 reducing the hospice cap by 20 percent is a net reduction  
13 in revenues of about 2.8 percent, thereabouts.

14           Kim is nodding, for the audience there.

15           And so it has the same aggregate effect on  
16 hospice revenues as a 3 percent across the board, which we  
17 might otherwise have contemplated, but has the benefit of  
18 targeting that reduction on those providers that have the  
19 longest length of stay and are more profitable. So, in  
20 that sense, from my perspective at least, there is a  
21 greater attraction to using this approach rather than an  
22 across-the-board update.

1 MS. BUTO: Jim, just to follow on that, my  
2 impression was, Kim, that you picked up a lot of the long-  
3 stay live discharge, highly profitable providers by moving  
4 to the 20 percent. If you went further down to say 40  
5 percent, I think it's possible you'd start getting into, I  
6 guess, what we would think of as providers who are less  
7 profitable and serving a higher acuity or a population that  
8 doesn't survive the hospice stay. So I don't know where  
9 that cut point is, but it struck me that you picked up a  
10 lot of those patients.

11 MS. NEUMAN: Right. I mean, that yellow bar that  
12 we're picking up with this policy option, those folks look  
13 pretty similar to the above-cap hospice folks. If we  
14 walked that reduction up further, you're moving more to the  
15 left, and I don't have the data right here, but you would  
16 incrementally be making the pool look more similar to the  
17 average. Yeah.

18 MR. PYENSON: Thank you. I had another --

19 DR. CROSSON: Are you still on --

20 MR. PYENSON: I had a different question, if I  
21 could, on the wage index, and I'm very glad that you raised  
22 the wage index. I think my question is going to be applied

1 to a lot of other areas where reimbursement is tied to wage  
2 index.

3           When I look at the wage indexes that are out  
4 there, for example, for hospitals, there's perhaps 3,000 or  
5 so wage indexes, and perhaps a quarter of them have been  
6 adjusted for the purpose of hospital reimbursement. But it  
7 seems as though that's not the case for hospice or others,  
8 and I'm wondering if you -- so I'm assuming you used the  
9 unadjusted wage index in your work.

10           MS. NEUMAN: So Medicare payments are wage-  
11 adjusted using the pre-reclass wage index for hospitals, as  
12 you're pointing out, and so when we did the cap work, we  
13 just followed suit to be consistent. It's sort of a  
14 different animal of question about what's the right wage  
15 index to use in hospice, and that's something we haven't in  
16 hospice particularly thought about. But I know that the  
17 Commission in general has thought about wage index and  
18 what's the right way to go more broadly.

19           MR. PYENSON: I would certainly welcome more  
20 about that. I think it's been a while since we've seen any  
21 material, the Commissioners have seen material on that, so  
22 I'm not sure if this is a stage one or stage two question,



1 Round 1 or Round 2. But I'd certainly welcome learning  
2 more about that.

3 DR. MATHEWS: Yeah. So I think -- and here, I'm  
4 looking for some historical memory -- we made a  
5 recommendation to do a comprehensive overhaul of the  
6 Medicare wage index or Medicare's approach to wage indexing  
7 in 2007 or thereabouts, and we did some modeling that  
8 showed a number of improvements to the approach we  
9 recommended relative to what's currently used in terms of  
10 discontinuities between contiguous geographic areas,  
11 circularity. Our approach would remedy a number of things,  
12 and we've continued to maintain that work since. And I  
13 think we can contemplate bringing it back and giving it the  
14 current status.

15 I'm not sure we can do it this cycle, given our  
16 schedule, but this is something we can easily do next year.

17 DR. CROSSON: I wonder if the complexity in this  
18 particular case is that we've got both institutional and  
19 non-institutional providers, hospital-based hospice care  
20 and then non-hospital-based hospice care.

21 MS. NEUMAN: Right. In hospice, we have that  
22 dynamic going on, they although for hospice purposes get

1 the pre-reclass wage index.

2 DR. PAUL GINSBURG: Yeah. I would think that  
3 whether hospice care is delivered by a hospital or  
4 freestanding, probably the types of labor used are pretty  
5 similar.

6 DR. CROSSON: Okay. Marge?

7 MS. MARJORIE GINSBURG: I'm also interested in  
8 knowing more about the live discharges.

9 I think you showed that they predominantly happen  
10 in for-profit institutions. They're not evenly divided  
11 between for-profit and non-profit.

12 Are surveys done in particular with those groups,  
13 particularly with the family members or the patients  
14 themselves about why they were discharged and their  
15 feelings about being discharged? I don't know whether  
16 they're volunteering to exit or whether they're being  
17 booted because the hospice doesn't want to take it on the  
18 head, you know, when they go too many days. So anything  
19 more about that?

20 MS. NEUMAN: So it's a really good question, and  
21 the CAHPS survey focuses on family members of decedents.  
22 So we don't have a tool right now, the Medicare program at

1 large, to understand the experiences of folks who have been  
2 discharged alive. So that is an area where there could be  
3 room for improvement.

4 DR. CROSSON: Okay. David. Oh, I'm sorry.  
5 Dana.

6 DR. SAFRAN: Thank you. So a few questions that  
7 will help me understand my point of view, or frame my point  
8 of view about the cap. No question about the wage  
9 adjustment part, but I'm just wondering where to set the  
10 right level.

11 So the first question is, the increased use of  
12 hospice among Medicare decedents is pretty remarkable.  
13 Years ago we were bemoaning the fact that it was so rarely  
14 used, and to see it's over 50 percent is pretty remarkable.  
15 I wonder if there are data on what that has done to  
16 Medicare spending for the relevant conditions where hospice  
17 is being used, end-of-life spending. What do we know about  
18 that?

19 MS. NEUMAN: So it's a complicated question,  
20 because it's hard to say what would have happened if  
21 someone didn't enter hospice. And so there's literature  
22 that looks at this question in different ways and comes to

1 different conclusions.

2           The Commission sponsored a study trying to look  
3 at the divergent findings in the literature and try  
4 different methodologies and see if we could figure out what  
5 we think, based on various different methodologies, what  
6 the effect of hospice is on aggregate Medicare spending.  
7 And what that study found was that we think in aggregate,  
8 the increased hospice use has not led to program savings  
9 overall. It may have increased costs slightly. That's  
10 what the study suggests.

11           But what underlies that is that hospice seems to  
12 save for patients in the last month or two of life -- you  
13 know, acute care that's avoided, and so forth. But when  
14 patients are in hospice for a long time, then the costs  
15 outweigh the savings.

16           And so what the study showed was that in  
17 aggregate, even though we see savings, and particularly for  
18 non-cancer patients, on the whole, it appears that we don't  
19 see savings, and that is because the costs for the long-  
20 stay patients outweigh or offset savings for shorter-stay  
21 patients.

22           DR. SAFRAN: Yeah. Okay. And that actually

1 points to what my second question was. So it was clear  
2 from the materials that cancer patients, you know, the  
3 stays are much shorter than neurological patients. And  
4 just trying to understand, number one, do neurological  
5 patients sort of make up -- are those the two principal  
6 areas of diagnoses for which hospice is being used? And  
7 with the neurological conditions -- maybe I should ask some  
8 of my clinician colleagues to weigh in on, you know, is the  
9 point of end-of-life just so much harder to predict with  
10 those conditions? So I just want to understand that a  
11 little bit.

12 MS. NEUMAN: So there are a couple of sort of  
13 larger-sized populations that hospice treats, and in some  
14 ways it reflects the decedent population overall. So there  
15 is cancer patients, as we talked about. Another big group  
16 is neurological patients, and another big group is patients  
17 with heart and circulatory conditions. So those are  
18 probably the three big groups.

19 On the point about neurological patients, and  
20 clinicians will have more information on this but I wanted  
21 to just point to, we have a footnote in the paper which  
22 sort of looks at length of stay for neurological patients

1 for for-profits and nonprofits, and we see that at the 75th  
2 and 90th percentiles, for-profits have much higher lengths  
3 of stay than nonprofits.

4 So there seems to be, among providers,  
5 differences in length of stay, even for difficult-to-  
6 predict conditions.

7 DR. SAFRAN: Interesting.

8 DR. DeSALVO: On this question, is neurological,  
9 does that bucket include stroke, or is that in circulatory?

10 MS. NEUMAN: Let me get back to you.

11 DR. CROSSON: Kim, the mic is off.

12 MS. NEUMAN: I will get back to you on that. I  
13 don't want to misspeak.

14 DR. CASALINO: Just a clinical response, Dana. I  
15 think that with something like -- I think Karen's question  
16 was a really good one because it's slightly different for  
17 that. But for things like amyotrophic lateral sclerosis,  
18 there is really no treatment and the patient is just going  
19 to decline. You don't know exactly at what rate but you're  
20 getting them some help early on.

21 You know, with cancer it's different because  
22 people want to be treated with whatever modalities they're

1 being treated with, until it's clear that there is no hope,  
2 and that can be pretty close to the time of death, rightly  
3 or wrongly.

4           So I think that's the reason for the difference  
5 in the two types of diseases.

6           DR. DeSALVO: Potentially, dementias are included  
7 in the neurological bucket, and it is extremely difficult.

8           DR. SAFRAN: Right. That's what I was imagining.  
9 So it's for another conversation, but I think it's worth  
10 our thinking more broadly about hospice policy, and, you  
11 know, how we try to consider the likely duration of some of  
12 these conditions and what that should mean for hospice  
13 care.

14           But my last question goes to the information that  
15 you had on Slide -- my notes have covered up the slide  
16 number -- 19.

17           DR. CASALINO: Karen and I were just talking. It  
18 could be that for patients with dementia or a slowly  
19 progressing neurological disease, essentially the long-stay  
20 hospice is being used as a substitute for home health care.  
21 And so that's a policy issue to be talked about, and what  
22 are the comparative costs and benefits and so on.

1 DR. SAFRAN: Right. Yeah, that's what I was  
2 thinking. Okay.

3 So on Slide 19, do we have information on, like  
4 if there was another column here on margins, can you tell  
5 us to what extent, you know, margin tracks with length of  
6 stay here, because I didn't see that information in the  
7 materials. Sorry of I missed it.

8 DR. CROSSON: Kim, the microphone keeps going  
9 out.

10 MS. NEUMAN: Sorry. I'm going to flip back a  
11 couple of slides. So right here, these bars track to those  
12 rows in the table.

13 DR. SAFRAN: Okay. Got it. Thanks.

14 DR. CROSSON: Brian.

15 DR. DeBUSK: First of all, thank you. Great  
16 report. Really good read.

17 I want to tie into something Bruce was comment  
18 on, on the wage index, and also express a little bit of the  
19 same question that Dana had around, you know, for example,  
20 a dementia patient versus, say, a cancer patient. I'm not  
21 sure that all long stays are bad actors, and I would  
22 appreciate some information on that.



1           But first I want to go to Chart 11 in the  
2 presentation, where it looks at the urban versus the rural  
3 Medicare margins. Could you speak to, you know, what could  
4 be causing those differences, and what adjusters are in  
5 place to account for, say, differences in metropolitan and  
6 rural care?

7           MS. NEUMAN: So hospice does not have any rural  
8 or urban adjusters, so those are the raw margins. There  
9 are differences in size. Some rural providers are smaller,  
10 and smaller providers have, you know, not as much economies  
11 of scale, so that's one factor that might influence it.

12           You know, we can think more about what other  
13 factors might drive that. It looks like it's about a,  
14 what, four-point spread? So we could look and see if we  
15 can add any more detail there.

16           DR. DeBUSK: Okay. I would just be curious about  
17 that.

18           The other thing, and this gets back into the wage  
19 index thing, my first question was going to be what  
20 percentage of the labor portion is applied, of the hospice  
21 wage index, is applied to the overall payment, but thanks  
22 to the excellent Medicare payment basics document that I

1 googled, yeah, found, it's 70 percent. Thank you. Really  
2 nice.

3           Could you speak to, one more time, the  
4 difference, though, in the hospice wage index and the  
5 hospital? I think I understand it but I'd like to hear one  
6 more time.

7           MS. NEUMAN: So hospice uses the pre-  
8 reclassification, wage index. So the hospital folks can do  
9 more justice to this than I can, but there are adjustments  
10 that are made to the hospital wage index. People are  
11 reclassified to various areas, and so forth. Those changes  
12 that get made in the hospital sector, to the wage index,  
13 that does not apply to hospice. They use the straight,  
14 initial wage index.

15           DR. DeBUSK: So they skip that step, the  
16 reclassification, the frontier states, all that, and then  
17 they apply budget neutrality, though, to hospice, just like  
18 they do to hospital wage index.

19           MS. NEUMAN: They are now applying budget  
20 neutrality. There was a time they didn't, but they do.

21           DR. DeBUSK: Okay. Okay. So the end product of  
22 both calculations is budget neutral. I was just curious to

1 see if there was any upward or downward bias there.

2           So my final question, and I could use help with  
3 the math, \$30,000 cap effectively. We want to knock it  
4 down 20 percent. But then we also want to apply the wage  
5 index to it. Could you speak to, knowing that it's applied  
6 to, say, 70 percent of the total, you know, I'm used to  
7 swings in the wage index of 2.8 on the high side, 0.7 on  
8 the low side. Can you speak to what impact would it have  
9 on the cap? Like what's the high and what's the low that  
10 we would experience here?

11           MS. NEUMAN: So there's that text box at the very  
12 end of the paper that gives you the percentile distribution  
13 of something that we call sort of like the ratio of the  
14 wage-adjusted payments to the not-wage-adjusted payments.  
15 So we calculate here's what you actually got paid, and  
16 here's what you would have gotten paid if the wage index  
17 didn't exist. It's on page 64.

18           And so what we see is at the 10th percentile, the  
19 wage adjustment reduces your payments by about 14 percent,  
20 and at the 90th percentile, it increases your payments by  
21 about 16 percent. And those numbers take into account the  
22 fact that the wage index only applies to, you know, 68, 70

1 percent of the payment, as you said.

2 DR. DeBUSK: Okay. Help me with this. This is  
3 the ratio of wage-adjusted payments to payments without.  
4 Oh, this is looking at who would be the most affected.  
5 There we go.

6 MS. NEUMAN: That shows you sort of, right now  
7 what the wage adjustment is doing to various people's  
8 payments.

9 DR. DeBUSK: Okay. So, for example, it would be,  
10 in this lowest percentile, then, it would be 20 percent,  
11 which is the reduction, plus an additional 14 percent on  
12 top of that.

13 MS. NEUMAN: Right.

14 DR. DeBUSK: And then the people that were  
15 basically in the highest percentile, they would get a 20  
16 percent cut, but then they would get 16 percent of that  
17 back.

18 MS. NEUMAN: Right.

19 DR. DeBUSK: So basically they wouldn't get a cut  
20 at all.

21 MS. NEUMAN: There are some people who wouldn't  
22 get a cut at all, yeah.

1 DR. DeBUSK: So we'd effectively be transferring  
2 money out of rural areas and into metropolitan areas, to  
3 attempting the cap.

4 MS. NEUMAN: I think -- if you look on -- there's  
5 another chart that sort of addresses that, on page 60,  
6 which shows you the rural and urban effects of the policy,  
7 and it shows it to you by length of stay. And what you can  
8 see there is that, point number one, whether you're rural  
9 or urban, if you have long stays you have high margins.  
10 Rural and urban doesn't matter. And then the second point  
11 is that this chart shows you that the policy option, which  
12 includes wage adjustment and reducing the cap, together,  
13 that policy option is really just focusing on the long-stay  
14 providers in both rural and urban areas, and the shorter-  
15 stay providers in both areas are largely unaffected.

16 DR. DeBUSK: Okay. And then you can get back to  
17 us with sort of the dementia versus cancer, and, you know,  
18 good guy but long stay versus bad guy, long stay.

19 MS. NEUMAN: So we can try to bring you more  
20 information on that. The good guy/bad guy --

21 [Laughter.]

22 DR. DeBUSK: Was I oversimplifying?

1 MS. NEUMAN: -- is not in my skill set.

2 DR. DeBUSK: Okay. Thank you.

3 DR. CROSSON: Okay. So we've got Jonathan,  
4 Jaewon, and Jon, and we have run out of time.

5 DR. JAFFERY: Great. Thanks. I'll try to be  
6 quick. So first I just want to add one other clinical  
7 point to Dana's question. I totally agree with what Larry  
8 and Karen had said and how that impacts maybe length of  
9 stay on some of these conditions that -- neurologic  
10 conditions that may have a longer time frame than the  
11 cancer patient. But there are also some other categories,  
12 like congestive heart failure, which there may be patients  
13 who then make some improved clinical steps. The reason I  
14 bring it up is that a policy perspective might contribute  
15 to some life discharges, more than some of these other  
16 conditions.

17 And then my question, on Slide 6 you show the  
18 supply of hospices increasing and how this is virtually all  
19 for-profit, and in thinking about our previous conversation  
20 about dialysis consolidation. And it's interesting. We've  
21 got these two sectors that, in some ways, primarily exist  
22 because of Medicare payment policies. I think hospice is

1 probably the only thing I can think of that's even got a  
2 higher percentage of Medicare payment as part of most of  
3 their book of business.

4           Do you have any sense about, with these  
5 increases, how many of them are totally new entrants into  
6 the field, or are we seeing any trends towards larger  
7 groups consolidating, getting market share across either  
8 regions or the country at large?

9           MS. NEUMAN: So I think we can bring you back  
10 some more granular information on that. In general, we are  
11 seeing both new entrants, so we are seeing new hospices  
12 coming in, especially as we've talked about in certain  
13 state, right? So we've seen, you know, some big, new  
14 entrants in certain states. And then we also do see  
15 providers leave. And then, in addition, there are mergers  
16 going on. So there are all three dynamics at play, and we  
17 haven't sort of disaggregate it. But, you know, that kind  
18 of thing is possible.

19           DR. GRABOWSKI: On this?

20           DR. CROSSON: Yes.

21           DR. GRABOWSKI: The other phenomenon, right, is  
22 there's some vertical integration, not just horizontal but

1 some nursing homes owning hospice. And those relationships  
2 have always struck me as being fraught with potential  
3 issues. I don't know if that's something. It may be a  
4 smaller part of this but it's certainly something to flag  
5 around kind of consolidation.

6 DR. CROSSON: Jaewon.

7 DR. RYU: Yeah. I have a couple of questions,  
8 one I think we've talked about already, but just the long  
9 length of stay and the cap dynamic and the clinical  
10 dynamic. You know, is the Dana and Larry and Karen and  
11 Jonathan discussion.

12 I guess my question is just, is there any way to  
13 tease apart? Is it because of the referral or is it  
14 because of who the hospice chooses to accept that drives  
15 the long length of stay? You had referenced earlier, on  
16 Slide 8, that under the nonprofit/for-profit and the  
17 difference in average length of stay, you know, there are  
18 two dynamics at play. One is for the same diagnosis there  
19 tends to be a longer length of stay in the for-profit, but  
20 then the other is they tend to enroll folks who tend to  
21 have a longer length of stay, and on that dynamic, is it  
22 possible to tease apart, is that happening because they're



1 seeking and getting referrals that are of a different  
2 patient mix or is it that they're accepting, or choosing to  
3 admit or accept a different mix of patients?

4           The reason why I ask that is I think  
5 understanding that dynamic is important to understanding  
6 the clinical one around will there be a disproportionate  
7 impact on specifically, you know, we've used the neuro  
8 example or the circulatory example. But I guess I'm still  
9 kind of hung up on how are they getting in and how are they  
10 selecting?

11           So that was question one. On the life  
12 discharges, I think it's similar to where Marge was going.  
13 It would be interesting to know, is it because the  
14 prognosis changes and improves, or is it because they quit  
15 the program? Do we have any insight into that?

16           MS. NEUMAN: We have a chart where we look at the  
17 reason for life discharge as reported on the claims. And  
18 so we can see that the two biggest groups are because  
19 they're either not terminally -- determined not to be  
20 terminally ill any longer, and then the other big group is  
21 because the beneficiary chooses not to enroll.

22           Underneath this data, there are, though,

1 questions about sort of, you know, is the beneficiary  
2 choosing not to enroll? Is the beneficiary being  
3 encouraged to leave hospice? So there is some --  
4 underneath the data, we don't know entirely sort of the  
5 dynamics that are going on.

6 DR. RYU: And do we know how much longer they  
7 live, the live discharges?

8 MS. NEUMAN: So we do have some very detailed  
9 work that we've done on older data that we can bring to  
10 you, and look at that, and that is something that we could  
11 dig into longer term as well.

12 DR. RYU: Thank you.

13 DR. CROSSON: Jon? Sorry.

14 DR. MATHEWS: Sorry. Just to go back to your  
15 first question, I think it is length of stay is a function  
16 of both activities that you mentioned. It's both seeking  
17 out referrals as well as choosing who to admit, and some of  
18 the larger hospice organizations, it's my understanding,  
19 are reasonably sophisticated in tracking how close to the  
20 cap they are getting almost in real time, tracking their  
21 aggregate length of stay, and they are able to change their  
22 referral sources, again, almost in real time. If they

1 start to see they're having cap issues, they might seek  
2 referrals from hospitals who are more likely to have  
3 shorter lengths of stay.

4 So there's degrees of sophistication in how  
5 hospices manage this process.

6 DR. CASALINO: Kim, on those point, is there any  
7 data on percentage of referrals that hospices decide that  
8 the patient is not eligible?

9 MS. NEUMAN: You mean referrals. So refused  
10 referrals?

11 DR. CASALINO: Yeah.

12 MS. NEUMAN: I don't believe that we have that  
13 kind of data.

14 DR. CROSSON: Jon?

15 DR. PERLIN: Thanks. Given, Jay, as you said  
16 we're out of time with this, on this topic, I'm going to  
17 take the prerogative going to Round 2 because Dana really  
18 started the question of what I was asking, but there are, I  
19 believe, a set of implications, which may be broader than  
20 what we can tackle this year but I believe really come  
21 forward.

22 In isolation, we've been looking. We're asking

1 the question: Do we have the right patient selection?  
2 We've noted the differences systematically between  
3 neurologic, end-stage neurologic disease and the length of  
4 stay and other patients with more acute deterioration.  
5 That's a good question within this context.

6 But more broadly, in the materials this year, the  
7 rate of -- this past year, the rate of hospice use was 50.7  
8 percent, and the truth is I don't know whether that's  
9 actually high or low. What I know is that there's an  
10 implication that there is an expanding group of individuals  
11 with dementing diseases who likely need a policy approach  
12 to support as their conditions deteriorate.

13 Simultaneously, as explored, what is the right  
14 number of patients who should go to hospice? Is this not a  
15 moment where we have to consider not just in isolation but  
16 in terms of the broader context of the Medicare program?

17 With that in mind, it strikes me, one of the  
18 current features of the Medicare hospice benefit is that  
19 the patients have to forego conventional care for terminal  
20 conditions and related conditions.

21 In 2005, for example, Aetna released an approach  
22 which actually allowed patients to include elements of

1 curative care, and this was a substantially progressive  
2 approach because it increased the uptake of hospice in  
3 particular.

4           So I think we have a set of questions to really  
5 ask about the changing demography of end-stage disease with  
6 an aging and increasingly chronic disease-burdened society,  
7 and associated with that, what are the policy implications  
8 not only for how those individuals are supported, but also  
9 in terms of whether the benefit is appropriately structured  
10 compared to when it was first framed?

11           So thanks.

12           DR. CROSSON: Okay. So Jon initiated the  
13 discussion period, and the discussion period is now open  
14 and soon to close.

15           Brian?

16           DR. DeBUSK: Super fast, Round 2.

17           My one comment -- and you could tell from my  
18 questions -- what I would do before we really finalize this  
19 thing, I would take the cap. I would back the 20 percent  
20 out. I would apply the 70 percent. I would pick a low  
21 wage index, like the .7, the .75s, apply it to 70 percent  
22 of the payment schedule, take a new look at the cap. And I

1 think you get about \$19,000. Take that \$19,000 and then  
2 look at that against some of these longer neurological-type  
3 patients in the rural areas, where they're already 4  
4 percent, 4 margin points behind their urban counterparts.

5 I would just make sure that we aren't stacking  
6 things up so much that when you get a rural patient, so  
7 you're down 4 points, then you take 20 percent off the cap,  
8 and then you apply a .7 wage index to 70 percent of their  
9 fee schedule, and then you get that neurological patient, I  
10 think you may have -- it may not just be feasible anymore.  
11 So what you may be effectively doing is eliminating hospice  
12 care for these longer neurological cases in rural areas.

13 I would just do a gut check before --

14 DR. MATHEWS: Yeah. So, Brian, just one thing to  
15 keep in mind is the cap is applied on an aggregate basis  
16 for each hospice, and I think there is material in the  
17 paper that provides an illustration along the lines that a  
18 hospice can have, in this example, half of their patients  
19 with average length of stay of 300 days and half with 30  
20 days and still be comfortably below current cap and I  
21 believe even a cap reduced by 20 percent.

22 MS. NEUMAN: With a cap reduced by 20 percent,

1 it's a bit below 300, but it's in here.

2 DR. MATHEWS: Yeah.

3 MS. NEUMAN: It's in the mid-200s.

4 DR. MATHEWS: And so reducing the cap does not  
5 mean that every single neurological patient is going to be  
6 looked at negatively by a hospice, but it's more in the  
7 aggregate, is the hospital complying with the applicable  
8 eligibility requirements and not admitting large numbers of  
9 patients who are going to have stays of 300 days?

10 DR. DeBUSK: Okay. So the thinking is even with  
11 the compounding of the setbacks in the cap that they can  
12 manage to that. That was to your earlier point. You think  
13 the behavioral response will be "Oh, we'll just take in  
14 more short-term patients, and it will balance"?

15 DR. MATHEWS: That's one potential response, or  
16 they might be more judicious about the timing of admission  
17 for patients with longer-term end-of-life degenerative  
18 diseases.

19 DR. DeBUSK: And say no from time to time.

20 DR. MATHEWS: Pardon?

21 DR. DeBUSK: Which means to say no from time to  
22 time.

1 DR. MATHEWS: Or not yet.

2 DR. CROSSON: Less active recruiting.

3 DR. DeBUSK: Okay.

4 DR. CROSSON: Kathy?

5 MS. BUTO: So I do think your question is back to  
6 Jon's question about we really need to look at the basic  
7 nature of the hospice benefit as it was originally  
8 designed, which was as an end-of-life option really aimed  
9 at cancer patients. I mean, that was the original idea.

10 Obviously, it's migrated to something else. We  
11 need to look at that because I think what everybody is  
12 talking about is, in a sense, creating or expanding the  
13 benefit and making it something different. So I think  
14 that's fair, but I don't think it's the update  
15 recommendation fair.

16 My one really quick question to you, Kim, is  
17 whether the wage index part of this, not the reduction in  
18 the cap and not the update recommendation, could be done by  
19 CMS, because I don't believe the legislation prohibits them  
20 from wage adjusting. But is it your view that we would  
21 have to get legislation to wage adjust the cap?

22 MS. NEUMAN: I'm not a lawyer, so I hesitate to



1 give an opinion.

2 I think perhaps we could go to CMS and ask them  
3 what their opinion is on this topic.

4 MS. BUTO: I just bring that up because I think  
5 it's helpful to us generally to know what things CMS might  
6 have within its own authority, given how difficult it is to  
7 get some of these things legislated, and that seems to be  
8 something that at least in my view, I would want to take a  
9 look at it if I was at CMS to see if you could do it anyway  
10 because it seems like a move in the direction of greater  
11 equity.

12 DR. PAUL GINSBURG: Kathy, on an issue like this,  
13 you need to keep in mind that if it's really unclear  
14 whether CMS has the authority and they go ahead and do it,  
15 they're likely to be sued, which in a sense would postpone  
16 the policy change for a long time.

17 MS. BUTO: Right. But I think that wouldn't stop  
18 us from looking at it and pointing out whether we think  
19 they have the authority, but you're right.

20 MS. NEUMAN: I would just add that there were a  
21 number of lawsuits about various ways that the cap was  
22 calculated in the past. So this is an area where they

1 might want clarity.

2 DR. CROSSON: Okay. Seeing no further comments,  
3 I'm going to try to parse this. So keep your eyes on me  
4 here.

5 This has been a good discussion, and I think it  
6 has drawn out what I think is becoming increasingly clear,  
7 as Kathy pointed out, and that is the hospice benefit has  
8 and is in the process of materially changing. And it's  
9 different now, and it's becoming more different than what  
10 was intended. This is a policy issue for the Commission,  
11 and I think we will absolutely have to take this up.

12 I'm not certain that that issue or some of the  
13 other requests for additional information that Kim could  
14 put into the material for January suggests that we cannot  
15 take a straw poll here in terms of -- I haven't heard any -  
16 - other than Kathy -- and I'm going to ask you in a sense -  
17 - I haven't heard anything that makes me think we don't  
18 want these recommendations.

19 Now, Kathy, we could change the second part of  
20 the recommendation to say something like "Congress should  
21 wage adjust and reduce the hospice aggregate cap by 20  
22 percent unless CMS is able to do this."

1 MS. BUTO: No, I wouldn't do that.

2 DR. CROSSON: You don't want to do that. Okay.

3 MS. BUTO: I think Kim is right. It's a lot  
4 cleaner to get Congress to direct in this area, and Paul's  
5 point too about litigation.

6 DR. CROSSON: Okay.

7 MS. BUTO: And since we want the rest of it, just  
8 doing the wage adjustment is not really enough.

9 DR. CROSSON: All right. So my assumption is  
10 that we have a broad support for these. Seeing no  
11 objection, we'll bring this forward in the expedited voting  
12 process in January.

13 Thank you, Kim.

14 [Pause.]

15 DR. CROSSON: Okay. Our final presentation and  
16 discussion for the December meeting is our annual update on  
17 the Medicare Advantage program.

18 I would note for the Commissioners that as you  
19 may remember from the November meeting, we did have a  
20 discussion about some options for impacting the relative  
21 payment rate for the MA program compared to the fee-for-  
22 service. We are going to be coming back to that issue or a

1 set of issues related to Medicare Advantage payment in the  
2 spring, and so we will not necessarily resolve or even try  
3 to substantially address that set of issues in this  
4 presentation.

5 With that, Luis and Andy, you have the floor.

6 MR. SERNA: Good morning. I am going to present  
7 our analysis of the Medicare Advantage enrollment, plan  
8 availability, and bids for 2020. Then Andy will give you  
9 an update on MA risk coding intensity and the current state  
10 of MA quality measurement.

11 As Jay said, we will not present any  
12 recommendations today, but there may be recommendations in  
13 the spring related to work that includes improving MA  
14 quality incentives.

15 Thirty-four percent of Medicare beneficiaries are  
16 now enrolled in MA plans, up from 24 percent in 2011.

17 The Affordable Care Act of 2010 established  
18 changes to MA payment rates, essentially phasing in a  
19 reduction of MA payment rates by 10 percentage points  
20 between 2011 and 2017. Despite some initial projections  
21 that the decrease in MA payment rates would coincide with  
22 enrollment declines, MA enrollment has continued to grow

1 rapidly.

2           In 2019, MA enrollment grew 10 percent to 22.5  
3 million enrollees. The 10 percent growth exceeds the  
4 growth of the prior year by 2 percentage points, coinciding  
5 with an increase in the number of plans bidding.

6           Medicare beneficiaries have a large number of  
7 plans from which to choose, and MA plans are available to  
8 almost all beneficiaries. For 2020, 99 percent of Medicare  
9 beneficiaries have at least one plan available; 93 percent  
10 have a zero-premium option that includes the Part D drug  
11 benefit, up from 90 percent in 2019. The average Medicare  
12 beneficiary can choose from 27 plans in 2020, up from 23  
13 choices in 2019.

14           I'll now briefly go over the MA payment system.  
15 Plans submit bids each year for the amount they think it  
16 will cost them to provide Part A and B benefits. Prior to  
17 risk adjustment, this is known as the base rate.

18           Each plan's bid is compared to a benchmark, which  
19 ranges from 115 percent of fee-for-service spending to 95  
20 percent of fee-for-service in the highest-spending counties.

21           Quality bonuses can increase plan benchmarks by  
22 as much as 10 percent.

1           For nearly all plans, Medicare pays the bid plus  
2 a rebate, calculated as a percentage of the difference  
3 between the bid and the benchmark. The rebate percentage  
4 ranges between 50 percent to 70 percent, depending on  
5 quality scores.

6           Plan rebates may go toward lower beneficiary cost  
7 sharing for A and B services, supplemental benefits, or  
8 enhanced Part D benefits.

9           However, Marge, as you alluded to in November,  
10 rebate dollars are paid for by the Medicare program.  
11 Moreover, not all rebate dollars go directly to  
12 beneficiaries. Plan rebates include administrative expenses  
13 and profit related to reducing A&B cost sharing and  
14 providing supplemental benefits.

15           The average rebate that plans have available for  
16 extra benefits in 2020 has increased to \$122 per member per  
17 month, a record high. The level of rebates, now at 13  
18 percent of total payment, reflects MA plans' ability to  
19 increase the efficiency of their bids relative to payment  
20 benchmarks.

21           However, because benchmarks have been much higher  
22 than fee-for-service spending, lower plan bids have not

1 translated to Medicare savings. In 2020, before accounting  
2 for coding differences between MA and fee-for-service, we  
3 estimate that benchmarks, represented by the blue line,  
4 will average 107 percent of fee-for-service spending.  
5 Payments, represented by the solid red line, will average  
6 100 percent of fee-for-services pending. Quality bonuses  
7 will add about 4 percentage points to MA benchmarks and 2  
8 to 3 percentage points in payments.

9           As Andy will discuss later, overall payments to  
10 MA plans will be about 2 percent higher than fee-for-  
11 service after accounting for our most recent estimate of  
12 coding practices by MA plans that result in higher risk  
13 scores. This is represented by the dotted line in light  
14 red.

15           When we look at overall bids relative to fee-for-  
16 service, represented by the green line, we see a slight  
17 decline from 89 percent in 2019 to 88 percent in 2020.

18           Next, we show how the level of fee-for-service  
19 spending in a plan's service area impacts its bid relative  
20 to fee-for-service.

21           As expected, plans bid high relative to fee-for-  
22 service in areas with low fee-for-service spending, and

1 plans bid low relative to fee-for-service where fee-for-  
2 service spending is high. However, even in the low  
3 spending areas, most plans bid below their local fee-for-  
4 service spending.

5           Let's look at the left-most column, circled in  
6 yellow, which shows the bids for plans concentrated in  
7 counties in the lowest spending quartile. We see that the  
8 median bid is 97 percent of fee-for-service. This means  
9 that for the second consecutive year, most plans in the  
10 highest benchmark counties are bidding below local fee-for-  
11 service spending.

12           However, the relative reduction of plan bids in  
13 these areas has not produced Medicare savings. For 2020,  
14 Medicare is still paying an average of 110 percent of fee-  
15 for-service spending in these areas. This is due to the  
16 benchmarks in those areas averaging 117 percent of fee-for-  
17 service spending with quality bonuses.

18           Now I turn it over to Andy.

19           DR. JOHNSON: We now turn to a discussion of risk  
20 adjustment and coding intensity in MA.

21           Medicare payments to MA plans are unique to each  
22 enrollee and are the product of two factors. The first is



1 a base rate that Luis described, and the second is a risk  
2 score, which is the ratio of a beneficiary's expected  
3 spending to average fee-for-service spending.

4 The risk model includes demographic information  
5 and certain medical conditions that are identified by  
6 diagnosis codes and grouped into hierarchical condition  
7 categories, or HCCs. The more HCCs indicated for a  
8 beneficiary, the larger the risk score and the larger the  
9 Medicare payment for that enrollee.

10 A risk score increases payment for beneficiaries  
11 who are more sick and are expected to have greater health  
12 care expenditures, and vice versa.

13 The risk model is estimated using fee-for-service  
14 data and therefore reflects the diagnostic coding practices  
15 in fee-for-service Medicare, where payments are more often  
16 based on procedure codes and there is little incentive to  
17 code all possible diagnoses.

18 In MA, there is a significant financial incentive  
19 to document all diagnoses, as more HCCs increase payments  
20 to the plan. The difference in fee-for-service and MA  
21 coding intensity causes beneficiaries of equivalent health  
22 status to have higher risk scores when enrolled in MA.

1           Our analysis of 2018 data found that MA risk  
2 scores were about 8 percent higher than fee-for-service  
3 beneficiaries with comparable health status. Each year,  
4 the Secretary reduces MA risk scores by a minimum amount  
5 mandated by law to account for the impact of coding  
6 differences. The adjustment was 5.91 percent in 2018.

7           The amount of coding intensity impact above the  
8 adjustment between 2 and 3 percent of MA risk scores  
9 generated about \$6 billion in payments to MA plans in  
10 excess of what fee-for-service Medicare would have spent  
11 for the same enrollees.

12           This bar chart shows the overall impact of coding  
13 intensity on MA risk scores, with the green portion of each  
14 bar representing the coding adjustment and the gray portion  
15 representing excess payment to MA plans. Our analysis of  
16 MA coding since 2007, has consistently found that greater  
17 coding intensity inflates MA risk scores by about one  
18 percentage point per year, relative to fee-for-service.  
19 This trend increases the overall divergence of fee-for-  
20 service and MA risk scores.

21           Two temporary factors have limited this  
22 divergence in certain years. The yellow arrows represent

1 the implementation of new risk score model versions that  
2 were less susceptible to coding differences. The red  
3 arrows represent two years of faster fee-for-service risk  
4 score growth following the implementation of ICD-10  
5 diagnosis codes. However, fee-for-service and MA growth  
6 rates have since returned to their prior norm, where MA and  
7 fee-for-service risk scores continue to diverge.

8 In the coming years, additional model changes are  
9 likely to exacerbate the difference in coding. The minimum  
10 coding adjustment, however, will remain a 5.9 percent.  
11 Therefore, we expect excess payments to MA plans to  
12 increase.

13 Apart from not adjusting for the full effect of  
14 coding intensity, the coding adjustment policy generates  
15 inequity across MA contracts. The coding adjustment is  
16 shown by the red line. Each gray column in this graph  
17 shows one MA contract's coding intensity relative to fee-  
18 for-service. As you can see, coding intensity varies  
19 significantly across MA contracts. Because the coding  
20 adjustment reduces all MA risk scores by the same amount,  
21 contracts on the left of the dashed line are penalized by  
22 the adjustment and contracts to the right are overpaid,

1 despite the adjustment.

2           In 2016, the Commission recommended a three-part  
3 approach that would make the coding adjustment more  
4 equitable across MA contracts and would account for the  
5 full effect of coding differences.

6           Now turning to a summary of quality. Through  
7 Carlos' work over several years, the Commission has  
8 concluded that MA quality cannot be meaningfully assessed  
9 through the current system and it should not be used as the  
10 basis for distributing bonus payments. Using the MA  
11 contract as the reporting unit is the source of many flaws  
12 in the current program. Quality assessment is masked  
13 across large and geographically dispersed contracts, and  
14 contract consolidation has exacerbated the issue, having  
15 moved nearly five million enrollees into bonus status over  
16 the past five years.

17           In addition, MA quality bonus program uses a  
18 large number of measures, including administrative  
19 measures, to judge quality. Some have sample sizes that  
20 are too small to provide a valid representation of quality  
21 in MA. Furthermore, the current system prevents  
22 beneficiaries from assessing quality in their local market

1 and comparing MA plan quality with the fee-for-service  
2 program.

3           Despite these issues, the MA quality bonus  
4 program provides highly-rated plans a bonus, in the form of  
5 a 5 percent increase in their benchmark, or in some  
6 geographic areas, a 10 percent increase. Eighty-two  
7 percent of MA enrollees are currently enrolled in contracts  
8 receiving a bonus, which would generate about \$6 billion in  
9 bonus payments.

10           We continue to address these issues through our  
11 work on the MA value incentive program.

12           To summarize, the MA program is extremely robust.  
13 Enrollment continues to grow, plan offerings continue to  
14 increase, and extra benefits are now valued at \$1,500  
15 annually per enrollee, a historical high for the fourth  
16 year.

17           Over the past decade, concerns about significant  
18 MA payment reductions, instituted through the Affordable  
19 Care Act, have not borne out. Instead, bids have come down  
20 in relation to fee-for-service, even in areas where  
21 sponsors might have found it challenging to operate  
22 successful plans, such as in low fee-for-service spending

1 areas where MA benchmarks are 115 percent of fee-for-  
2 service spending.

3           Despite the health of the program, we have  
4 identified some policy areas of concern in recent years.  
5 We will continue to track issues stemming from MA coding  
6 intensity and incompleteness in the encounter data. Staff  
7 will present an update on our work to improve the MA  
8 quality bonus program in future meetings this cycle.

9           DR. CROSSON: Okay. Thank you, Andy and Luis.  
10 And we are now open for clarifying questions. Let's see,  
11 Brian, Jonathan, Bruce, Pat.

12           DR. DeBUSK: Thank you. Great report. It was a  
13 really good read. I had a couple of questions. Let's go  
14 to Chart 10 where you talk about the coding difference.  
15 You know, if I remember correctly we have historically said  
16 that the coding differential is about 3 to 5 percent was  
17 sort of the working number when I first joined the  
18 Commission. I was a little surprised. Can you speak to,  
19 since 2016, it doesn't look like it's even cleared 2.5  
20 percent. Is that correct?

21           DR. JOHNSON: These are -- we're talking about  
22 the gray --

1 DR. DeBUSK: The net. The net coding  
2 differential.

3 DR. JOHNSON: Yes. Yes. And so it did decrease  
4 between 2015 and 2017, and in both of those years there was  
5 two things going on. One was the introduction of a risk  
6 model that tended to reduce the differences in coding  
7 between MA and fee-for-service. There was some attempt to  
8 identify diagnoses where the MA and fee-for-service coding  
9 differential was greatest and exclude those from the model,  
10 was part of CMS' reforms. And then the second effect was  
11 the fee-for-service coding rate increased for two years,  
12 but that has since subsided.

13 DR. DeBUSK: Can you speak to what's driving the  
14 fee-for-service coding increases?

15 DR. JOHNSON: It's hard to say for sure. I tend  
16 to think it is mostly due to the ICD-10 diagnosis code  
17 implementation, because the trend in fee-for-service  
18 relative to MA coding rates has been the same for many  
19 years, but it dramatically changed in 2015, when ICD-10  
20 codes were introduced. It slightly changed again in 2016,  
21 almost starting to return to the normal pattern of MA rates  
22 increasing faster than fee-for-service rates. And then in

1 2017 to 2018, we are now back to what we saw prior to that  
2 period, in terms of relative growth rates.

3 DR. DeBUSK: So it's sort of mixed results on  
4 whether or not they're going to continue to diverge or  
5 converge. Do we have to wait and see or could you speak to  
6 -- where do you think it's going?

7 DR. JOHNSON: It seems likely that they will  
8 continue to diverge, that the relative rates are back on  
9 track, and in the next couple of years a few risk model  
10 changes we think are likely to exacerbate the difference in  
11 MA and fee-for-service rates.

12 DR. DeBUSK: Okay. And then I also had a --  
13 thank you -- I also had a question on Chart 7. You talk  
14 about, you know, the bid, or the benchmark at 107 percent,  
15 the bid is at 88 percent, and the payments at 100 percent,  
16 you know, net of the coding adjustment. How do we account  
17 for -- and this is a genuine question; this is not a Round  
18 2 -- how do you account for the fact that sort of the first  
19 thing the MA plans have to do is buy a Medigap light plan.  
20 I think on the reading material, on page 16, you talk about  
21 that.

22 It looks like about, what, 80 percent of their



1 rebate, of their \$122, goes into cost-sharing reductions.  
2 How do we account for that, because in one world the  
3 beneficiary pays for a Medigap plan and in the other world  
4 it's the private insurer that pays for essentially a  
5 Medigap light plan. Actuarially, can you help me there? I  
6 mean, what does an MA-equivalent Medigap plan, what would a  
7 beneficiary pay for something like that?

8 DR. JOHNSON: I'm not sure that we can compare  
9 the relative cost-sharing that's offered through the extra  
10 benefit in MA plans to what Medigap would be. Is that what  
11 you would say?

12 MR. SERNA: Right. So given current data sources  
13 we're not able to do that. So we estimate these  
14 prospectively, using CMS' projected fee-for-service  
15 spending in each county, standardized by risk. So it  
16 doesn't take into account any comparisons or any  
17 comparability with Medigap plans.

18 DR. DeBUSK: Okay. Is the nominal Medigap plan,  
19 though, a little more generous than, say, the nominal MA  
20 cost-sharing reductions?

21 MR. SERNA: I don't think we're able to say that.

22 DR. CROSSON: Bruce, do you want to --

1 DR. DeBUSK: Bruce, please.

2 MR. PYENSON: So the MA, the bid is based on the  
3 actuarial equivalent of the fee-for-service benefits.  
4 Medigap fills in, essentially, all of the cost-sharing.  
5 And, you know, you could argue that it's not 100 percent  
6 but it's fairly substantial. The MA has an out-of-pocket  
7 limit set at the ACA limit, so there is substantial cost-  
8 sharing, almost always, in Medicare Advantage plans. It  
9 gets filled in but that's -- you know, you could look at  
10 some of the surveys of what's out there to create actuarial  
11 values for that.

12 But a fee-for-service plus a Medigap is more  
13 complete coverage than you're going to get from MA, even  
14 with the fill-in of use of rebate for extra benefits.

15 DR. DeBUSK: So if we were sitting at \$900, and  
16 one beneficiary in fee-for-service, say, spends \$150 a  
17 month to buy a good Medigap plan, that same \$900, we're  
18 using some of that \$122 rebate to cushion cost-sharing, but  
19 then the beneficiary may have to throw in, is it \$60? Is  
20 it \$90? Is it \$30?

21 MR. PYENSON: Something like that. Of course, it  
22 varies a lot because MA plans vary a lot and have different

1 strategies for attracting members.

2 DR. DeBUSK: Okay. I'll save everything else for  
3 Round 2. I'm just trying to get to the bottom of apples to  
4 apples.

5 MR. PYENSON: One way of looking at it, and Pat  
6 has another answer, if you look at how MA plans, where the  
7 cost-sharing is filled in by Medicaid for the dual  
8 eligibles, that gives you the feel for how important cost-  
9 sharing is.

10 DR. CROSSON: Pat, on this point.

11 MS. WANG: I was just -- I don't know the precise  
12 answer to your question. I just wanted to note that the  
13 apples-to-apples, the majority of MA plans today still are  
14 HMOs, and that is not an apple-to-apple with Medigap, which  
15 is open access. So, you know, your question would be more  
16 relevant for folks who are buying PPO products. Maybe you  
17 could kind of look at that and I think there's been some  
18 growth in that, because some of the Medigap, you know,  
19 letters or plan options are phasing out.

20 But it's not an apples-to-apples when you're  
21 looking at HMO versus Medigap, because they're two  
22 completely different benefit designs.

1 DR. CROSSON: Pat, let me just be clear I  
2 understand. So are you talking just then about the out-of-  
3 pocket burden or are you talking about something larger, in  
4 terms of --

5 MS. WANG: No. It's product design. It's  
6 network PPO, dissimilar to Medigap because it's open access  
7 to any provider. There's no network.

8 DR. CROSSON: That's what I thought you meant.

9 MS. WANG: Yeah. So I'm just saying it's hard to  
10 kind of -- I don't think that there's a precise answer.  
11 There's not one answer to it.

12 DR. DeBUSK: Well, I'm oversimplifying, but what  
13 I was trying to get to is, oh, what MA is. You made a  
14 great point, by the way. All MA is, is you enter into  
15 enrollment, you give up the any willing provider aspect.  
16 They essentially buy you a Medigap policy plus you throw in  
17 an extra, you know, 40 or whatever Bruce tells me, dollars  
18 per month.

19 I'm just trying to figure out, sort of  
20 conceptually, what --

21 MS. WANG: Yeah.

22 DR. DeBUSK: Okay.

1 DR. CROSSON: Okay. Marge on this as well?

2 MS. MARJORIE GINSBURG: Yes. And you know I'm a  
3 Medicare counselor in California so I can only speak to  
4 California. But the main difference is, if you're on  
5 original Medicare you can buy a supplemental plan, which  
6 right now coverage virtually all the cost-sharing a patient  
7 is going to have. That changes a little bit next month.  
8 If you get a Medicare Advantage plan, you cannot buy a  
9 supplemental plan. You are not allowed to buy. But in  
10 exchange they do have lower cost-sharing than if you were  
11 in original Medicare only, which is 80 percent A, 80  
12 percent B. But the cost-sharing is there, but it's not as  
13 big as 20 percent.

14 So that's clearly the tradeoff. Original  
15 Medicare, you pay a lot more up front, because you're  
16 buying the Part D plan premium, and you're paying for  
17 supplemental. In Medicare Advantage, much lower up-front  
18 costs but you're seeing it as a patient. You're seeing  
19 higher costs than you would otherwise. Is that clear?

20 DR. DeBUSK: That's great. Thank you. And the  
21 rest is Round 2, so thanks.

22 MS. MARJORIE GINSBURG: Now that may be different

1 in other states. That's California.

2 DR. CROSSON: Okay. Jonathan.

3 DR. JAFFERY: Thanks. I want to go back to some  
4 of the coding intensity stuff and actually just start with,  
5 Brian had brought up the question about why we were maybe  
6 seeing more fee-for-service. And so one thing is I wonder  
7 if -- the thing that came to my mind had to do with ACOs  
8 and people starting to get into risk adjustment on the fee-  
9 for-service side, so I wondered if you thought about that  
10 and if you're seen an impact on that.

11 And then the other thing is just this, thinking  
12 about this in reading the chapter, which was excellent, by  
13 the way, it's hard not to just see this as sort of an  
14 accelerating game. And now we've got some differences in  
15 how the risk adjustment works in MA versus ACOs. In some  
16 of these things we've seen really a cottage industry. It's  
17 a lot of time and work for physicians and other providers.

18 And so I wonder if you are aware of anyone  
19 working on trying to come up with completely different  
20 methodologies away from just patient-by-patient coding and  
21 documentation to get at a better risk adjustment  
22 methodology, whether it's CMS or anyone else. I'm looking

1 at you, Karen. Not really, Karen.

2 DR. JOHNSON: Not that I'm aware of for purposes  
3 of use in the Medicare Advantage program. I think there  
4 are ideas about them in academic literature, but to  
5 implement, you know, would require a different basis of  
6 data, likelier than claims, and there are a lot of  
7 complexities and concerns about whether or not utilization  
8 information is included or not, and if you're paying more  
9 for more utilization. So not that I'm aware of.

10 And on your first point about the ACO coding, I  
11 think that is certainly something I will continue to track  
12 over the years, or in the coming years. From my  
13 understanding, the ACOs that have the most incentive to put  
14 effort into coding, the next-gen ACOs, and the share of  
15 fee-for-service in those has been very slow. It doesn't  
16 necessary explain the shift in fee-for-service coding rates  
17 over the last couple of years, but I think you're right  
18 that in the coming years it's going to be something to  
19 watch.

20 DR. CROSSON: Jaewon, are you on this point?

21 DR. RYU: Sort of, yeah.

22 DR. CROSSON: Sort of? Go ahead.

1 DR. RYU: On page 42 of the readings it gets to  
2 this. You mentioned some of the things that plans use in  
3 order to capture the diagnoses, but how much visibility --  
4 it's your data comment -- how much visibility do we have  
5 into, you know, health risk assessments? Obviously that's  
6 been the focus of a lot of discussion in recent years, but  
7 around how much of the coding intensity comes from  
8 something like that versus some of the other levers there?

9 DR. JOHNSON: As part of our work leading to the  
10 2016 recommendation, I think we estimated that health risk  
11 assessments accounted for about 1 to 2 percent of the  
12 overall difference, of the 8 percent. That would be  
13 between 6 and 7 percent if you got rid of health risk  
14 assessment diagnoses.

15 As far as what the rest is made up of, and tying  
16 it to the strategies described in the chapter, I'm not sure  
17 that we're able to disentangle what strategies account for  
18 what share. One thing we could look into, now that we are  
19 having more years of the encounter data, is the share of  
20 diagnoses that come from chart review, which are commonly  
21 not done in the fee-for-service world but are often done in  
22 MA.



1 DR. CROSSON: Bruce.

2 MR. PYENSON: Thank you for a terrific chapter.  
3 There's a couple of questions I have, more along the lines  
4 of puzzles. You've outlined very well here the issues with  
5 Medicare Advantage encounter data, but for five years many  
6 of the same organizations have been submitting data for  
7 risk adjustment and other purposes for their marketplace  
8 ACA blocks of business, some organizations, to CMS, through  
9 what they call an EDGE server process. And that seems to  
10 work okay, well enough for tens of millions of lives and  
11 risk adjustment and other purposes.

12 And I'm not sure sort of who to point the finger  
13 at, you know, or what's going on with why that system that  
14 seems very functional for concurrent data is -- somehow we  
15 can't seem to even get retrospective data on very good  
16 measures. And this affects, you know, of course the risk  
17 adjustment but also many of the quality metrics, which  
18 could be generated likewise. So that's one question I  
19 have. I have another one.

20 DR. JOHNSON: I'll answer that one first, so I  
21 remember. So I think through discussions with many of the  
22 plans there's been reports that submitting the encounter

1 records was a big issue early on, and there were a lot of  
2 changes to the algorithms that CMS uses to review  
3 encounters, and there's a lot of effort done and a lot of  
4 back-and-forth that plans had to work with CMS on in order  
5 to submit their encounter data.

6           Based on our conversations, it seems like many of  
7 the transmission issues have mostly subsided, and, you  
8 know, through our encounter data work in the June chapter  
9 of last year we did compare the encounter data to several  
10 sources of other MA utilization information. And to my  
11 knowledge I don't think the EDGE server would necessarily  
12 solve the issues that remain, because I think that speaks  
13 more to the method of transmission of encounter data, which  
14 seems to be more smooth now than it was in the beginning.

15           MR. PYENSON: So this time next year, we'll have  
16 a different story?

17           DR. JOHNSON: I wouldn't say that.

18           MR. PYENSON: My second question is on the  
19 construction of the benchmark, and this gets, I think, to  
20 some of Brian's question. There's been some publication  
21 recently that looked at the induced utilization of Medigap,  
22 and I think the vast majority of Medicare beneficiaries

1 have some form of supplemental insurance, either through  
2 Medicaid or through employer, retiree, or Medigap. And  
3 some of the estimates -- one of the published estimates was  
4 close to 20 percent of additional Medicare cost.

5 I'm not saying that's right or wrong, but there's  
6 certainly something. And my understanding is that gets  
7 built into the benchmark, provided to MA plans. So the  
8 extra cost to Medicare from beneficiaries who have bought  
9 Medigap is already part of the benchmark for MA.

10 If that's the case, what does that mean about the  
11 ability of MA plans to generate a rebate, to provide extra  
12 benefits?

13 DR. JOHNSON: I think any inducement from Medigap  
14 policies is included in the fee-for-service benchmarks.  
15 I'm not sure we can say specifically about what it provides  
16 to plans about their ability to generate rebates, except  
17 that higher benchmarks would give greater leeway for a plan  
18 to have a larger spread between their bid and benchmark.

19 MR. SERNA: And just to be clear, the  
20 supplemental coverage isn't directly in the benchmark. The  
21 inducement of utilization would be but not the supplemental  
22 coverage.

1 DR. CROSSON: Nicely made point, couched as a  
2 question. Very skillful.

3 [Laughter.]

4 DR. CROSSON: Okay. Pat?

5 MS. WANG: I just to make sure that I understand  
6 table, chart 7 and how to make sure to read it.

7 So what this is saying is that in 2020, the  
8 average benchmark was 107 percent. The plans bid 88  
9 percent, and they got paid 100 percent, right? So the 100  
10 percent represents the amount after CMS, whatever the  
11 rebate was? CMS took its share, so they got paid.

12 As between the 88 percent of the A/B bid and the  
13 100 percent payment, is it possible to translate into what  
14 percentage of that went into beneficiary supplemental  
15 benefits or cost sharing or all the rest? Because, Luis,  
16 as you said, you know, it can be used for a lot of  
17 different purposes. Do you know how much were sort of  
18 beneficiary-specific? And I would include in that  
19 reduction in cost sharing as well as true supplemental.

20 MR. SERNA: So for the rebate amount for non-  
21 SNPs, about 49 percent of the rebate is cost sharing.  
22 About 18 percent is for supplemental benefits, and the rest

1 is a split, as Part D benefits, and a small sliver for  
2 reduced Part B premium.

3 MS. WANG: Oh, interesting. Thank you.

4 Going back to Slide 11, which a lot of people had  
5 great questions about -- I also had a similar question to  
6 Jonathan about possible impacts or changes within fee-for-  
7 service coding behavior, but would you just confirm for me?  
8 Because I just don't know. Do ACOs use the HCC risk  
9 adjustment model? Is it the same, same exact thing?

10 MR. SERNA: Yeah.

11 MS. WANG: Interesting.

12 MR. SERNA: It's the same exact thing, but there  
13 are limits to coding increases in both MSSP and next-gen  
14 that don't apply to MA plans.

15 MS. WANG: Okay. But the underlying coding  
16 happens, and then there's some sort of limitation placed on  
17 top of it?

18 MR. SERNA: For ACOs, yes.

19 MS. WANG: Yeah, okay. But to the extent that  
20 ACOs are improving documentation and coding and fee-for-  
21 service because now they are paying attention, that would  
22 affect the MA risk scores, right, or the comparison of fee-

1 for-service --

2 MR. SERNA: Yeah, correct.

3 MS. WANG: Okay. Can you go through a little bit  
4 more what -- and somebody asked the question. Jonathan.  
5 Is there a better way to do risk adjustment if there were  
6 100 percent encounter submission? Would that enable a  
7 different, better process?

8 DR. JOHNSON: It would remove the issue of using  
9 fee-for-service data as the basis, and so it would  
10 essentially take the Medicare payment to the MA plan out of  
11 the issue, and that it's not going to be based on a fee-  
12 for-service basis. So we wouldn't have to track that set  
13 of gray bars.

14 However, if you turn to the next slide, Luis,  
15 there would still be differences across plans, but that  
16 competition for coding -- so competition for coding at the  
17 MA contract level would still be there, but it would just  
18 be among the plans instead of having an effect on the total  
19 payments that Medicare makes to MA plans.

20 MS. WANG: Interesting. So if it was 100 percent  
21 based on encounter submission, would there be a need for a  
22 coding intensity adjustment, or would you still need to --

1 DR. JOHNSON: Not for a separate adjustment like  
2 the Secretary makes now. So the 5.9 percent adjustment  
3 could go away.

4 MS. WANG: I see. Okay, okay.

5 The only other thing that I would say in terms of  
6 the EDGE server, what you said is what I understand also to  
7 be differences between the MA and the encounter data and  
8 the EDGE server process. It's just always been described  
9 to me, EDGE server as a lot simpler. The benefit package  
10 is a lot smaller. Their work has shown that the match  
11 between like sort of the acute care stuff is -- that's the  
12 other thing. In the ACA world, there is no fee-for-service  
13 comparator. So you don't actually know how accurate the  
14 information is that's being submitted through the EDGE  
15 server, which is sort of interesting, but the complexity of  
16 some of the like post-acute and other sectors seems to  
17 still be really a problem with encounter data submission  
18 and accuracy, so just that point.

19 DR. CROSSON: Great. Thank you, Pat.

20 So David and Amol?

21 DR. GRABOWSKI: Yeah. Pat twice said if we had  
22 complete encounter data, and I think that's a big if. I

1 think your report does a great job of tracking sort of the  
2 validation, you know, just what's happening over time with  
3 your validation efforts with the different datasets. It  
4 looks really flat right now. It's not improving.

5 I know we made a recommendation around encounter  
6 data. What's the status of that? Is CMS actually  
7 implementing some of this, such that we can achieve that  
8 complete encounter data? This would be so beneficial on so  
9 many different fronts.

10 DR. JOHNSON: I'm not aware of any changes that  
11 CMS has made to either track or report back to plans on  
12 additional completeness metrics.

13 I think your assessment that it seems like the  
14 completeness had a period of improving and is not roughly  
15 flat is correct. I think I would just caution again that  
16 there is a significant portion of services that we don't  
17 have a comparator for.

18 DR. JOHNSON: Just as a follow-up, I can't  
19 remember, Jim, when we made that recommendation about  
20 encounter data, but is there any way to kind of go back to  
21 that? We had a year in there where we wanted to see  
22 complete data. I can't remember if it was 2023. Is there



1 any way to get them on a faster pace here?

2 DR. MATHEWS: We can check in with the agency and  
3 get a little more detail if they are increasing their  
4 efforts and report back out.

5 DR. CROSSON: Amol?

6 DR. NAVATHE: So thank you for a lot of  
7 explanation of the coding differences, and the work is, I  
8 think, really very helpful and quite revealing.

9 A couple of questions. One thing, on this chart  
10 itself, I am wondering if you could just clarify exactly  
11 the methodology of what we're looking at. I'm not sure I  
12 totally understood it. It seemed like perhaps to some  
13 extent, we're normalizing by looking at people who enroll  
14 in a certain year and then looking at growth based on that  
15 timing of enrollment and using their historic kind of pre-  
16 enrollment factors as the way to sort of compare like to  
17 like. Is that what we're doing here, or is there something  
18 different that we're doing here? I'm not sure I totally  
19 understood.

20 DR. JOHNSON: So, in this chart, we assign each  
21 enrollee to either fee-for-service or a specific MA  
22 contract based on their enrollment in 2018, so the most

1 recent year of risk scores we have. We follow all of the  
2 enrollees back as far as they were continuously enrolled in  
3 A and B Medicare. So it includes if an enrollee is in an  
4 MA plan in 2018 but maybe switched back and forth a couple  
5 times. It would capture those differences. And if we go  
6 back as far as 2007, if people were enrolled continuously  
7 for that long.

8           The other comparison, I think, is we exclude PACE  
9 contracts and special needs plans, just because the  
10 comparison to a general fee-for-service population wouldn't  
11 be fair for those specific populations of enrollee.

12           And I believe in this analysis, we compared  
13 contracts with their local fee-for-service market area, not  
14 the fee-for-service national average.

15           DR. NAVATHE: So, to some extent, if I'm  
16 understanding correctly, there's two pieces of information  
17 that are commingled in this, which is to the extent that  
18 there were plans who truly had bigger changes or smaller  
19 changes, that variation would also be reflected in here.  
20 It's not exclusively, quote/unquote, "differences" in  
21 coding practices?

22           DR. JOHNSON: The part I didn't mention is we

1 also control for differences in the age and gender  
2 distribution between the fee-for-service and Medicare  
3 Advantage. So, to the extent that there are differences  
4 outside of those controls, that would be included in there.

5 DR. NAVATHE: Okay. Thank you for explaining  
6 that.

7 The second question is a clarifying question or  
8 kind of related to this ACO piece, because I think a number  
9 of Commissioners have brought it up.

10 My understanding is that yes, to some extent, at  
11 a very aggregate level, coding under ACOs is beneficial for  
12 ACOs, but if you actually look at a contract-by-contract  
13 basis, the risk adjustment is essentially frozen at the  
14 time from the benchmark basically from performance. So  
15 once you have a member who is going to be attributed to you  
16 coding more actively in performance year one or performance  
17 year two doesn't create a benefit, and so I was wondering  
18 if that is accurate and if that might influence our  
19 interpretation of what's happening in the kind of fee-for-  
20 service baseline increase in coding.

21 MR. SERNA: So for ACOs, coding more actively or  
22 more completely would benefit them when they rebase. So

1 that's one thing. There is always an incentive to code  
2 more completely.

3           Secondly, the new MSSP rules, you can increase  
4 your coding 3 percent for each performance year. So that  
5 is somewhat flat the more you code, but again, when you  
6 rebase --

7           DR. NAVATHE: I see. So you can't get some  
8 incremental benefit. It's capped, but the real true  
9 benefit or largest benefit would come at rebase time frame.  
10 But there is some marginal incentive in the performance  
11 year.

12           MR. SERNA: Right.

13           DR. DeBUSK: And on that, I think, even with the  
14 older ACO design, you can go down. So, for example, if you  
15 brought in a bunch of new healthier beneficiaries and your  
16 score went down, they did take your benchmark down  
17 accordingly. So you would have to code a little bit up  
18 just to hedge, just in case you got some healthy people  
19 attributed to you.

20           DR. NAVATHE: Okay. Thank you.

21           My last question --

22           MR. SERNA: I'll also add one more thing.

1 There's also regional adjustment. So to the extent if  
2 you're an ACO, if your coding is relatively more complete  
3 than your region, that also benefits to you there.

4 DR. NAVATHE: Thank you. That's super helpful.

5 I have one last question. I commend you on your  
6 sort of articulation of the details of the HCO program. I  
7 think that's really helpful.

8 The last question is I totally agree with the  
9 comments that getting to full encounter data would be a  
10 major boon. I think my question is sort of the thoughts of  
11 how we use that. Is the idea then that we would be able to  
12 risk-adjust within the MA program very effectively, or is  
13 the thought also -- and this is the place where my question  
14 is. Would it really help in the fee-for-service to MA  
15 translation to some extent? If we know that there is some  
16 selection that happens in people who join MA relative to  
17 fee-for-service, if there's any difference in the likeness  
18 of those populations, then that won't help us do that  
19 crossover as accurately. It certainly will help within the  
20 MA adjustment.

21 So can you clarify? When we've made  
22 recommendations in the past and how we're thinking about

1 using that, what is the thought process there?

2 DR. JOHNSON: One aspect of our recommendation  
3 and the related work was to continue to use the encounter  
4 data for the basis of HCCs to try and boost the incentive  
5 to submit more encounter data.

6 I think the coding adjustment law says that the  
7 adjustment will be in effect until the Secretary uses  
8 Medicare Advantage diagnostic cost and use data in order to  
9 calibrate the risk adjustment model, and it does seem like  
10 there is some contemplation of going to an encounter data-  
11 based risk adjustment model for MA.

12 I think whether or not the improvements in the  
13 accuracy of being able to predict MA costs because the  
14 basis of the risk adjustment is MA data, I think there are  
15 some pros and cons. There was a discussion in April about  
16 the relative benefits, but the Commission has not come down  
17 on either side of whether or not that is a good thing or a  
18 bad thing.

19 DR. NAVATHE: Thank you.

20 DR. GRABOWSKI: I thought we wanted to make --  
21 maybe you said this and I missed it, but utilization-based  
22 comparisons of readmissions, hospitalizations across fee-

1 for-service and MA with the encounter data. I think that  
2 would be a huge --

3 DR. JOHNSON: Yes, absolutely. I only meant to  
4 speak to incentive for greater encounter data for risk  
5 adjustment purposes, but that would be one of the biggest.

6 DR. CROSSON: Okay. We will now move on to the  
7 discussion period, having used up all the time for the  
8 morning. But I do think it's important to make sure that  
9 we have provided Andy and Luis with thoughts for  
10 improvements what is already a very well-constructed report  
11 and update on Medicare Advantage.

12 So if there are any issues of that sort, like we  
13 would like to see this added to the report, let's do that.

14 I saw Brian and then Karen.

15 DR. DeBUSK: As you can tell from my Round 1  
16 question, I would urge you, as we're looking at benchmarks,  
17 bids, rebates, all that, to incorporate some of the  
18 Medigap. I mean, I hate to see when they say, "Well,  
19 program spending is at 100 percent of fee-for-service  
20 spending," knowing of that \$122, a certain portion -- and I  
21 don't know exactly how much of that it should be -- has to  
22 be spent on some cost-sharing reductions, or basically, you

1 have a non-viable MA plan. I mean, you'd have to spend  
2 something there.

3 I hate to walk into this thinking, "Oh, it's  
4 program spending-neutral, and shouldn't the program be  
5 generating some cost savings?" I mean, it is generating  
6 beneficiary savings right now, probably to the tune of 10  
7 to 12 percent of the benchmark, because again, I think page  
8 16, you talked about 49 percent of the entire benchmark  
9 goes just to the A and B cost sharing.

10 So, again, when we look at the program and  
11 overall, is it saving Medicare money, there's a beneficiary  
12 aspect to this that I hope we keep in mind.

13 DR. PAUL GINSBURG: Yeah, actually, Brian, I  
14 thought it was all there, in a sense, where the rebates is  
15 what the beneficiary is coming out with and the payments,  
16 you know, in relation to 100, is the degree of  
17 overpayments, when you put in the quality bonuses and risk  
18 adjustment. So, in a sense, I think it's all there, other  
19 than saying, maybe going into it a little bit more, what  
20 the rebate is going for, which we've heard that there is  
21 data on that.

22 DR. DeBUSK: Well, I'm just thinking in the OM



1 side you've got \$900 you're going to spend. On the MA side  
2 you've got \$900 you're going to spend. It's just that in  
3 the OM side the first thing we do is go to --

4 DR. PAUL GINSBURG: What's the OM side?

5 DR. DeBUSK: -- original Medicare. In OM, you  
6 take that \$900 and then go to the beneficiary and say, "I  
7 need another \$150, \$160 a month" for you to buy your  
8 Medigap plan, whereas in the MA side, we go to the MA plan  
9 and say, "Hey, here's your \$122 rebate. Now go buy a  
10 Medigap light plan with the first tranche of your savings."  
11 And I think those are just fundamentally different when we  
12 try to compare the two programs, in terms of taxpayers and  
13 in terms of beneficiaries. I think it's just slight --  
14 it's apples and oranges.

15 DR. PAUL GINSBURG: I just thought the 34 percent  
16 of beneficiaries enrolling in MA, many of them have figured  
17 out that they're getting a free Medigap plan in the  
18 process.

19 DR. CROSSON: Okay. I've got Karen and then Dana  
20 and Amol and Bruce.

21 DR. DeSALVO: Oh boy. Thank you, guys. I wanted  
22 to ask for you to consider putting a nod to the social

1 determinants of health work in the chapter, given how the  
2 MA plans have been pioneers in this space. They were given  
3 latitude by Congress a couple of years ago and there's been  
4 ongoing guidance from the Administration. There seems to  
5 be a lot of interesting benefits, supplemental benefits  
6 being provide in a broad array of areas, and it's yet to be  
7 seen if those are of interest to the beneficiaries.

8           But given the significant change to addressing  
9 whole health, it would be important for us, I think, to at  
10 least acknowledge that and watch it to see if that's  
11 something that seems of interest and benefit to the  
12 beneficiaries.

13           DR. CROSSON: Thank you. Paul.

14           DR. PAUL GINSBURG: Yeah, I was just going to  
15 say, actually, two things. One is, as far as give  
16 consideration to whether there is a recommendation about  
17 encounter data that would be useful to put in the March  
18 reports. And the other point I wanted to make is that I  
19 wasn't sure that if there are any places, when you're  
20 comparing, you adjusted for both quality bonuses and risk  
21 adjustment at the same time. It always seemed to be one or  
22 the other. So I found myself being a little bit confused.

1 DR. CROSSON: Dana.

2 DR. SAFRAN: Just two quick, small comments about  
3 the risk adjustment divergence issue. One is, I shared  
4 Jonathan's hypothesis that it could have something to do  
5 with ACOs, and I take your point that, you know, a small  
6 number of ACOs, but I would suspect that those  
7 organizations are changing coding -- once they change  
8 coding they're changing coding. So I just think it's worth  
9 a look there to see what role that could play and what the  
10 implications are going forward, given the direction CMS is  
11 taking around the ACO program.

12 And the other comment is, you know, it's long  
13 struck me that the changes we see at the population level  
14 in risk scores tell a totally different story from the  
15 story we see when we look at changes in patients'  
16 functional health status scores over time. And the  
17 Medicare program does have that latter information from the  
18 HOS survey.

19 And so I think it could be worth just something  
20 in the chapter about that and about the importance --  
21 somebody brought up and I forget who; apologies -- of  
22 considering whether there is just a whole new approach we

1 could be taking to risk adjustment. Thanks.

2 MR. PYENSON: Dana, could you clarify which way  
3 do those go?

4 DR. SAFRAN: So in functional status, self-  
5 reported functional status, you know, changes like watching  
6 the grass grow or paint dry, like it's very, very slow,  
7 even in the Medicare population, a year, I think if I  
8 remember the numbers right. So it suggests much slower,  
9 less dramatic changes in how people are feeling and  
10 functioning than what we see with changes in risk scores,  
11 which suggests every year our populations getting 3, 4  
12 percent sicker.

13 DR. CROSSON: Okay. So I've got Bruce and then  
14 Pat.

15 MR. PYENSON: Thank you very much for the  
16 chapter. I know, in past years before my term as a  
17 Commissioner, the Commission did address the role of  
18 Medigap and induced utilization. And I agree with Brian  
19 that it would be helpful to have that, perhaps that work  
20 looked at again in the context of Medicare Advantage and  
21 the creation of the benchmarks. I don't know if that  
22 belongs in this chapter, or perhaps this chapter next year,

1 but to at least recognize the importance of that issue,  
2 because we have choices for beneficiaries and two  
3 substantial and different programs going on. So  
4 understanding the interplay there I think would be really  
5 helpful for our understanding.

6 DR. CROSSON: Thank you, Bruce. Amol.

7 DR. NAVATHE: So one very discrete suggestion and  
8 one very general suggestion. So the discrete suggestion --  
9 well, let me start with the general suggestion, actually,  
10 because the discrete fits under it.

11 So the general suggestion is, when I read the  
12 mailing materials, I think there is a lot of, obviously,  
13 clear focus on the coding piece. I think one part that --  
14 I guess this may be as an economist and I'm sort of  
15 obsessed with, is this idea that there's still a selection  
16 effect here, in terms of who gets into MA. This relates to  
17 Karen's point, which is that there are other factors that  
18 are also at play here that may be very important.

19 So I think it would be helpful to see a little  
20 bit of discussion of that, which I think is related to the  
21 coding piece as well, to provide context for what might be  
22 happening. And, over time, I think this is not necessarily

1 for the next version of this, but over time it might be  
2 nice to see more work trying to understand exactly what's  
3 happening with the selection and how the populations  
4 outside of the specific coding pieces here may actually be  
5 different or similar, and how that may be changing over  
6 time.

7           So I think we talked a little bit about using  
8 something the health and retirement study or something like  
9 that as a way to get at that, and so I just wanted to put a  
10 plug in for that for the future.

11           The subpoint that I think is more of a discrete  
12 suggestion is, when we do analysis like this I think an  
13 alternative way to view it is instead of looking at  
14 enrollment into 2018 and then going backwards and looking  
15 at changes in risk scores, maybe to actually look at  
16 individuals who were enrolled in fee-for-service and then  
17 switch in a given enrollment year, say 2012, 2013, whatever  
18 it is, and then follow those populations prospectively from  
19 there, using the common fee-for-service time, 2012 or 2011,  
20 whatever it is, as a way to say, okay, we knew these  
21 patients looked quite similar up to this point, and as a  
22 cohort then follow them forward.

1           That would, I think, give us, at least me,  
2 greater confidence that what we're seeing is perhaps  
3 netting out more of some of the other endogenous  
4 differences and could be much more related to the coding  
5 intensity piece. And especially when you're comparing  
6 across MA plans but probably controlling for some of those  
7 selection effects as well. And I think it would give me a  
8 little bit more confidence when we look at the variation  
9 here.

10           DR. JOHNSON: I should say we did do some of that  
11 analysis in the past, that has since fallen out of the  
12 chapter, but we can bring it back. And I think the main  
13 finding was over several different cohorts the first year  
14 of switching from fee-for-service to MA was about a 6  
15 percent increase in risk scores relative to the change in  
16 the otherwise fee-for-service group, and then it leveled  
17 off to 1 or 1.5 percent over time. But we can bring that  
18 discussion back.

19           DR. NAVATHE: Great. Thank you.

20           DR. CASALINO: On this point, I think, I'm not  
21 sure, but it could be that people switched from Medicare  
22 Advantage to fee-for-service when they get sicker. And so

1 if we were to look at what happened to the risk score and  
2 actual cost of care for people in the year or two after  
3 they switch from Medicare Advantage to fee-for-service, and  
4 try to get a group that looks matched on risk score, or  
5 even on diagnosis, that stays in Medicare Advantage, and  
6 looks at what happens with their risk scores and looks at  
7 what happens with their costs, I bet you we find that the  
8 people who switched to Medicare Advantage, although they  
9 look the same in risk score, wind up having a higher cost  
10 because they're sicker in ways that the diagnoses are not  
11 necessarily going to get it.

12 DR. CROSSON: Okay. Pat, I think you have the  
13 last word.

14 MS. WANG: Okay. This is quick. I just was  
15 curious whether, in the discussion of sort of the  
16 percentage of the rebate dollars that are going to sort of  
17 alleviate cost-sharing or what have you, Part B premiums,  
18 in the bids, whether you have ever looked at not just the  
19 dollars that are spent but changes in the way that plans  
20 design cost-sharing. Because you know, the point is they  
21 have total flexibility on where they're going to apply  
22 cost-sharing as long as it meets the bid submission rules,



1 so eliminating copays for primary care, for example, you  
2 know, using copays for certain things, cost-sharing for  
3 others, redoing the inpatient deductible.

4           And the only reason I mention it is that it might  
5 be interesting information to the extent that there is a  
6 point that, you know, we've talked about supplemental  
7 benefits and buying down cost-sharing, but that plans  
8 actually change the benefit structure from traditional  
9 Medicare in ways that might be interesting for traditional  
10 Medicare to know about.

11           DR. JOHNSON: I like that idea a lot. I think we  
12 might be limited by what's available in the bid data and  
13 that we can parse out the rebates into five categories.  
14 But what's within the cost-sharing might not be difficult,  
15 but we'll see if we can --

16           DR. DeSALVO: Just to add onto that, that's one  
17 of the areas where understanding the social determinants of  
18 health benefits will be very helpful, because the fee  
19 schedule may want to begin covering the delivery service or  
20 transportation.

21           DR. CROSSON: Okay. Very good discussion. Good  
22 presentation. And you've got some richness here to add to

1 your report. We look forward to reading it. Thank you,  
2 Andy and Luis.

3 DR. CROSSON: We now have time for a public  
4 comment period. If there are any of our guests who wish to  
5 make a public comment, step to the microphone. I will  
6 point out -- just let the table clear -- I will make a  
7 point that this is an opportunity. It is not the only  
8 opportunity that is available to communicate with the  
9 MedPAC staff. But I would ask you to come forward now, and  
10 if you would like to introduce yourself and include any  
11 organization that you may represent, or are speaking for in  
12 some way, do that. And we would ask you to limit your  
13 comments to two minutes, and when this light returns, that  
14 two minutes will have expired. Thanks.

15 MS. ACS: Good morning. My name is Annie Acs,  
16 and I am the Director of Health Policy and Innovation at  
17 NHPCO, the National Hospice and Palliative Care  
18 Organization. On behalf of our President and CEO, Edo  
19 Banach, I respectfully submit comments on MedPAC's staff  
20 recommendations.

21 NHPCO is the largest membership organization  
22 representing the entire spectrum of not-for-profit and for-

1 profit hospice and palliative care programs and  
2 professionals in the United States. MedPAC is tasked with  
3 analyzing access to care, quality of care, and cost  
4 containment of care spending. We are deeply concerned that  
5 the proposed recommendations to modify the aggregate cap  
6 will undermine all three of these tenets: access, quality,  
7 and cost containment.

8 I offer this perspective for the following  
9 reasons. We are concerned about creating a new barrier to  
10 beneficiary access to high-quality hospice care that would  
11 result by implementing the proposed changes to the  
12 aggregate cap, as we hear from providers that urban  
13 providers that serve rural areas may reduce their service  
14 areas to mitigate cap risk, or rural providers with a small  
15 census may be forced to go out of business because the  
16 aggregate cap has been reduced so dramatically.

17 We agree that changes in the aggregate cap may  
18 result in delays to accessing hospice care. Medium length  
19 of stay is already less than three weeks. These changes  
20 will lead to shorter lengths of stay and more expensive,  
21 acute, inpatient care. These are seriously ill patients  
22 with high needs for services, many living in rural and

1 underserved areas. We should be providing more care  
2 earlier.

3 We strongly believe that a reformed hospice  
4 benefit and a pre-hospice community palliative care benefit  
5 is essential to addressing these needs. We wish we were  
6 discussing these needs instead of debating an outdated cap  
7 mechanism that already deprives people of needed  
8 interdisciplinary care and drives people to a care system  
9 that does not meet their needs.

10 We would like to work with MedPAC to determine  
11 current savings to the system when hospice is chosen as an  
12 alternative to costlier services, as this analysis is  
13 necessary in informing any proposals to the change to the  
14 aggregate cap.

15 On behalf of NHPCO I thank you for your service.  
16 We will continue to offer our assistance to MedPAC in your  
17 important role in advising Congress. Thank you.

18 DR. CROSSON: Thank you for your comments.

19 Seeing no further individuals at any of the  
20 microphones, we are adjourned until January 2020.

21 [Whereupon, at 11:49 a.m., the meeting was  
22 adjourned.]