# MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
MARJORIE GINSBURG, BSN, MPH
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
JAEWON RYU, MD, JD
DANA GELB SAFRAN, ScD
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

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1 P R O C E E D I N G S

2 [9:24 a.m.]

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

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

19 MS. BLONIARZ: Good morning. This session will
20 kick off the payment adequacy assessments for 2020. So in
21 this session, Ariel and I will review the payment adequacy
22 assessment for physician and other health professional

1 services and present the Chairman's draft recommendation.
2 And Brian will present a separate set of draft
3 recommendations that you talked about last in October about
4 payment policies for advanced practice registered nurses
5 and physician assistants. And we'd like to thank Kevin
6 Hayes, Carolyn San Soucie, and Emma Achola for their help
7 putting it together.
8 Here is the Commission's payment adequacy
9 framework that we use for all sectors. There are four key
10 concepts: access to care, access to capital, quality, and
11 Medicare payments and provider costs.
12 For clinician services, we directly measure
13 beneficiary access using a telephone survey asking people
14 about whether they can get the care they need, and we also
15 review supply of providers and volume of services. We
16 don't review access to capital, given the many small
17 entities that make up the sector.
18 For quality, we look at a few population-based
19 measures assessing some features of the ambulatory care
20 environment. And I'll also give you an early read-out of
21 Medicare's new value-based purchasing program.
22 Clinicians do not report their costs to the

1 Medicare program, so we don't calculate a financial margin.
2 For the last category, we review differences in
3 compensation and the ratio of Medicare's payment rates to
4 private insurance payment rates.
5 This is some background on the sector. Total
6 spending for clinician services in all settings was $69
7 billion in 2017, or 14 percent of fee-for-service benefit
8 spending.
9 There are just under a million clinicians billing
10 the program, and services provided by physicians and other
11 health professionals in all settings are paid using the
12 physician fee schedule under Part B of Medicare.
13 Under current law, there is no statutory update
14 to the fee schedule conversion factor in 2020. But there
15 is a 5 percent incentive payment for certain clinician
16 participants in Advanced Alternative Payment Models.
17 For access, we rely heavily on a yearly telephone
18 survey asking Medicare beneficiaries and individuals with
19 private insurance about their ability to access care they
20 need.
21 For many years, beneficiary access to clinician
22 services has been stable and as good as or better than

1 access for privately insured individuals. That remains the
2 case in 2018.
3 Some groups experience more trouble with access.
4 In particular, minority beneficiaries -- black and Hispanic
5 -- report waiting longer than they wanted to in order to
6 obtain needed care than non-Hispanic whites.
7 There continues to be almost no detectable
8 difference in reported access between rural and urban
9 beneficiaries in the survey.
10 Here's a longer time trend for one of the
11 measures that we track, with Medicare on the left and the
12 privately insured population on the right.
13 Overall, Medicare beneficiaries are less likely
14 than privately insured individuals to report that they had
15 to wait longer than they wanted for regular or routine
16 care.
17 And you can also see here that there appears to
18 be a bit of a secular rise over time among both groups
19 since about 2012.
20 Moving to quality, MedPAC has established a set
21 of principles for quality measurement in Medicare. The
22 quality measurement should be patient-oriented, encourage

1 coordination, and promote change across the delivery
2 system. Quality incentive programs should use a small set
3 of clinical quality, patient experience, and resource use
4 measures.
5 Along these lines, in your mailing materials
6 we've reported national data for a couple of population-
7 based measures. But those don't form a complete picture of
8 quality in this sector, so we've generally reported that
9 quality is indeterminate.
10 But I would also draw a contrast between the
11 Commission principles and Medicare's current quality
12 program. That program, the merit-based incentive payment
13 system, or MIPs, assesses performance using measures chosen
14 and reported by clinicians themselves. So there are a lot
15 of process measures and a lot of measures with very
16 compressed performance. And for these reasons and others,
17 the Commission recommended eliminating MIPS in the spring
18 of this year.
19 But here's a brief overview of how MIPS is
20 working for the first year of the program. For year one,
21 CMS set a very low MIPS threshold -- 3 points out of 100.
22 Basically, clinicians had to report one measure to receive

1 a neutral or positive payment adjustment, and nearly all
2 clinicians did so.
3 In particular, 24 percent of clinicians qualified
4 for a positive MIPS adjustment, and an additional 71
5 percent qualified for a positive adjustment plus an
6 exceptional performance bonus. And just to reiterate that,
7 95 percent of clinicians in the first year were above the
8 performance threshold of 3 points out of 100.
9 Overall, as we generally predicted, MIPS does not
10 appear to be a good or effective way of identifying high-
11 or low-performing providers. And the process will get more
12 complex, idiosyncratic, and arbitrary over time.
13 So I'll turn it over to Ariel for the rest of the
14 payment adequacy assessment.
15 MR. WINTER: Another indicator of access is the
16 share of clinicians who are in Medicare's participating
17 provider program, which means that they agree to take
18 assignment for all claims. In other words, they accept the
19 fee schedule amount as payment in full.
20 In 2018, 96 percent of clinicians are in the
21 participating provider program, and almost all claims are
22 paid on assignment.

1 We also look at annual changes in the number of
2 clinicians who bill Medicare. The overall number of
3 clinicians -- not adjusted for enrollment growth --
4 increased in 2017.
5 When we account for enrollment growth, the total
6 number of clinicians per beneficiary was about the same in
7 2016 and 2017.
8 The number of primary care physicians and
9 specialists per beneficiary fell slightly, but the number
10 of advanced practice nurses and physician assistants per
11 beneficiary increased.
12 We also compare Medicare's payment rates for
13 clinician services with commercial rates paid by PPOs. n
14 2017, Medicare's payment rates were 75 percent of
15 commercial PPO rates, the same as 2016.
16 The next indicator of payment adequacy is volume
17 growth. Volume growth accounts for both changes in the
18 number of services and changes in the intensity or
19 complexity of services. For example, the substitution of a
20 CT scan for a plain X-ray represents an increase in
21 intensity.
22 Across all fee schedule services, average annual

1 volume growth per fee-for-service beneficiary was 1.0
2 percent between 2012 and 2016.
3 In 2017, volume growth was slightly higher at 1.3
4 percent. This growth occurred while services were shifting
5 from physician offices to hospital outpatient departments,
6 which had the effect of dampening volume growth. So in the
7 absence of this change in setting, volume growth would have
8 been higher.
9 In 2017, growth by type of service ranged from
10 1.0 percent for evaluation and management services to 2.2
11 percent for major procedures.
12 Next we look at physician compensation.
13 In 2017, median compensation from all payers was
14 much higher for some specialties than others, similar to
15 prior years.
16 The specialty groups with the highest median
17 compensation were radiology, at $460,000; the nonsurgical,
18 procedural specialties, such as cardiology and
19 gastroenterology, at $426,000; and surgical specialties, at
20 $420,000. By contrast, median compensation for primary
21 care physicians was $242,000.
22 Mispricing in Medicare's fee schedule for

1 clinician services may contribute to these income
2 disparities. This is because primary care physicians tend
3 to focus on ambulatory E&M visits, which are underpriced in
4 the fee schedule relative to other services.
5 Addressing the mispricing in the fee schedule
6 could increase payment rates for ambulatory E&M visits and
7 reduce the compensation disparities among specialties.
8 In prior reports, the Commission has recommended
9 ways to correct inaccuracies in the fee schedule.
10 To summarize our analysis, payments appear to be
11 adequate. Access indicators are generally stable, as
12 measured by our annual telephone survey, the share of
13 clinicians who are in Medicare's participating provider
14 program, and the number of clinicians billing Medicare per
15 beneficiary.
16 Quality was indeterminate. The ratio of
17 Medicare's payment rates to private PPO rates did not
18 change, and there was an increase in the volume of
19 services.
20 So the Chairman's first draft recommendation
21 reads: For calendar year 2020, the Congress should update
22 the 2019 Medicare payment rates for physician and other

1 health professional services by the amount determined under
2 current law.
3 As Kate said earlier, current law calls for no
4 update.
5 In terms of implications, there would be no
6 change in spending compared with current law, and this
7 should maintain beneficiaries' access to care and
8 providers' willingness and ability to furnish care.
9 Now I'll hand things over to Brian.
10 MR. O'DONNELL: So, switching gears a bit, I'll
11 now talk about Medicare's payment policies for advanced
12 practice registered nurses -- APRNs -- and physician
13 assistants -- PAs.
14 This work was started in response to Commissioner
15 interest, expressed during our January 2018 meeting on
16 rebalancing the physician fee schedule, and the Commission
17 most recently discussed this topic at its October meeting.
18 In today's presentation, I'll provide some
19 background on APRNs and PAs, their billing trends, and
20 estimates of "incident to" billing before discussing the
21 Chairman's draft recommendations.
22 Moving on to the background, the term APRN

1 includes four categories of clinicians: nurse
2 practitioners, or NPs; certified registered nurse
3 anesthetists; clinical nurse specialists; and certified
4 nurse midwives.
5 APRNs are registered nurses with additional
6 training, most commonly a master's degree. Similarly, PAs
7 must graduate from a PA program, which is generally a post-
8 baccalaureate master's.
9 States license APRNs and PAs and determine the
10 activities that these clinicians can perform. Over time,
11 states have substantially increased the authority and
12 independence of APRNs and PAs.
13 Before I move to the next slide, it's worth
14 noting that this presentation focuses on NPs and PAs
15 because they are the two largest subgroups of APRNs and
16 PAs, but I'd be happy to discuss the other types of APRNs
17 on question.
18 This next slide provides an overview of the
19 specialties in which NPs and PAs practice. NPs and PAs
20 have historically been concentrated in primary care.
21 However, they increasingly practice outside of primary
22 care, in specialties such as dermatology and orthopedics.

1 In fact, recent estimates suggest that only half of NPs and
2 27 percent of PAs practice in primary care.
3 Despite the variety of specialties in which they
4 practice, Medicare has limited specialty information for
5 these clinicians. For instance, Medicare classifies all
6 NPs as one specialty. This shift in specialty selection is
7 also important because it likely means that, over time,
8 Medicare's "incident to" billing policy increasingly
9 provides additional funding for specialty services.
10 So moving on to Medicare's billing rules, this
11 slide walks through the basics of direct billing and
12 "incident to" billing using a service performed by a
13 physician assistant as an example.
14 If billing directly -- the left side of the
15 graphic -- the service is billed with the PA's NPI, and
16 Medicare's payment rate is 85 percent of the fee schedule
17 amount.
18 If billing the same service under Medicare's
19 "incident to" rules -- the right side of the graphic -- the
20 service is billed with the supervising physician's NPI, and
21 Medicare's payment rate is 100 percent of the fee schedule
22 amount.

1 It's also worth noting that "incident to" billing
2 is not allowed in all circumstances. For example, a PA's
3 service provided in a hospital cannot be billed "incident
4 to" and instead must be billed directly.
5 This next slide provides an overview of trends in
6 allowed charges billed by NPs and PAs and the number of
7 such clinicians that billed Medicare from 2010 to 2017.
8 I won't walk through all the details, but the
9 number of NPs and PAs billing Medicare and the allowed
10 charges they billed have grown rapidly from 2010 to 2017.
11 For example, over that time period, allowed
12 charges billed by NPs tripled from $1.2 billion to $3.8
13 billion, an average growth rate of 17 percent per year.
14 These numbers only represent directly billed
15 services. Therefore, the allowed charges and number of NPs
16 and PAs are understated because of "incident to" billing.
17 While we know the numbers on the previous slide
18 are too low, we don't know the precise magnitude of the
19 undercount because Medicare claims don't indicate when a
20 service is billed "incident to."
21 Therefore, to give the Commission a better sense
22 of the prevalence of "incident to" billing, we conducted

1 two original analyses, both of which suggest that a
2 substantial share of services performed by NPs and PAs are
3 billed "incident to."
4 For example, we estimate that roughly 40 percent
5 of Medicare E&M office visits that NPs performed for
6 established patients in physician offices were billed under
7 a physician's NPI in 2016.
8 In your mailing materials, we walk through a list
9 of potential motivations for addressing "incident to"
10 billing, and it's worth noting a few here.
11 At a very basic level, "incident to" billing
12 limits transparency by obscuring policymakers' knowledge of
13 who is actually providing care for Medicare beneficiaries.
14 "Incident to" billing could also inhibit accurate
15 valuation of fee schedule services and increases Medicare
16 and beneficiary spending.
17 These issues have likely been accentuated over
18 time as the number of APRNs and PAs billing Medicare has
19 increased dramatically.
20 Medicare's limited specialty information for
21 APRNs and PAs may also create issues, especially as these
22 clinicians increasingly practice outside of primary care.

1 For example, Medicare's limited specialty data
2 impedes the program's ability to target resources towards
3 areas of concern, such as primary care, and inhibits the
4 operation of programs that rely on identifying primary care
5 providers.
6 Given these issues, the Chairman has two draft
7 recommendations related to APRNs and PAs, the first of
8 which reads: The Congress should require APRNs and PAs to
9 bill the Medicare program directly, eliminating "incident
10 to" billing for services they provide.
11 In terms of implications for program spending,
12 the draft recommendation would produce modest savings
13 compared with current law.
14 The draft recommendation would also reduce
15 beneficiaries' financial liabilities and is not expected to
16 adversely affect beneficiaries' access to care.
17 In terms of effects on providers, APRN and PA
18 services would be billed under their own NPIs instead of
19 physicians' NPIs. And some practices that employ APRNs and
20 PAs would experience a modest decline in revenues.
21 The Chairman's next draft recommendation reads:
22 The Secretary should refine Medicare's specialty

1 designations for APRNs and PAs.

2 The draft recommendation is not expected to

3 substantially affect program spending, beneficiaries'

4 access to care or financial liabilities, or provider

5 revenues.

6 This last slide summarizes the Chairman's three

7 draft recommendations that Ariel, Kate, and I have

8 discussed today.

9 In addition to comments on the draft

10 recommendations, we are seeking feedback on any information

11 or context the Commission would like to include in future

12 write-ups of these draft recommendations.

13 With that, we look forward to your comments, and

14 I turn it back to Jay.

15 DR. CROSSON: Thank you, Kate, Ariel, and Brian.

16 I appreciate the presentation. We're now open for

17 clarifying questions. Jon.

18 DR. CHRISTIANSON: I guess both of these are for

19 Brian. So on your implications, I think I would add to

20 that slide the good point that you made earlier, which is

21 with "incident to" billing, we don't know who's delivering

22 care to Medicare beneficiaries. That's one of the

1 implications there.

2 And the other thing there's a question, under the

3 Medicare Advantage Plan do we have any idea -- which now

4 is, of course, a third of beneficiaries -- do we have any

5 idea whether they're getting care from advanced practice

6 nurse or PA versus a physician? Is there anything in the

7 encounter data that tells us that or any way we can tell?

8 MR. O'DONNELL: So I don't know on that first

9 point, but we did look at some MA plans' policies and

10 whether they follow the "incident to" billing rules or not,

11 and so a lot of plans do. MA plans do follow fee-for-

12 service "incident to" rules, but we found a few examples

13 where they didn't.

14 So to the extent you look at the MA data -- and

15 I'm looking at my MA teammates. To the extent you did

16 look, you would encounter some of the same issues that we

17 have in fee-for-service.

18 DR. CROSSON: Okay. Jon, Jonathan. Kathy.

19 Jonathan.

20 DR. JAFFERY: Yeah. Just a quick clarifying

21 question, and this is for Brian. In the mailing material,

22 talking about some of the potential drawbacks for the last

1 point around special designations, but the point that APRNs
2 and PAs might work across specialties, is there any
3 evidence that that happens or to what extent it happens?
4 MR. O'DONNELL: So, no, I don't think we have
5 that.
6 What we did is we went out and talked to folks.
7 We did hear examples of this happening, and so that's why
8 we put that in there.
9 DR. CROSSON: Kathy.
10 MS. BUTO: Ariel, I think this is for you. Have
11 we always considered volume to include both units of
12 service and intensity?
13 MR. WINTER: Yeah. So we've been doing this
14 table --
15 MS. BUTO: For a number of years? I just haven't
16 noticed?
17 MR. WINTER: -- this analysis at least since I've
18 been here, which is 2001, and maybe that's about when it
19 started. I'm trying to get Kevin's eye here. And we show
20 both changes in units of service, which is simply that.
21 MS. BUTO: Right.
22 MR. WINTER: And we also show the changes in

1 volume, which is units of service multiplied by the RVUs
2 for each of those services, which is a measure of
3 intensity, volume and intensity.
4 MS. BUTO: Yeah. But we haven't shown them
5 separately because they seem like very different factors,
6 both the unit of service and then the intensity that may
7 relate to increased use of technology or upgrading the
8 nature of the service that's given.
9 I only bring this up because it seems to me that
10 when we're looking at, down the road, issues around payment
11 or even looking at appropriate payment, we want to better
12 understand intensity versus increase in volume.
13 The paper points out that -- I think it is Care
14 management has the highest percentage increase in volume,
15 but it is really minuscule in terms of overall spending,
16 expenditures in Medicare.
17 I'm trying to tease apart these different factors
18 and how important they are.
19 MR. WINTER: So when you say show them
20 separately, we currently show separately the change in
21 units of service and the change in volume, which is a
22 combination of both units and intensity. Are you

1 suggesting we should show separately --

2 MS. BUTO: Units and intensity.

3 MR. WINTER: -- the units from intensity?

4 MS. BUTO: Right.

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

6 that.

7 DR. CROSSON: Other questions? Bruce.

8 DR. PYENSON: Thank you very much.

9 I think this is a question for Brian. There is a

10 very dramatic exhibit in the materials in Figure 6, which

11 shows the updates and the fee for physicians year after

12 year and the spending per beneficiary along with the

13 Medicare Expenditure Index.

14 My understanding is the Medicare Expenditure

15 Index, which had been used for physician updates, is based

16 on a sole practitioner, the expenses incurred by sole

17 proprietor physician working on his own or her own in an

18 office.

19 I am not an expert in the area, but it seems if

20 that's the case, it's not going to capture the kinds of

21 changes with nurse practitioners and physician assistants

22 that we've talked about. I'm wondering if that's even

1 appropriate on this table because it could be used in a
2 misleading -- misinterpreted as saying here's what Medicare
3 says the underlying costs are and look at how little
4 physicians are getting. It's almost an apples-and-oranges.
5 I wonder if you could address that, Ariel.
6 MR. WINTER: So the cost categories in the MEI
7 come from the 2006 survey conducted by the AMI and
8 specialty societies called the Physician Practice
9 Information Survey, PPIS, and it included a wide range of
10 physicians, physician practices, both employed and self-
11 employed, solo, multi, solo in larger practices, and so my
12 understanding is the AMI does reflect at least the cost
13 categories reflective of a wide range of physician
14 organizations.
15 That being said, the data are from 2006, and so,
16 clearly, there have been changes in -- probably been
17 changes in the structure of physician costs over time, and
18 those changes are not -- because the MEI has not been re-
19 based since then, it does not reflect those changes.
20 You did mention the influence of NPs and PAs, and
21 beginning in 2014, CMS revised the MEI to factor in the
22 increase in MPs and PAs who bill Medicare independently,

1 and they did so by increasing the physician compensation
2 weight for that category to reflect NPs and PAs that bill
3 independently starting in 2014. So they did try to account
4 for that, and that was in response to a recommendation from
5 the MEI Technical Advisory Panel.
6 DR. PYENSON: Thank you.
7 DR. CROSSON: Okay. Jaewon.
8 DR. RYU: Thank you for a wonderful chapter.
9 I want to get back to Kathy's question around
10 volume growth and teasing apart the units and the
11 intensity. I think the other component I'd be curious
12 about is mix, patient mix, disease burden.
13 I know you mentioned in the readings that age and
14 sex, the demographics have not proven to be substantially
15 impactful there, but disease burden itself, I'm wondering
16 if we know anything about the interplay between that and
17 the volume growth.
18 MR. WINTER: When we've looked at this in the
19 past, there has not been a substantial relationship between
20 change in disease burden and change in volume growth, but
21 we can go back and see if there's more recent literature on
22 that topic.

1 DR. CROSSON: Paul.

2 DR. PAUL GINSBURG: Yes. You mentioned that the

3 practice expense information comes from a 2006 survey. Are

4 there any plans to update that survey at CMS?

5 MR. WINTER: No plans. There are no plans as far

6 as I know.

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

8 go ahead.

9 MR. WINTER: We highlighted this issue in our

10 June 2018 report chapter on rebalancing the fee schedule

11 towards ambulatory E&M.

12 DR. PAUL GINSBURG: That's right. We'll leave it

13 up to you as to whether it's worth another mention.

14 In a sense, this is -- we spend many, many

15 billions of dollars a year in physician payments. We have

16 a lot of problems with keeping the fee schedule up to date,

17 and this seems to be -- given what a survey would cost, it

18 seems to be a no-brainer that we should be doing these

19 surveys much more often. I'm wondering if we could be

20 influential by pointing this out and urging CMS to quickly

21 and subsequently on a somewhat regular basis to be updating

22 these data.

1 DR. CROSSON: I think that seems like a
2 reasonable suggestion.
3 Sue.
4 MS. THOMPSON: Yes. Thank you for this chapter.
5 I think my question is for Kate. Given the
6 difficulty or maybe just the fact that MA has not
7 penetrated, MA plans have not penetrated rural parts of our
8 country, and it's thought and experienced that many times
9 network adequacy has been an issue from a standpoint of
10 access to specialists. But yet the surveys year after year
11 show there's not a great deal of difference from surveying
12 the Medicare beneficiary around access to both primary care
13 and specialists.
14 So is that an issue of the rules of network
15 adequacy with MA, or is it a component of the survey
16 itself? Because network adequacy continues to be a
17 challenge in terms of making MA plans available to rural
18 parts of our country. So I'm just interested in your
19 thought about that.
20 MS. BLONIARZ: I'm not sure about the MA piece of
21 it, but what I would say about access is when Jeff did a
22 fair bit of work on the rural, for the rural report, my

1 recollection is that service use is actually fairly similar
2 between urban and rural.
3 What we see in terms of reported access, what
4 beneficiaries tell us seems to be similar, and there seems
5 to be slightly clinicians in rural areas have higher
6 volume, I believe, or see more patients in a day, which
7 might kind of mitigate, if there are fewer providers in a
8 region, and then also some beneficiaries in rural areas
9 drive to suburban or urban areas for their care.
10 So that's kind of what I can recall just overall
11 on access. I'm not sure about the MA network adequacy
12 piece.
13 DR. CROSSON: Brian.
14 DR. DeBUSK: On a related note, does the survey
15 capture whether the beneficiary is seeing an extender or an
16 actual physician?
17 MS. BLONIARZ: So we've seen for years that
18 beneficiaries in rural areas are much more likely to see an
19 NP or a PA for all or most of their primary care. That's a
20 trend or that's a pattern we've seen for a long time.
21 DR. DeBUSK: So it's safe to assume that there
22 are a number of beneficiaries that are using an extender as

1 their primary care physician?

2 MS. BLONIARZ: Yeah, that's right.

3 DR. CROSSON: Marge.

4 MS. MARJORIE GINSBURG: I am curious if primary

5 care was easier for Medicare beneficiaries than those in

6 private plans, that there were fewer problems, they had

7 easier access to care.

8 Since Medicare doesn't pay as well, I assume, as

9 primary care physicians who are paid under private

10 insurance, why is it that there's less of an access problem

11 for people seeing a physician under Medicare than private

12 insurance?

13 MS. BLONIARZ: This is something I talked about a

14 little bit in the mandated report that we have to do this

15 year on physician payment and its relationship to these

16 measures.

17 There is not a tremendous amount of correlation

18 between payment rates and access, not like you might expect

19 to see. So areas that have very high private payer rates,

20 that's often because the provider groups have a lot of

21 negotiating power. But it doesn't seem to translate to

22 widespread unfettered access for whatever reason.

1 I think the other thing is that Medicare fee-for-
2 service, at least among payers, is seen as a relatively
3 good payer, not because of its payment rates, but because
4 it doesn't usually have prior authorization or step
5 therapy. There are no networks. The payment is relatively
6 quickly.
7 So I think there are a couple of other things
8 other than payment rates that seem to affect it.
9 DR. CROSSON: Paul.
10 DR. PAUL GINSBURG: If I could add something,
11 Marge. I remember back in the days of the Physician
12 Payment Review Commission, there was a family physician
13 from a small town in Texas. I think it was one of two
14 physicians. In a sense, there is this dynamic of if you're
15 in a large urban area, you can decide to see fewer Medicare
16 patients and figure that they will still get care.
17 But if you are the only physician or one of the
18 small number of physicians, not treating Medicare patients
19 is akin to saying they won't get care. So I think it's
20 just the culture, is, of course, we take care of everyone,
21 including the uninsured.
22 DR. CROSSON: Okay. We're going to move ahead to

1 the discussion in a second.

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

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

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

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

1 taken place so far.

2 It is our intention to continue to work on this

3 issue, and the expectation is that within the next year or

4 so, we will be coming back with more specific proposals and

5 a reiteration of our position in this regard.

6 So let's move on to a discussion of the

7 recommendations. If we could have the last slide up?

8 I think for purposes of time, even though we have

9 both an updated recommendation as well as a policy change

10 here, we'll take these together as opposed to dividing the

11 question.

12 The discussion here should be directed at the

13 recommendations. I would urge Commissioners, in making

14 comments, to say, in effect, whether or not they support

15 the recommendations or don't, and if there's a Commissioner

16 who feels that they cannot support the recommendations, say

17 why, and if possible, make a suggestion for how it could be

18 improved.

19 So we'll take Paul first.

20 DR. PAUL GINSBURG: Yes. I'm glad you mentioned

21 the previous work on primary care payments by the

22 Commission.

1 I was thinking very much about the June 2018
2 chapter, which recommended for outpatient evaluation
3 management services, that there would be higher rates
4 coming out of the payment from other services by
5 physicians, and I was wondering whether we can use this
6 opportunity for our annual recommendation to Congress on
7 payment updates to actually put in a concrete thing as to
8 maybe 1, 2 percent increase for these evaluation management
9 services and an offsetting decrease for other services that
10 would be much budget-neutral rather than forgetting about,
11 because unlike the previous year's recommendation about
12 physician payment, the one in June 2018 really fits into an
13 updated recommendation. So that's my comment there.
14 I'm supportive of the recommendations on the
15 "incident to" billing.
16 DR. CROSSON: And, Paul, I apologize. I should
17 have mentioned that as well as the other two.
18 DR. PAUL GINSBURG: Yeah.
19 DR. CROSSON: Go ahead, Jim.
20 DR. MATHEWS: Just to clarify, though, we did not
21 make a formal recommendation regarding that rebalancing of
22 the fee schedule. We proposed it as a potential way to

1 address some of the inequities that have evolved over time,
2 given greater efficiencies of procedural services, but we
3 didn't bring that to a vote in front of the Commission.
4 DR. PAUL GINSBURG: Well, then perhaps this would
5 be an opportunity to bring it to a vote on basically using
6 an incremental year-by-year basis to move in that
7 direction.
8 DR. CROSSON: As a general policy issue, we like
9 to kind of have continuity between what we discuss and
10 present here as a recommendation in December and what we
11 vote on in January. So I'd like to hear in the subsequent
12 discussion, support for or lack of support for Paul's
13 suggestion because if I come to the conclusion at the end
14 of this discussion that that's something we should do, we
15 will carry that forward into January. If not, we will not.
16 Is that clear?
17 Okay. Kathy.
18 MS. BUTO: So to Paul's suggestion, I have no
19 problem reiterating the June 2018 sense of the Commission,
20 but I would have an issue of specifically recommending a
21 certain increase in fees for E&M services because it's a
22 complicated issue. And I think in June, we tried to say

1 this is multifactorial, so we wanted to bring back in
2 issues around the primary care bonus, a number of other
3 things that -- factors like we ought to take a broader look
4 at primary care supply. I think you would also want to
5 discuss the role of nurse practitioners and physician
6 assistants.
7 I just feel like it's a bigger conversation and
8 don't feel ready to just hone in on the fee because I think
9 the fee is only one component. So that's kind of where I
10 would be. Could be persuaded, but I sort of feel like this
11 would just be hitting at that one issue.
12 I support the recommendations. I would just like
13 to point out a couple of things. One is on the issue that
14 I raised before of the sort of bringing together of --
15 under volume, both intensity and units of service. The
16 reason I brought that up is this comes up in the context of
17 the payment update as a way to talk about volume, as a way
18 to talk about the adequacy of payment. And I think that's
19 appropriate, and it's well done.
20 What I feel like we may miss in a way is looking
21 at the flip side of this, which is if we could look
22 separately at units of service and intensity, we might be

1 able to identify some areas of high growth, where the
2 reimbursement system is actually driving intensity more
3 inappropriately, and areas where we might look from a
4 policy perspective to better target policies in the future
5 in this area, not in the payment chapter, per se. But I
6 just want to make sure we don't lose that ability to hone
7 in and assess what's really going on with total
8 expenditures, units of service, and intensity as we look at
9 appropriate payment, not just in the update.
10 And, secondly, I think I've said this before, but
11 maybe not strongly enough, is I really have an issue with
12 talking about compensation, total compensation. I think
13 it's fine here, again, in the context of overall
14 appropriate incentive to participate in Medicare and
15 therefore provide access, but I don't think payment equity
16 among primary care and specialty is the same thing as
17 payment adequacy for primary care.
18 I don't think adequacy is a different issue than
19 equity, and I don't think -- I personally am not for paying
20 all physicians the same amount. And I don't think anyone
21 is driving there, but the implication of our continuing to
22 focus on compensation seems to imply that we want to drive

1 primary care at the same level of compensation as other
2 specialties. And I don't think we'd say that, and I really
3 don't want to support that.
4 So I just feel like we ought to tread there more
5 lightly. I think it's fine in this chapter, but I do
6 support the recommendation.
7 DR. CROSSON: Yeah, thank you, Kathy. Maybe it's
8 an opportunity to clarify what we -- you know, what our
9 compelling interest in here is. It is not paying all
10 physicians the same, and I know you didn't really mean
11 that. But it's not even -- to my mind, it's not even a
12 sense of equity. The issue, I think, that we've been
13 pursuing, and at least as I think about it is, to what
14 degree is payment from the Medicaid program an important
15 element in the choice of specialty that physicians coming
16 out of medical school make? It's not the only element. We
17 know that. There are other issues with respect to work-
18 life balance, as it's currently called, and other things
19 that make physicians choose certain specialties over
20 another. But income, particularly in the face of debt
21 burden, is one of those things.
22 From the perspective of the Medicare program, I

1 think it is in our interest to do the best we can to see
2 that enough physicians choose adult primary care so that,
3 over time, Medicare beneficiaries have a choice of from
4 whom they would like to receive that care. And in many
5 cases that care is provided, in an excellent way, by nurse
6 practitioners, physician assistants, and other.
7 What I don't think we want to evolve as a country
8 into a situation where a Medicare beneficiary that wants to
9 receive primary care services in general, or certain
10 primary care services from a physician, cannot because
11 there are none. And that is the problem, I think, that
12 we've tried to address over time.
13 Okay. Jonathan. Jonathan, go ahead.
14 DR. JAFFERY: Yeah, thank you. So to start off
15 with addressing Paul's recommendation, and maybe building
16 on what Kathy and Jaewon were just talking about in terms
17 of adequacy versus equity, I do think that this is
18 something that probably does require a bit more discussion.
19 I think the question of whether we're trying to
20 raise primary care compensation or whatnot to try and
21 assure that there is an adequate workforce in the future
22 versus thinking about something, through Paul's

1 recommendation, about redistributing towards E&M visits.
2 There is an issue that goes beyond primary care, and so the
3 E&M visit one maybe helps get at that a little bit in that
4 there are some other specialties, in particularly maybe
5 some of the medical subspecialties that are also mostly E&M
6 based, and I think we want to preserve access, adequate
7 access to those specialists as well, or that workforce,
8 going forward. So I think there is some nuance here that
9 probably warrants some further discussion.
10 In terms of the three recommendations, I am
11 supportive of them. The only thing I wanted to call out
12 specifically was regarding number 3, refining the specialty
13 designations, because this was talked about in the report,
14 but pretty briefly. We talked about one of the benefits
15 would be -- or one of the problems with the current system
16 is that it inhibits some of the operations of programs that
17 rely on identifying PCPs. We talked about that a little
18 bit at a previous meeting but I just want to reiterate that
19 that is a significant barrier, I think, to operating some
20 of these programs. And so it wasn't really called out
21 extensively in the discussion but it is, in my perspective,
22 a pretty big deal, so I am very supportive of that piece.

1 DR. CROSSON: Okay. I saw Dana.
2 DR. SAFRAN: Thanks. Yeah. So I'll start by
3 saying I am in support of the recommendations, and just to
4 make a comment about how important I think one of the
5 benefits of recommendation number 2, and ending incident
6 billing, as well as recommendation 3, is that, you know,
7 with payment reform have come, and we hope will come
8 additional changes in the way teams are structured within
9 care settings, and the whole idea of practicing to the top
10 of the license and so forth to help drive efficiencies in
11 care. And this will enable us to not only be blind to how
12 that is unfolding and which types of clinicians are being
13 used for which types of care, but also to then study how
14 effective are different care patterns in terms of who is
15 serving what purposes. So I am in full support of that.
16 On the issue that we're talking about, that Paul
17 has raised, my thinking, like what Kathy and Jonathan have
18 just outlined, is that it is a really important issue but
19 I'm not ready for us to jump into recommendation about
20 compensation for primary care. You know, I guess I'd
21 reflect that over the last year, in particular, I hear kind
22 of an increasing policy discussion about prices in the U.S.

1 as a big part of our cost problem, and so this notion that,
2 gee, there is inequity and we have to bring primary care up
3 to make it more fair, I think calls the question of is that
4 the right direction? Is that where we have to go? And
5 that then calls into question our training system and the
6 kind of debt, you know, clinicians come out of training
7 with.

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

13 DR. CROSSON: Thank you. Brian.

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

1 specifically in the payment update report. But again, I
2 think it's an opportunity to at least include a placeholder
3 there.
4 Dana, I really liked what you said about the role
5 of teams and extenders and how that fits, and that really
6 gets into my comments about number 2 and number 3. Getting
7 rid of the "incident to" billing has been a long time
8 coming. I think that's long overdue and I think it's
9 excellent policy, for a number of reasons, not just for
10 clinical reasons but also for data integrity issues.
11 I do have some concern that there's so much
12 state-by-state variation in the role that these extenders
13 play, and I think, again, Dana, to your comment about this
14 team-based approach, I think there's an opportunity here to
15 provide some standards and some direction on what are
16 expectations are for these extenders. I mean, taking them
17 from 100 percent, through "incident to" billing, taking
18 them from 100 percent of the fee schedule down to 85
19 percent, at least in the non-hospital setting, again is
20 good policy, but I would hope that we could also -- you
21 know, I would even propose a fourth bold-faced
22 recommendation here that would direct the Secretary to also

1 explore methods of allowing these extenders to complete
2 their degrees, some type of terminal degree where they
3 could become a licensed physician. And again, I don't know
4 the specific pathway there but I think that this would be
5 an opportunity for the Secretary to explore the
6 alternatives in some type of degree completion program.
7 So again, I support all the recommendations as
8 written, but I hope that we will explore a little bit more
9 around degree completion as well as what role do we expect
10 these extenders to play in a modern medical health care
11 delivery team.
12 Thank you.
13 DR. CROSSON: Brian, let me ask you a question.
14 While I understand the final point you made there it's kind
15 of hard to put something into a recommendation that we
16 haven't had a discussion among ourselves, or an adequate
17 discussion about. Would you be satisfied if that issue was
18 brought up in the text?
19 DR. DeBUSK: Absolutely, and to your point I
20 agree. We really haven't explored the role of the
21 extenders. But I do hope -- and, I mean, I'd love to get
22 other Commissioner feedback on potentially a recommendation

1 that would at least direct the Secretary to explore degree
2 completion opportunities for these extenders.
3 DR. CROSSON: So let me just see if I understand.
4 You're saying you want a bold-faced recommendation?
5 DR. DeBUSK: I'm throwing it out there as an
6 idea, expected at least a few of my fellow Commissioners to
7 tear it up.
8 DR. CROSSON: Okay. Well, we'll see if we can
9 oblige you.
10 Paul, on this.
11 DR. PAUL GINSBURG: I'm very eager to get into
12 this, Brian, because, you know, to me, with nurse
13 practitioners and physician assistants, the success of that
14 is that, so we've seen that there is a lot in medical care
15 that people that are trained less extensively than
16 physicians can productively do. And to take this and say,
17 well, we just want it to be a path to becoming a physician
18 by way of then going to medical school seems to defeat the
19 entire purpose of these physician extender categories. So
20 I am quite resistant about that.
21 DR. CROSSON: Well, it didn't take long, Brian,
22 but go ahead.

1 DR. DeBUSK: Okay. If I can defend myself here.
2 I'm not suggesting that all, or even a majority of these
3 extenders should go on and do degree completion programs.
4 It's frustrating to me to see people, to your point, who
5 have demonstrated that they're very successful in
6 delivering care. And the thought that if this person did
7 want to go back and become a physician to say, "Hey, I've
8 got a great idea. You're going to start over from
9 scratch," as if you've never taken your first post-graduate
10 class, and sit through medical school.
11 To me, it seems like there has to be a compromise
12 there, because your only other alternative -- and this is
13 why I had bundled it to some of Dana's comments about the
14 team -- your only other alternative is to try to come up
15 with a uniform standard of what these extenders can and
16 can't do. And if I'm looking at someone who has been in
17 the field for 10 years, very successful, very good at what
18 they do, versus, say, someone who got their nurse
19 practitioner degree in a 24-month Internet program, you
20 know, it's hard to say, "Hey, here's a one-size-fits-all
21 policy. This person can prescribe. This person can do
22 procedures."

1 So, to me, it seems like there needs to be a step
2 in there, at some level. But to your point, I don't think
3 the majority of these people will do degree completion
4 programs, nor should they.
5 DR. CROSSON: Okay. Over these, these
6 recommendations here on the board here. Bruce, and then
7 we'll go over here.
8 MR. PYENSON: I support the recommendations. I
9 think they're really very good. I would welcome finding a
10 way to introduce into the recommendation Paul's idea that
11 the fee schedule has gotten out of sync because of
12 productivity and other issues to the detriment of non-
13 procedural techniques. So if we could find a way to
14 introduce that, you know, with reference to the work we've
15 done.
16 But I would support work along the lines that
17 Brian has mentioned, on the different paths for the
18 physician supply of the future. And I think that gets into
19 some other issues of funding, and what Dana mentioned
20 about, you know, the debt and how GME and IME and all of
21 that works. So I think that's a really important issue for
22 the future of the health care system. I'm not sure how to

1 fit it into this chapter, but I do support that.

2 DR. CROSSON: Well, let me just say. I usually

3 do this at the end but I just want to -- maybe this will

4 help, or not. Because I think where I'm going to go here

5 is suggest that in the chapter we have a text box that

6 takes on this issue of adequacy of primary care services,

7 and incorporates our recommendations from 2011 through the

8 Secretary, our recommendation 2015 to the Congress, the

9 recommendations with respect to, or the considerations in

10 the 2018 June report with respect to E&M services, and even

11 this potential -- because this would be about how do we get

12 more physicians available to Medicare beneficiaries for

13 adult primary care services. And Brian, you're suggesting,

14 which is there is, for some individuals, there this

15 additional pathway such that there would be more

16 physicians. So I can visualize a text box, you

17 know, going over what we've said before, some of the

18 considerations here in the discussion. But so far I don't

19 hear a consensus to change the recommendations on the

20 board.

21 Let's go for further discussion. Karen.

22 DR. DeSALVO: I'm not going to touch that third

1 rail, except in a slightly different way. So I support the
2 recommendations, I think particularly this issue around
3 "incident to" is an important one for us to address, and
4 better understanding who is delivering care comes out of
5 number 3.
6 I just want to call out what I see is a signal in
7 some of the data around this issue of pipeline, because
8 even where we were trying to solve -- if you're trying to
9 solve for access through leverage PAs and NPs, it's clear
10 to me from the data that they are migrating, also, to
11 specialty care. So there's something fundamentally broken
12 in the way that we're assessing what it costs, and all the
13 meanings of that word, to practice primary care. And so I
14 very much support this idea of better assessing not only
15 the financial cost but then thinking about the care
16 environment, which is to Paul and Dana's points about how
17 quickly can we move to a care environment where it's really
18 team-based and not so predicated on a fee schedule but
19 really thinking more about global payment.
20 DR. CROSSON: Thank you, Karen. And again, this
21 is an opportunity, I think, to be more specific. I said we
22 were going to come back to this issue of pipeline. We

1 actually are this spring, so we will picking that up.
2 Sue.
3 MS. THOMPSON: I want to go on record in support
4 of these three recommendations, and I particularly want to
5 call out recommendation number 2, and recognize that these
6 advanced practice nurses and PAs are playing an
7 increasingly important role in terms of providing front-
8 line primary care. And while I am not wanting to open up
9 the discussion again about the third rail, I am quite
10 intrigued with the third rail, because we have referred to
11 them as physician extenders. They are becoming the face of
12 primary care, and I think it is in that tension that we're
13 feeling all of this. And I think we need to spend time
14 thinking about -- and I think the data, as the "incident
15 to" goes away and the data becomes much more clear about
16 who is actually providing the care, I predict we will be
17 quite impressed with that data, and I look forward to it.
18 But I also look forward to the fact of advancing our
19 conversations about the recognition and the role that these
20 professionals are playing in our health care system today,
21 because of our inability to fill these primary care slots.
22 DR. CROSSON: Right. And, Sue, thank you for

1 that, and again, it reminds me that -- and I think, to a
2 certain degree, you're channeling a Commissioner who used
3 to sit in that seat a lot of the time named Mary Naylor,
4 who was the one who changed our typical language from
5 physician update to physician and other providers. And so
6 I think to the extent that we should be able to achieve, we
7 should be using that terminology rather than physician
8 extenders, and I thank you for that point.
9 Moving on. Marge.
10 MS. MARJORIE GINSBURG: I will touch the third
11 rail just very briefly. Only my objection to the term
12 "degree completion." I am a nurse. I have sister who is a
13 nurse practitioner. She didn't go on from her RN degree to
14 get a nurse practitioner degree, in order to step her way
15 to be a physician. She has no desire to be a physician.
16 And I think I'm sort of reflecting Sue's comments as well.
17 There is a lot of obviously professional pride in the work
18 they do, and to make this in any way appear that they are
19 simply physicians that haven't yet happened yet is really a
20 mistake.
21 However, having said that, the idea of -- and I
22 can't believe there isn't already a medical school

1 somewhere who has -- I know there are medical schools who
2 take, I think it was Temple, that take people out of
3 college after their third year and move them immediately
4 and get a college degree and an MD in six years, that there
5 isn't a medical school that hasn't said, particularly to
6 master's-based nurse practitioners, those who are
7 interested, we can have you go through an MD program in X
8 amount of time, rather than --
9 I don't want to belabor that, but I did just want
10 to mention that.
11 I also wanted to mention I support all three of
12 these. I found it interesting that the rationale in the
13 report for getting rid of the "incident to" was not very
14 compelling to me. "Restrains policy-makers' ability to
15 evaluate the cost and quality of care by NPs and PAs,
16 undermining the accurate valuation of MD services, increase
17 costs" -- we get that -- "and raising program integrity
18 issues." Those other ones, this idea of increased cost,
19 feel very soft to me, and I wonder, assuming we go through
20 with this, that we're going to get incredible pushback, and
21 that a lot of programs are going to, you know, go to
22 Congress and say, "Don't take that out. You're going to

1 kill us financially."

2 I say that only because I wonder whether there's

3 -- I support it, but is there any compromise about

4 capturing some of the -- mitigating some of the problems we

5 have in the report while still getting what we think is

6 reasonable and just, and that is that they are not using

7 "incident to." I don't know if I've fuzzied that up, but

8 just the rationale seems, except for the cost issue, seems

9 fuzzy to me.

10 DR. CROSSON: So, Marge, let me be clear then,

11 whether or not you support the recommendation and you'd

12 like to see the justification clarified better, or you

13 don't support the recommendation.

14 MS. MARJORIE GINSBURG: I do support it [off

15 microphone].

16 DR. CROSSON: Okay.

17 MS. MARJORIE GINSBURG: [Comments off

18 microphone.]

19 DR. CROSSON: Yeah, thank you. On that point,

20 Brian?

21 DR. DeBUSK: First of all, your comment about the

22 degree completion, I was using that term as remarkably tone

1 deaf, even by my standards.

2 [Laughter.]

3 DR. DeBUSK: So you will not hear that term come

4 up again. You made an excellent point there.

5 And I think to your point earlier about the

6 programs, the medical education programs, I think the

7 difficulty would be in getting the programs accredited. So

8 if you wanted to say, well, come in as a PA, come in as a

9 nurse practitioner, we'll give you a certain amount of

10 course credit already, we'll accelerate maybe your anatomy

11 class or your physiology class because you already have

12 that background, I think that's where I think the Secretary

13 could provide maybe some insight working with accrediting

14 bodies and trying to develop that alternative pathway.

15 DR. CROSSON: Okay. Let me see where we are. On

16 this same point? Or we have got hands -- okay. I had Dana

17 first, then Jon, then Kathy.

18 DR. SAFRAN: So on the third rail -- and I know

19 we're not trying to solve this today, but I also know it's

20 a compelling point and we're going to take it away and

21 think about it. So the thing I just want to get on the

22 table, which I think was a little bit of where Paul was

1 coming from in reacting, is, you know, that part of what
2 we're learning by having the team-based care is that not
3 everything needs the skill and knowledge of a physician.
4 And so the idea that we need to sort of move more
5 clinicians along that pathway to that degree is one that I
6 just have to question. You know, we've talked over the
7 past many months about the emerging understanding of the
8 importance of social determinants of health and, in fact,
9 that physician training is very poorly adapted and current
10 delivery systems very poorly adapted to address those; that
11 nursing training comes closer; that community health
12 workers come even closer.
13 So before we sort of decide that we need to
14 enhance the physician workforce by, you know, moving people
15 who have other kinds of training along, I just think we
16 also need to give thought to how are we actually going to
17 produce more health in the population, and what is the
18 workforce we need for that, as opposed to how are we going
19 to produce more health care services.
20 DR. CROSSON: Okay. Jon and Kathy, and then I
21 think -- and Jaewon, and then we're going to wrap up.
22 DR. CHRISTIANSON: I support the recommendations.

1 I have a couple comments or thoughts.
2 I think it's a good thing to know who's
3 delivering care. I wasn't reassured by Brian's comment,
4 but I think this will help us know who's delivering care
5 for two-thirds of our beneficiaries, but not for another
6 third who are in MA plans. So I'm not sure how that all
7 works out or how we get that. We talk a lot about being
8 able to compare in the future, MA plans versus fee-for-
9 service and these sorts of things. So I wish we would be
10 able to get more information there.
11 The other thing I would say is that this whole
12 discussion, kind of there's an elephant in the room here,
13 which is, you know, really if nurse practitioners and PAs
14 are delivering the same -- up to the top of their license,
15 delivering the same quality care as physicians, why don't
16 they get paid the same? I mean, what's the point of this
17 85 percent versus 100 percent thing if the care is the same
18 in many cases? So that's probably a next step we're going
19 to have to deal with.
20 DR. CROSSON: Okay. Kathy.
21 MS. BUTO: I just wanted to make a comment back
22 to Karen's comment about the migration of nurse

1 practitioners and PAs to specialty. Just family experience
2 recently with both cardiac surgery and neurology, nurse
3 practitioners are really performing E&M services even for
4 specialty that are invaluable. So I want to make sure that
5 as we look at this issue, we don't look to discourage that
6 substitution, because that's a useful substitution as well,
7 I think.
8 DR. CROSSON: And Jaewon.
9 DR. RYU: So it's that migration that I think I'm
10 a little bit concerned about. I support the
11 recommendation. I do wonder, especially as it pertains to
12 hospital systems and multispecialty groups, whether this
13 has some impact on how they choose to allocate nurse
14 practitioners and PAs to different areas of the delivery
15 system and how that may have an unintended consequence on
16 the primary care areas of those systems, because I think
17 the economics fundamentally change when the reimbursement -
18 - that 15 percent drop currently in the hospital world, you
19 know, you don't have "incident to" billing, well, now you
20 have parity between what the revenue would be for those
21 services. And I don't know how that plays out or comes out
22 in the wash, but that unintended consequence, it would be

1 good to understand a little bit of that, although I am
2 still supportive of the recommendation.
3 DR. CROSSON: Okay. Yes, Paul.
4 DR. PAUL GINSBURG: Responding to Jon with his
5 raising the issue of what happens in MA, is there a way to
6 state this recommendation in a way that it would apply to
7 MA as well?
8 DR. CROSSON: Jon, do you want to --
9 MS. BLONIARZ: I think we should probably check
10 with the MA people. Generally, I think stuff like this is
11 at the plan's discretion.
12 DR. CHRISTIANSON: In the encounter data? Would
13 you have to require that the MA has a code that says this
14 kind of provider -- you'd have to really go back and --
15 Jeff is shaking his head, so that's not there now. And so
16 I think this is a whole other discussion, Paul.
17 DR. CROSSON: Okay. So that could be a later
18 consideration.
19 I think we do need to move on. Let me tell you
20 what my conundrum is, and that is whether or not we come
21 back in January for a full presentation and full discussion
22 or we do this in the expedited way. Normally speaking, one

1 of the considerations is if there's not agreement on the
2 recommendations and, you know, we need to tweak them, then
3 we'll bring it back.

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

14 So my inclination here, since there is, I think,
15 pretty much unanimous support for the recommendations that
16 we've got, is to assume that with some changes in the text
17 that have been suggested, including the emphasis around
18 primary care and E&M that were mentioned, that we assume we
19 have Commission support here for the recommendations and,
20 therefore, we'll have an expedited presentation in January,
21 and we will then take on the pipeline issue and some of
22 these other issues that have been brought up in -- what is

1 it? -- March or April, either March or April. But I want
2 to see if there's any objection to that.
3 [No response.]
4 DR. CROSSON: Seeing no objection, that's what
5 we'll do. So thank you, Kate, Ariel, and Brian, for the
6 presentation. This was a good discussion, and thanks to
7 Commissioners, and we'll move on.
8 [Pause.]
9 DR. CROSSON: We're going to move on now to the
10 second item of business for the December meeting, and
11 that's assessment of the payment adequacy for ambulatory
12 surgical centers, Dan and Zach. And it looks like, Dan,
13 you're going to begin, right?
14 DR. ZABINSKI: Yes.
15 DR. CROSSON: Thank you.
16 DR. ZABINSKI: I'm doing the talking. Of course,
17 all the mistakes are Zach's.
18 [Laughter.]
19 DR. ZABINSKI: In our assessment of payment
20 adequacy for ambulatory surgical centers, we use the
21 following measures: access to care, as measured by the
22 capacity and supply of providers and the volume of

1 services; aggregate Medicare payments; and access to
2 capital. Also, we have quality data for evaluation; and,
3 finally, we're able to use margins or other cost-based
4 measures because ASCs don't submit cost data to CMS.
5 Important facts about ASCs in 2017 are that:
6 Medicare fee-for-service payments to ASCs were nearly $4.6
7 billion; the number of fee-for-service beneficiaries served
8 in ASCs was 3.4 million; and the number of Medicare-
9 certified ASCs was about 5,600. Also, the ASC conversion
10 factor will receive an update of 2.1 percent in 2019.
11 Finally, most ASCs have some degree of physician
12 ownership, and corporate entities such as hospital systems
13 have shown growing interest in owning ASCs.
14 We think it is important to compare ASCs with
15 hospital outpatient departments because HOPDs are the
16 setting that's most similar to ASCs and the ASC payment
17 system is based on the outpatient prospective payment
18 system.
19 There are some benefits to having surgical
20 services provided in ASCs rather than HOPDs because ASCs
21 offer efficiencies over HOPDs such as shorter waiting times
22 for patients and greater control over the work environment

1 for physicians.

2 In addition, ASCs have much lower Medicare
3 payment rates than HOPDs, which can result in lower
4 payments for Medicare and lower cost sharing for patients.

5 However, encouraging greater use of ASCs should
6 be considered alongside studies that show that the presence
7 of ASCs in a market is associated with greater volume of
8 surgical procedures.

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

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

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

19 As we see, the number of fee-for-service
20 beneficiaries served increased slightly, and the volume of
21 services per fee-for-service beneficiary, the number of
22 Medicare-certified ASCs, and Medicare payment per fee-for-

1 service beneficiary had strong growth.

2 In particular, the very large increase in

3 payments per fee-for-service beneficiary was largely due to

4 a strong increase in the complexity of services in ASCs.

5 To evaluate ASCs' access to capital, we examined

6 the growth in the number of ASCs because capital is needed

7 for new facilities. A positive growth of 2.4 percent in

8 the number of ASCs in 2017 indicates that access to capital

9 has been adequate.

10 Also, there has been a fair amount of

11 acquisitions and partnerships with ASCs by hospital systems

12 and other health care companies. But keep in mind that the

13 number of ASCs involved is less than 15 percent of all

14 ASCs.

15 Also, it is important to understand that

16 Medicare is only a small part of ASCs' total revenue,

17 perhaps 20 percent. Therefore, Medicare payments may have

18 a small effect on decisions to create new ASCs.

19 We have data from 2013 through 2016 from the ASC

20 Quality Reporting program, or the ASCQR, and most of the

21 quality measures showed slight improvement during that

22 period.

1 However, some measures, such as the share of
2 average risk patients that had the appropriate follow-up
3 interval after a colonoscopy, are well below the maximum of
4 100 percent, so there is room for improvement.
5 We believe CMS should strengthen the list of
6 measures in the ASCQR. In recent regulatory action, CMS
7 decided to discontinue six ASCQR measures. In response,
8 CMS could expand the list by adding claims-based outcomes
9 measures because the current set of outcomes measures in
10 the ASCQR do not apply to all specialties that are
11 practiced in ASCs.
12 Also, we are concerned about CMS' decision to
13 delay use of the CAHPS-based patient experience measures.
14 One of the Commission's principles for measuring quality is
15 that patient experience should be included, and the CAHPS
16 measure would satisfy that principle.
17 Finally, the Congress should consider the
18 Commission's 2012 recommendation to implement a value-based
19 purchasing program for ASCs.
20 To summarize our ASC findings, indicators of
21 payment adequacy suggest access is good. In 2017, all four
22 of the measures of payment adequacy improved.

1 The increase in the number of ASCs suggests that
2 access to capital is good, and corporate entities such as
3 hospital systems have obtained and invested in ASCs.
4 Quality data show slight improvement in most
5 measures, but the measures used in the program should be
6 strengthened.
7 We remain concerned that ASCs don't submit cost
8 data, even though the Commission has recommended several
9 times to do so. We see no reason why ASCs should not
10 collect and submit cost data, as other small providers such
11 as hospices and home health agencies furnish cost data.
12 Moreover, ASCs in Pennsylvania submit cost and
13 revenue data each year to a PA state agency without any
14 apparent adverse effects.
15 Before moving to draft recommendations, we want
16 to discuss an important regulatory change.
17 From 2010 through 2018, CMS based the update to
18 the ASC conversion factor on the consumer price index for
19 urban consumers, or CPI-U.
20 But for 2019 through 2023, CMS has decided to
21 base the update on the hospital market basket, which is
22 almost always higher than the CPI-U. During that period,

1 CMS plans to assess the possibility of collecting cost data
2 from ASCs.
3 The reason for the regulatory change is that CMS
4 is concerned that the large differences in payment rates
5 between the ASC and the HOPD payment systems has caused
6 services to migrate from ASCs to HOPDs. And CMS believes
7 that using the higher hospital market basket will encourage
8 services to migrate back to ASCs.
9 In its 2018 comment letter on ASC payments, the
10 Commission disagreed with using the hospital market basket
11 to update ASC payments because the cost structure is very
12 different between ASCs and HOPDs.
13 Also, the Commission sees no reason why ASCs
14 should not submit cost data, so CMS should use its
15 authority and collect cost data immediately.
16 For the Commission's consideration, the Chairman
17 has the following draft recommendation: The Congress
18 should eliminate the calendar year 2020 update to the
19 conversion factor for ambulatory surgical centers.
20 Given our findings of payment adequacy and our
21 stated goals, eliminating the update is warranted. This is
22 consistent with our general position of recommending

1 updates only when needed.

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

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

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

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

20 Implementing this recommendation would not
21 change Medicare program spending, and we also anticipate no
22 effect on beneficiaries. But ASCs would incur some

1 additional administrative costs.

2 So that concludes our presentation, and we

3 appreciate your time. We would like to open up the session

4 to discussion about our analyses and the draft

5 recommendations.

6 DR. CHRISTIANSON: Okay. Do we have

7 clarification questions? Apparently, Zach is taking notes.

8 [Laughter.]

9 DR. GRABOWSKI: Great. Thanks for this chapter,

10 and I'm glad you raised the issue of the lack of cost data.

11 I find that frustrating. It was frustrating last year when

12 I first learned that, and I'm still frustrated by it.

13 I'm intrigued by the State of Pennsylvania. You

14 noted the all-payer margin in Pennsylvania is 25 percent.

15 So two questions. First, does the state calculate a

16 Medicare margin?

17 DR. ZABINSKI: No, they don't.

18 DR. GRABOWSKI: Two, could we get those data and

19 actually calculate that ourselves? Could we do more with

20 that data to kind of analyze it?

21 DR. ZABINSKI: The agency that does it, the

22 Pennsylvania Health Care Cost Containment Commission, I

1 think it is, or Council -- whatever -- they were
2 forthcoming in, you know, supplying me kind of the raw cost
3 and revenue data, the aggregates for each ASC. I'm not
4 sure how receptive they would be to -- you know, or if they
5 even collect it by type of payer. So I'm not sure what
6 sort of Medicare margin we'd be able to get. I could look
7 into it, though.
8 DR. GRABOWSKI: Just to follow up on that, it
9 seems like this could be a nice data resource, given all
10 that's out there right now. Are some data better than no
11 data? And so I would just push us to try to go as far as
12 we can with those data.
13 DR. CHRISTIANSON: Kathy.
14 MS. BUTO: So two questions, Dan. One is, I
15 think on Slide 3, you point out that there's a greater
16 corporate interest in ASCs, meaning, I guess, hospitals are
17 getting more interested in acquiring ASCs. Do we have any
18 concern about physician ownership of ASCs? I know they're
19 exempt from the Stark rules, and I know the administration
20 is looking at liberalizing physician ownership and/or
21 reducing the scope of Stark. I think you pointed out that,
22 where they exist, there is an increase in volume. So I'm

1 just wondering if we think that's an issue, and I'm trying
2 to match that up with the issue of more corporate
3 ownership. Is that good or bad? Is that a substitution
4 for OPD? What's your perspective on that?
5 MR. GAUMER: I don't think we've ever kind of
6 criticized the physician ownership component of ASCs in
7 particular, but we are seeing fairly significant growth in
8 hospital ownership of ASCs, and it appears to be the big
9 guys, the large national chains that are getting into it,
10 and also private equity firms that are making large
11 acquisitions of --
12 MS. BUTO: Okay, so not hospitals.
13 MR. GAUMER: Pardon?
14 MS. BUTO: I thought you mentioned hospitals.
15 MR. GAUMER: Yeah, so large hospital associations
16 -- or hospital systems. Tenet in particular was one this
17 year that's doubled down on ASCs quite a bit.
18 MS. BUTO: That would seem to at least suggest a
19 shift to a lower-cost setting from the OPD, but maybe it's
20 just an increase in overall volume of services.
21 MR. GAUMER: And that is what we are reading in
22 their annual filings with the SEC, that it's typically a

1 push to try to lower volume -- go to a lower-value setting
2 to try to --
3 PARTICIPANT: Lower cost.
4 MR. GAUMER: Excuse me, lower-cost setting. Wow.
5 Lower-cost setting to try to get with the population health
6 trends.
7 MS. BUTO: Okay. And then the last question is
8 on Slide 5. Dan, I think you mentioned the Medicare
9 payment per fee-for-service beneficiary number, the change,
10 7.7 percent. That is at least partly due or largely due to
11 an increase in complexity?
12 DR. ZABINSKI: Yeah --
13 MS. BUTO: So let me -- so back to -- and then
14 volume per fee-for-service beneficiary, fairly small change
15 increase. So you haven't in this case, unlike the
16 physician payment area, you're not combining intensity or
17 complexity with volume, correct?
18 DR. ZABINSKI: No, we're not.
19 MS. BUTO: Okay.
20 DR. ZABINSKI: The large growth in the payment
21 per beneficiary, it's sort of a confluence of a number of
22 factors that -- the volume increase is actually

1 historically pretty large. There's the large increase in
2 the complexity of the cases, and also the payment update
3 was pretty large, relatively speaking, to previous years in
4 ASCs, and they all kind of combine together for a very
5 large increase overall when you put it all together.
6 MS. BUTO: Thanks.
7 DR. CHRISTIANSON: Other questions of
8 clarification? Pat and Bruce.
9 MS. WANG: On Slide 9, Dan, you talked about the
10 change in using the hospital update versus the CPI-U, and
11 the reasons are stated in the middle. CMS was concerned
12 about different payment rates and wanted to shift more back
13 to the HOPD setting. I don't under -- can you say more
14 about that? Why is that considered desirable? How was
15 that supposed to happen? Was there an assumption that
16 physician referral patterns would change? And why --
17 DR. ZABINSKI: Yeah, it's a case of they want to
18 increase the ASC payment rates relative to the HOPD, making
19 that sector more attractive. I think it's pretty much as
20 simple as that.
21 MS. WANG: Why? If the ASCs are providing the
22 same services at a lower cost, why would CMS be interested

1 in inflating expenditures for the service?
2 DR. ZABINSKI: I think the concern -- there was,
3 starting about 2012 through, say, 2016, there was a pretty
4 good slowdown, even a slight decrease in some years, in the
5 volume that's occurring in ASCs, while the HOPD was seeing
6 pretty strong growth in the ambulatory surgical procedures.
7 And I think CMS got concerned about it and wanted to find a
8 way to get more services done in the cheaper setting. You
9 know, increasing the ASC payment rates at the same rate as
10 HOPDs really kind of, you know, narrowed the difference
11 between the two payments, but it's not going to make it any
12 larger. And I think that's sort of the -- they want to
13 sort of stem the tide essentially of a shift from -- at
14 least what they think is occurring from ASCs to HOPDs and
15 try to get the shift to go back.
16 MS. WANG: Okay. I take that on face value. But
17 it kind of is a segue to my second question about without
18 cost data in an am surg center, these are all just proxy
19 considerations for what things might cost or how much they
20 might be increasing. It's detached from the reality of
21 actual information. As David said, every year that we've
22 talked about this, everybody gets frustrated. And I know

1 that when we have made firm statements to the effect that
2 ASCs should file cost reports, we get pushback from the
3 industry that says, "Well, we do file a lot of cost
4 information."
5 Can you help us parse that? Is there information
6 that is being filed now with Medicare that would allow some
7 understanding of costs and cost growth and allow the
8 calculation more accurately of Medicare margins? And, you
9 know, it's just baffling that a whole sector doesn't file
10 cost information, so it's a clarification question for you.
11 DR. ZABINSKI: I'm not aware of any information
12 that the ASCs furnish to CMS that would allow us to
13 determine what their costs are. As I said, the ASCs in
14 Pennsylvania, to my knowledge that's the most complete
15 information that's available, and I really haven't seen
16 anything beyond that.
17 MR. GAUMER: And this is why we turned to
18 Pennsylvania. You know, we also look at SEC filings, like
19 I said before, and a lot of the ASC companies that are
20 publicly traded have other lines of business that are
21 embedded into those filings as well. So it's even hard to
22 pull the ASC piece of that business out from other

1 physician practices that they may own and that kind of a
2 thing. So we really are handcuffed.
3 DR. CROSSON: Okay. Bruce.
4 MR. PYENSON: Thank you very much. I've got two
5 very different questions. On Table 5-5 of the material,
6 there's a list of the common surgical service, and just a
7 couple of questions about that. We have talked about
8 services potentially migrating from or to hospital
9 outpatient am surg centers, but many or maybe even most or
10 all of the services listed here could also be performed in
11 physician office. So in addition to the differential price
12 between hospital outpatient and am surg, there's probably a
13 cost differential with physician office as well. And
14 that's -- I'm not sure if we've addressed that and what the
15 implications are for that in the report.
16 A related issue is imaging isn't on here in the
17 list, and I believe the Medicare fee schedule for imaging
18 doesn't distinguish between -- there's no separation
19 between physician office and freestanding imaging center.
20 They're considered the same. And if that's the case, my
21 impression is there's a lot of imaging that's done with the
22 code indicating an ambulatory surgery center, and why

1 that's not in here. So that's my first set of questions
2 around what goes on.
3 DR. ZABINSKI: All right. Let's see. On the
4 imaging, well, okay. The Medicare ASC payment system,
5 imaging services are -- they have their own lines in terms
6 that they have their own payment rate and that sort of
7 thing.
8 We gathered the information from the ASC claims,
9 and the number of imaging services is very small. Maybe
10 there's a distinction between what CMS defines as an ASC
11 for the purposes of its payment system and what you're
12 thinking of as an ASC in terms of the types that furnish a
13 lot of imaging services. That's the only explanation I
14 have for that.
15 DR. PYENSON: I'll just shift from physician
16 office, the differential fees, where it's purely a
17 physician component, of course, if it's a physician office
18 versus moving to an ASC.
19 So, for example, colonoscopies can be performed
20 in a physician office, and there's no facility fee for
21 physician office versus what we're seeing on Table 5-5.
22 Presumably, there's, of course, a professional component

1 plus there's a facility fee.

2 In this analysis, it seems like we haven't looked

3 at those differentials.

4 DR. ZABINSKI: No, we haven't.

5 We have considered just going in that direction,

6 but the only thing we ever considered is that -- a number

7 of years ago, we considered, compared ASC and HOPD in terms

8 of site-neutral payments between the two, but we haven't

9 really thought about the physician office in ASC component.

10 MS. BUTO: Dan, just a clarification on Bruce's

11 point. Maybe it doesn't exist anymore, but there used to

12 be a rule that if something was done more than 50 percent

13 of the time in the physician's office, it was not eligible

14 for ASC payments. I don't know if that's still there or

15 not.

16 DR. ZABINSKI: Yeah. What they do is they pay

17 the lesser of the standard ASC rate or the non-facility

18 expense rate from the physician fee schedule for those

19 services that are done more than 50 percent of the time in

20 physician offices.

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

22 DR. PYENSON: One different question. On page 30

1 of the materials, there's a bullet. This is talking about
2 the cost report. I'll read it: Total charges across all
3 payers and charges for Medicare patients. CMS could
4 allocate total facility cost to Medicare based on
5 Medicare's proportion of total charges.
6 This is where you're describing a cost report.
7 That seems to imply using the current charges-based
8 infrastructure of Medicare cost reports; for example, the
9 hospital Medicare cost report or others.
10 But do you know if ASCs even have such a thing as
11 a charge master? Because that seems to be implied in that.
12 DR. ZABINSKI: I'm not aware of it.
13 MR. GAUMER: Yeah. We've never heard of a charge
14 master that goes across systems of ASCs or anything. No.
15 DR. PYENSON: So what does that mean in terms of
16 the recommendation to use the charges-based system?
17 DR. ZABINSKI: Well, this is just -- I wouldn't
18 call that a recommendation. It's a thought in the
19 direction one might go. This is a really unknown area.
20 It's really a black box, and it's going to have to be
21 worked out.
22 DR. CROSSON: Excuse me, Dan. I think Bruce is

1 referring to recommendation No. 2.

2 DR. ZABINSKI: Collecting cost data, yes.

3 DR. CROSSON: Collecting and report cost data.

4 DR. ZABINSKI: Right.

5 DR. CROSSON: Right.

6 DR. ZABINSKI: But in terms of using charges,

7 that's not -- in and of itself, we're saying it to use

8 charges and not a recommendation. It's a thought of here's

9 how one might get started on it.

10 DR. CROSSON: Oh, I see. All right. I'm sorry.

11 Bruce, did I misinterpret what you were saying?

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

13 DR. CROSSON: Okay. It's unusual.

14 DR. PYENSON: In the later conversation, I'll

15 have a suggestion.

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

17 DR. DeBUSK: I have two clarifying questions, but

18 I'll ask the first one first. On Chart 9, could you walk

19 me through from the moment the ASC schedule -- and I've

20 seen -- we've done this before, and I've read it before,

21 but I'd like you to walk me through. From the moment they

22 started the ASC fee schedule, it was a percentage of OPPS

1 fee schedule, from the moment they carved it out. Could
2 you walk me through roughly what percentage that was and
3 then how it's evolved over the lifetime with different --
4 because I know one gets CPI-U updates. One gets market
5 basket updates.
6 So if you could just -- for a clarifying
7 question, where did they start? And describe their
8 trajectories over, say, the last eight to ten years.
9 DR. ZABINSKI: Well, initially, my recollection
10 is back in 2008 when the current version of the ASC payment
11 system was established, it was about -- ASC payment rates
12 were about 65 percent of HOPD rates.
13 Since then, well, it's been a slow, steady
14 decline over time, and now in the area of 52 to 53 percent.
15 DR. DeBUSK: Okay. So at 52 percent, every time
16 a case moves from the HOPD to the ASC, the program enjoys
17 about a 48 percent savings on that case?
18 DR. ZABINSKI: Correct.
19 DR. DeBUSK: Okay. Well, then here's my second
20 question. I want you to check my math, and this is not a
21 rhetorical question. It's legitimate. If you're looking
22 at a 2.6 percent update on a $4.6 billion spend, I've got

1 that as $119 million, round numbers. If I'm going to save
2 52 cents on the dollar, what I need to do is convert about
3 $260 million worth of HOPD business to get my 2.6 back,
4 right? 260, if I take 48 cents on the dollar of that in
5 savings, that will get me to my 119.
6 So if I'm looking at $260 million and the OPPS
7 spend is $66 billion, all I need to do to get my 2.6 back
8 is to convert 0.4 percent of the HOPD spend to the ASC, and
9 all of a sudden, I'm back in the black. Do those round
10 numbers make sense?
11 DR. ZABINSKI: I will completely defer to you on
12 that. They seem reasonable to me.
13 DR. DeBUSK: Again, this is why I wanted someone
14 to check because I've been playing with these numbers, and
15 it just seems if we do advance the schedule, if we give
16 them a 2.6 percent update and we only have to get one-half
17 of 1 percent or less than one-half of 1 percent of these
18 procedures shifted, it seems like an overwhelmingly easy
19 decision to make.
20 DR. SAFRAN: Except that very little gets
21 shifted, and it's just increased new volume and new
22 capacity. That's the question.

1 DR. DeBUSK: Well, is it inducing volume? I
2 think that's a legitimate question, but that's a Round 2.
3 DR. PAUL GINSBURG: Yeah. I mean, I think that's
4 a great question.
5 DR. RYU: Or would it shift anyway, even in the
6 absence of the 2.6? I think that's the other question.
7 DR. ZABINSKI: I would say the data we have for
8 2017, one could argue it's only one year. I don't want to
9 draw any conclusions from it, but the growth in the ASC,
10 the services that are covered under the ASC system was much
11 stronger in ASCs than it was in HOPD. So one could say
12 that perhaps there was already beginning of a shift back,
13 but it's only one year. You can't reach a conclusion from
14 that, I don't think, but --
15 DR. DeBUSK: In the reading materials, you
16 mentioned that the growth had appeared to have flattened
17 out at one point, and so presumably, this 2.6 is to spur
18 that growth.
19 Okay, that's it. No more questions.
20 DR. CROSSON: Bruce, did you have a comment on
21 this?
22 DR. PYENSON: Yeah. Just on that, there's

1 another shift from physician office to ASC that would need
2 to be balanced out of that, I think.
3 DR. ZABINSKI: Yeah. I was just going to say we
4 really know very little about how relative payments
5 determine the proportions, the shifts, and it would be
6 great to find out. It would be a significant study, I
7 think, to do it. I'm not sure that it's worth the staff's
8 time, but I think we ought to figure that we really have a
9 great deal of uncertainty. It's hard to have that go into
10 our recommendations.
11 DR. CROSSON: Okay. Dana.
12 DR. SAFRAN: Thank you.
13 I just have two questions for you. The first one
14 has to do with quality measurement. I saw your summary of
15 what's known in your recommendations about some additional
16 quality measures for ASC. Do we have any way to compare,
17 understanding there could be some nontrivial case-mix
18 differences between the hospital outpatient and the ASC?
19 Do we have any way to compare across those settings on
20 existing quality measures? And, specifically, I'm
21 interested in the hospital-acquired complication measures.
22 MR. GAUMER: So there's not complete symmetry

1 between the measures that are used on the outpatient and
2 the ASC side, and that's something that we've been talking
3 about for a few years now.
4 One of the reasons why we want to do these
5 subsequent hospitalization measures, which we think are a
6 really good idea that CMS is starting to implement these,
7 but I think the data just are not there yet. The measures
8 are just not there yet on either side.
9 DR. SAFRAN: Okay. And the algorithms for HACs
10 don't allow us to actually just take the claims data and
11 compute what they would be in the ASCs?
12 MR. GAUMER: That's not something we've tried
13 yet, so we'd have to give that some thought.
14 DR. SAFRAN: I'd encourage you to look into that.
15 Yeah.
16 MR. GAUMER: Okay.
17 DR. SAFRAN: I mean, I can just say that some
18 clinicians that I know and work with who are expert in the
19 quality and safety field believe that there's a lot about
20 the ASC setting that makes it safer. So I think that would
21 be good to know.
22 My other question ties back a little bit to where

1 Brian was going and just gets at the issue of volume
2 increases that you pointed to, and I'm wondering if there
3 are methods that you've thought about or that might get
4 included in the chapter to start to get at appropriateness.
5 MR. GAUMER: Can you say that one more time?
6 DR. SAFRAN: So you point to volume increases,
7 and you note differences in markets where there are ASC and
8 not. So it's suggesting if you build it, they will come,
9 right?
10 So do you have any mechanisms to think about
11 appropriateness that you're going to be talking about in
12 the chapter?
13 MR. GAUMER: Let's see. We don't really. That's
14 something we could consider as well. We've thought a
15 little bit more this year about where these facilities are
16 locating and how they're tending to cluster in certain
17 locations and why.
18 Do you have thoughts on this?
19 DR. ZABINSKI: That's a complicated issue to
20 address, something to consider, though, of course. That's
21 about it.
22 MS. BUTO: Dan --

1 DR. SAFRAN: I'll just add and then pass the mic
2 that in some of the work that we've been doing that uses
3 patient-reported outcome measurement before and after
4 procedures, it's leading to some pretty fascinating
5 insights where you can know with baseline data with 90-plus
6 percent certainty whether a patient will or won't benefit
7 from a procedure. We've looked at hip and knee, and so
8 it's pretty compelling. You have to find a way to make it
9 not gameable, but I'd just offer that as one idea.
10 DR. CROSSON: Kathy, do you want to comment on
11 that?
12 MS. BUTO: I wanted to comment that at least if
13 you look at the 20 procedures in Table 5-5, a lot of them
14 are ophthalmology and GI procedures, and CMS, I know in
15 coverage guidelines, whether administered by the MACs or
16 whoever, set certain thresholds for appropriateness or
17 medical review. And I think that sort of serves as an
18 appropriateness guideline.
19 They may not be perfect, but it's a way they
20 ensure that there are at least some standards that are
21 applied and whether or not something is approved for
22 payment.

1 DR. CROSSON: Karen. Pass?
2 Sue.
3 MS. THOMPSON: I'll be quick. I have two quick
4 questions. In the narrative, you note the beneficiaries
5 who live in rural areas can travel to urban areas because
6 obviously the geographic location is much more predominant
7 in urban areas. So we know if they do or not? Do we have
8 any data to help us look at the utilization of rural
9 beneficiaries?
10 MR. GAUMER: We have not looked to see what share
11 of surgeries for rural beneficiaries are occurring at ASCs
12 and how that's changed over time.
13 We've looked at that on the hospital side, and we
14 have seen an increase in benes from rural locations coming
15 into urban hospitals to get surgery done. That's gone up
16 in the last five years, but we have not looked at that in
17 ASC. And that's an increasing thought. We could do that.
18 MS. THOMPSON: And the second question -- and I
19 don't expect a ton of dialogue about this, but what's going
20 on in Maryland? I mean, 40 ASCs per -- I mean, the next
21 grouping is 20. It's double, and so does that have
22 anything to do with their all-payer model?

1 MR. GAUMER: Dan lives in Maryland, so he's going
2 to answer this.
3 MS. THOMPSON: Thank you, Dan.
4 [Laughter.]
5 DR. ZABINSKI: I'll tell you just within the
6 short distance of my house, there's a lot of ASCs. There
7 really are.
8 The only thing I can chalk it up to, Maryland
9 actually has a CON law on ASCs, which should say, well, why
10 are they so high, but they have this loophole that says you
11 don't have to get one if you're a very small ASC. Most
12 ASCs are very small, so it's essentially a moot point.
13 But other states don't have CON laws, and they're
14 not nearly as high as Maryland. So, yeah, it's a good
15 question of what's going on.
16 I don't have an answer perhaps that it's the all-
17 payer. I'm not sure.
18 DR. RYU: It's my guess that that's what it is
19 because the ASCs would come out of their waiver, and
20 services that sit inside that inpatient waiver, there's a
21 limitation if you're a health system as far as what your
22 profitability is there. And so the more services you can

1 move out, I think, I would imagine it helps them.
2 DR. CROSSON: Okay. As a potential explanation,
3 thank you.
4 So we're going to move on now to the discussion
5 period. We have the recommendations on two different
6 slides, but I think everybody knows what they are. No
7 update and then a reaffirmation of our requirement for cost
8 reporting. So we'll take them together as a discussion.
9 We'll start with Jon.
10 DR. PERLIN: Well, thanks, and thanks for an
11 interesting presentation on this topic.
12 I'm kind of with Brian in terms of the logic, why
13 you'd disincentivize something that has substantial savings
14 relative to alternative sites of care.
15 This is anecdotal, but I think we should validate
16 with data. I don't think this is going to be substantive
17 for office practice not only for the mechanistic aspects of
18 Medicare policy, as noted, but a lot of these things are
19 intensely complex. And there's a lot of specialized
20 equipment, et cetera.
21 Putting that aside, actually going a slightly
22 different direction here and built from Dana's observation

1 of clarifying, the chapter goes through pains to outline
2 the necessity of some quality measures. I really think we
3 need to focus on value here and to build the infrastructure
4 if we're thinking about value in the future.
5 I'd like to see either with great clarity in the
6 text or alternatively as a specific recommendation for us
7 to build a set of quality measures. Otherwise we can't
8 understand the relationship of outcomes to cost. Ideally,
9 they'd have some capacity for risk adjustment to understand
10 the relative complexity of patients compared to other
11 settings, HOPD and hospital specifically. And I think
12 there's some very fundamental measures that are quite
13 specific, transfer to hospital being the most obvious, as
14 you've indicated quite correctly in the chapter.
15 Additionally, other things like surgical site
16 infection, but one could think here of that same sort of
17 quadrat of safety quality, efficiency, and experience as
18 the basis for understanding this slate of outcomes for the
19 resources utilized.
20 Thanks.
21 DR. CROSSON: Jon, I'm going to ask you in a
22 second to clarify where you are with the recommendations.

1 But I think in partial answer to where I think
2 you're going, at least in terms of discussions in prior
3 years, I think the Commission has been kind of reluctant to
4 provide updates in the absence of understanding what the
5 costs were for the reasons you said, basically. It's
6 difficult for us to make a judgment, whether it's about
7 margin or it's about value, without that information. So I
8 think that's partly behind where we are with the
9 recommendations.
10 But where are you on the recommendations?
11 DR. PERLIN: I'm ambivalent for the reason that
12 Brian mentioned, but can live with the recommendation.
13 DR. CROSSON: Okay. Brian.
14 DR. DeBUSK: I'll start with the easy one first.
15 If you could go to recommendation number 2, I do support
16 the recommendation as written. I think it is -- that they
17 absolutely need to provide cost reports. Furthermore, I
18 think they need to continue to report meaningful quality
19 measures. And again, I would go even a step further to say
20 that there should be measures in place to make sure that
21 there isn't induction and that these procedures aren't
22 unnecessary or low-value care. So again, I think anything

1 we do in that space I could completely support.

2 Going back to recommendation number 1, I'm a

3 little bit torn because I do understand -- and, Jae, you

4 just mentioned -- in the absence of cost report data it is

5 difficult to make a recommendation, and I do feel like

6 that's -- I do think that's something that we would have to

7 consider.

8 Having said that, I do think ASCs play a really

9 important role in surgical care, because I do think they

10 preserve a pathway to physician autonomy. They also -- you

11 know, there's a lot of collective angst here about policies

12 that drive physicians toward employment. You know, this is

13 one of the few areas where we can actually encourage and

14 foster the development of this payment area and help

15 maintain some physician autonomy. And it's frustrating to

16 me to think, you know, what other opportunity are we going

17 to get to create a pathway to physician autonomy that comes

18 packaged with a 52 percent -- or, I'm sorry, 48 percent

19 program savings, if we can migrate the procedures from the

20 OPPS to the ASC correctly. And, Dana, your point was well

21 made. If we don't manage the transition correctly it could

22 be a huge disaster.

1 The final thing is I really do want to support
2 this area, and that's why I was encouraged to see that CMS
3 was going to give them the market basket update this year.
4 I do want to support this area for one other reason, which
5 is it does allow physicians to self-select -- the ones that
6 are more entrepreneurial, the ones that are more willing to
7 take on risk. I like the fact that we've given them this
8 safe haven, if you will, where they can operate, because I
9 suspect these are the same doctors that we're going to come
10 back to and say, "Hey, I've got a great idea. Why don't
11 you participate in a two-sided ACO?" or "Why don't you take
12 on risk?" And I think it's just -- I think giving them
13 this area -- it's a relatively small payment area -- I hope
14 as we go into the January meeting and have discussions
15 about this update that we'll balance the need to preserve
16 physician autonomy with our long-standing position that if
17 you don't file cost reports we can't responsibly give you
18 an update.
19 So, Jae, I apologize but I'm sort of -- I'm
20 looking forward to January. How's that?
21 DR. CROSSON: I'm not sure I am.
22 [Laughter.]

1 DR. CROSSON: But thank you. That's so much
2 clearer.
3 Kathy and Karen.
4 MS. BUTO: I support the recommendations. I
5 actually question how much migration we're going to see
6 from OPDs in to ASCs, where ASCs exist. Maybe you're
7 talking about stimulation more formation of ASCs, which is,
8 I think, a slightly different issue. Because I look at the
9 procedures and the gastroenterologists and ophthalmologists
10 are two of the most aggressive in setting up ASCs, and so I
11 know that they're already where there are opportunities
12 looking to do that.
13 I would ask that, Zach, you and Dan look at some
14 of the coverage guidelines that will address some of the
15 concerns I hear about appropriateness, because I think some
16 of them are the ones that medical review guidelines that
17 are being followed put a break on inappropriate
18 utilization. So at least some reference to some of those
19 would be helpful, for cataract surgery and maybe for
20 colonoscopy and endoscopy.
21 DR. CROSSON: Karen.
22 DR. DeSALVO: I support the recommendations. I

1 want to particularly talk about the second, which is
2 related to accountability. I think any responsible
3 business would want to be accountable to the taxpayers and
4 so they ought to be publishing their cost data, just as we
5 ought to be holding them accountable for value or quality
6 as a pathway to that.
7 I just would like to add a dimension about what
8 it feels like on the ground when ambulatory surgery centers
9 arrive. One of the unintended consequences is that
10 specialists can stop having hospital privileges, which
11 means that when you arrive in the ER and you need a
12 gastroenterologist or an ophthalmologist, because you've
13 got some trauma or an emergency, you may not have anyone on
14 staff. And I don't know the prevalence of that but it's a
15 very common clinical narrative that has many physicians
16 concerned. So for all of the good that we've discussed, I
17 do think there are other consequences that we should pay
18 attention to.
19 And I just wanted to go back to Pennsylvania or
20 any other opportunities where we might have a proxy, where
21 they may have some more data, not just only in cost but
22 perhaps in quality or migration from other environments

1 that we could try to begin to get some sense to help guide
2 the future policy in this area.
3 DR. CROSSON: Thank you. David.
4 DR. GRABOWSKI: Great. Thanks. I'm also
5 supportive of the Chairman's draft recommendations. I
6 really like this principle. If you won't show us your cost
7 data we won't give you a rate increase. I think that
8 should be very firm.
9 Two other points I wanted to touch on. One,
10 Brian, this issue of savings that you're pushing towards.
11 I'm really skeptical of where that substitution is going to
12 come from and whether it's going to come. And so I don't
13 know if this is new spending or kind of actual savings.
14 I'd be really careful there without further analysis. The
15 second -- and I'm really glad Dana and Jon pushed us about
16 the quality measures here. I think they're really lacking
17 in this sector and we could go a lot further there. So I
18 hope we'll continue not just to push on cost data but also
19 on the quality measures. Thanks.
20 DR. CROSSON: Okay. Marge, Dana, and Pat.
21 MS. MARJORIE GINSBURG: I'm a little confused
22 about the relative cost of ASCs and hospital outpatient

1 departments. So my understanding is it costs more to get
2 the work done in the hospital outpatient department than it
3 does in an ASC. ASCs are -- their revenue from Medicare
4 looks very good, which is one of the reasons. So why, if
5 the equivalent procedure can be done in a less-expensive
6 setting, then is any of this doing anything to push the
7 services out of outpatient departments into ASCs? And if
8 not, why not? Or, said a different way, if it's less
9 expensive to do in an ASC, shouldn't we drop what the
10 reimbursement is to outpatient departments to be equivalent
11 to the site where it's most effective -- most efficient.
12 Excuse me.
13 That's all. Oh, and I do support the
14 recommendations.
15 DR. MATHEWS: If I could weigh in here, Marge.
16 So with respect to whether or not the presence of the
17 lower-cost setting is sufficient to drive utilization, that
18 is very much an open question, and there is some research
19 that suggests that an ASC comes into a market and it's not
20 necessarily siphoning off services from a higher-cost
21 setting but it's actually inducing additional utilization.
22 So that's one issue where the data is not completely clear.

1 Then with respect to whether or not you want to
2 set hospital outpatient department payment rates at the
3 level of the lower-cost setting, that is something we have
4 contemplated in the past. It's been several years ago now.
5 We did not bring this to a formal, you know, recommendation
6 for a vote in front of the Commission. But the issue here
7 that we need to be sensitive to is that ASCs are not
8 uniformly available in all parts of the country, and so if
9 you set the OPD rates at a level that might work in
10 Maryland and not compromise access that could be a disaster
11 if you tried to do the same thing in Nebraska or a state
12 where there are no ASCs as alternative, lower-cost settings
13 for these services. So we would want to be careful about,
14 you know, reducing OPD rates to an ASC level of payment.
15 DR. CROSSON: Dana.
16 DR. SAFRAN: Thanks. So I'm in support of both
17 recommendations as written. You know, I think the point
18 that Brian raised, you know, is, of course, one that we
19 should be thinking about, but I think we've had enough
20 other conversation here about the uncertainty of whether
21 the volume -- whether the additional volume that we see is
22 appropriate. A complete lack of information about what the

1 costs are, and so whether an addition 2.6 percent is
2 actually needed to support the cost structure. The last
3 thing we want to do is drive up the cost structure by
4 driving up the rates.
5 And also the lack of data to help us compare
6 quality across the setting, compels, I think, from my
7 perspective, just to hold off, get a broader view of this.
8 And, you know, assuming things look as we, you know, little
9 bits of data tell us they might look, let's think about how
10 we can confidently try to put incentives in place to move
11 care from hospital outpatient to ASC where that is
12 appropriate.
13 And one mistake I'll just mention that we don't
14 want to make, that was made by Massachusetts policymakers
15 was to say that ASCs had to be tied to a hospital. So
16 enough said there.
17 DR. CROSSON: Okay. So I had Pat, and now
18 Jonathan, Bruce, and Paul -- Pat? I'm sorry.
19 DR. PAUL GINSBURG: Just to save us time to say
20 that the way David said it is perfect for me.
21 DR. CROSSON: Okay. Adding quality. Is that
22 right? Now I'm confused. All right. So I've got Pat,

1 Paul is off, Jonathan, and Bruce. Right?
2 MS. WANG: I'll be brief. I support the
3 recommendations as written. I think the part of the
4 statement that I agree with David, because David, you know,
5 had a lot of substance in his comments, and as a general
6 principle I agree with what David says.
7 But just to sort of put a period at the end of
8 the sentence that, you know, there's no reason -- I don't
9 think we should tolerate that a sector doesn't submit cost
10 information and the fact that we're even talking about a
11 2.6 percent update, which is kind of substantial, you know,
12 in the absence of real cost information and, you know, the
13 transparency of what's going on and whether it's good, bad,
14 or indifferent is a problem for me. Even if there were
15 cost data, I don't think that there is at all enough
16 information to say that we should induce additional volume
17 in the centers and that there actually would be a
18 substitutive effect for hospital outpatient departments. I
19 don't think that we know nearly enough about that. The
20 fact that Medicare beneficiary access where the ASCs are
21 located seems to be good and increasing suggests that
22 there's not a problem with the current payment rate. So I

1 think the recommendations are very appropriate.

2 DR. CROSSON: Jonathan.

3 DR. JAFFERY: Thanks. I am also supportive of

4 both recommendations, and I won't reiterate it for the

5 reasons that have just been said. The lack of cost data is

6 very frustrating so I'm sure those of you who have been

7 sitting through this multiple years must be extremely

8 frustrated.

9 The only other comment I wanted to make was to

10 respond to something I think Brian had said a little bit

11 ago about this group of providers, maybe their

12 entrepreneurship and encouraging that in looking forward

13 towards two-sided risk models. And I guess I'm fairly

14 skeptical at this point, that these providers will have the

15 same level of sort of entrepreneurship. I think the risk

16 is very different if you're talking about jumping into a

17 volume-driven model of care delivery than a two-sided risk

18 model that's based on different outcomes, financial

19 outcomes.

20 DR. CROSSON: Thank you. Bruce.

21 MR. PYENSON: I support the recommendations but

22 as someone who works with claims data, and has for years,

1 the cost report issue has been -- throughout the health
2 care system has been troubling because of the dominance of
3 charge master that vary from one organization to the next.
4 And that's a legacy of Medicare cost reports for decades
5 and decades. And it would be a real shame if we don't take
6 this opportunity to say a little bit about what sort of
7 cost reporting we want.
8 And a simple way to do that, which I've mentioned
9 in the past, is to have a universal charge master, that
10 everyone is an ASC uses the same charge master. Now they
11 can negotiate whatever they want with private payers and so
12 forth, but to have that in place, that would be, in my
13 opinion, a great thing for hospitals, for the Medicare
14 system to force on hospitals as well.
15 But that's a bigger job. We have a clean slate
16 here so let's get it right. Let's not repeat, you know,
17 this nightmare of cost report accounting that dominates so
18 much of the data that we have to deal with. So I'd really
19 like to see if we could get a phrase or a sentence or two
20 on that into the recommendation. I see a few nodding
21 heads.
22 Just to pick up on, I think Kathy made a really

1 excellent point on the appropriateness guidelines that are
2 already in place. And since colonoscopies are a really big
3 item here, and probably most of them are screening, and
4 there are definitely guidelines for how often colonoscopies
5 should be repeated, if you're going to follow up on Kathy's
6 suggestion, if you could ask someone at CMS if they
7 actually tabulate that data. Like if it's supposed to be
8 10 years between colonoscopies when someone is not high
9 risk, if they actually look back in the data. Maybe a
10 question or two. Thanks.
11 DR. CROSSON: Okay. Thank you. Good discussion
12 again. We're going to need to move on.
13 I would like to summarize. I think there are two
14 issues on the table here. The first is we do not have
15 unanimity in support of the recommendations. Therefore, on
16 that criterion, we will bring this back for further
17 discussion in January.
18 Secondly, there have been some suggestions --
19 MR. PYENSON: I thought it was unanimous.
20 DR. CROSSON: No. I've got two Commissioners --
21 unless -- let me ask Jon and Brian to state their positions
22 then.

1 DR. PERLIN: I said I had some ambivalence for
2 the reasons mentioned but I'm supportive.
3 DR. CROSSON: Okay. Brian, you --
4 DR. DeBUSK: And I had mentioned, you know,
5 trying to weigh not filing the cost report data versus the
6 update. If my fellow Commissioners feel that the absence
7 of cost data outweighs, then I'm on board. So I'm a yes
8 vote.
9 DR. CROSSON: Okay. Brian, in all honesty I
10 think that's where we would end up in January, to be frank.
11 Yeah, Jonathan.
12 DR. PERLIN: I do think, though, that we heard a
13 pretty good signal about the importance of quality
14 measures, so we have some further work to do on that.
15 DR. CROSSON: We did. We did. Sorry. Without
16 objection, I'm going to suggest that -- and we had two
17 suggestions for improving the second recommendation, yours,
18 Bruce, and then the more common one with respect to adding
19 quality to that. So I'm going to ask the staff, Jim and
20 the staff, to consider, without objection, adding to the
21 second recommendation, to the extent that it's feasible, so
22 that you can come back and say -- and I realize time is

1 short, but if there are some general thoughts about how to
2 improve quality reporting, and if you, perhaps in
3 discussions with Bruce, can come to a conclusion that it
4 would be appropriate to add universal to that notion, then
5 we would do that in January. We would come back with the
6 same first recommendation, perhaps a slightly amended
7 second recommendation, and if I hear no objection to that,
8 that's what we'll do.
9 DR. DeSALVO: And to merge in the quality
10 measurement with cost --
11 DR. CROSSON: It would be --
12 DR. DeSALVO: -- and accountability.
13 DR. CROSSON: And again, I'm making it up on the
14 spot, but it would be to require cost reporting and then to
15 potentially require more advanced quality reporting.
16 Because I think that's the suggestion I heard. David, is
17 that right? Karen?
18 DR. GRABOWSKI: Yes.
19 DR. CROSSON: Karen, is that troubling?
20 DR. DeSALVO: Yeah. It's not troubling. It's
21 about accountability and it's important. I just wouldn't
22 want -- I think the cost seems to be such an important

1 issue in and of itself I just wonder if there's -- if there
2 is a recommendation which also is about developing quality
3 measures that allow for comparability between types of
4 service and for outcomes.
5 DR. CROSSON: You're saying separate
6 recommendation.
7 DR. DeSALVO: Add a third.
8 DR. CROSSON: A third recommendation.
9 DR. GRABOWSKI: I like that suggestion of
10 separating them out.
11 DR. MATHEWS: So if I can get in here for a
12 second. So, one, I don't think we will have difficulty
13 reflecting the collective discussion here in the next draft
14 of the chapter. So to the extent we want to highlight
15 issues related to the kinds of costs that we think would be
16 beneficial to collect we can do that. We can also
17 emphasize the need for robust and comparable quality
18 information that would allow us to assess meaningful
19 differences between ASCs and OPDs. We can do all of that
20 in the narrative underlying the discussion, and to the
21 extent we need to enhance what we've got now I don't think
22 that's going to be a problem.

1 I am a little concerned about being extremely
2 specific about inserting the word, say, "via a universal
3 charge master" in the bold-faced recommendation language.
4 I would be hesitant to tie the Secretary's hands in a way
5 that -- speaking only for myself -- I wouldn't necessarily
6 understand the downstream implications of. And so my
7 preference -- speaking only for myself and the staff --
8 would be to be at this level of generality with respect to
9 the cost reporting recommendation.
10 And then with respect to a bold-faced
11 recommendation on quality, I'd like to reserve the right to
12 determine whether or not that's feasible to come back in
13 January. I think there's going to be some analytic work
14 that we would need to do, and I just can't guarantee we can
15 do that in the next, you know, basically three weeks.
16 There is also a question -- and this is for you,
17 collectively, to adjudicate. We typically do have a two-
18 times rule when we present recommendations for the
19 Commission's consideration, and this would be one that we
20 would be making out of whole cloth. And what you should be
21 hearing here is some skittishness on my part about making a
22 substantial recommendation along these lines for a vote in

1 January, which, in effect, is tomorrow for present
2 purposes.
3 So I can commit to a more robust discussion in
4 the text. I would like some leeway in terms of what we can
5 do with respect to bold-face recommendations.
6 DR. CROSSON: Kathy.
7 MS. BUTO: I support Jim on this because I think
8 this bears more discussion, not just -- the term "quality"
9 has a lot of appeal but I don't know exactly what people
10 are talking about. I would add to that the appropriateness
11 issue that Dana initially raised. I'd like a little more
12 discussion about whether we think CMS ought to step up to
13 the plate more and provide more guidance in that regard, on
14 the front end, not just measure quality either process or
15 outcomes on the back end.
16 So I think this bears a little more discussion
17 before we take it on, but I think there can be a strong
18 statement of our intent to take it on without having a
19 specific recommendation. It's just very tough to imagine
20 our recommending anything on quality except a process at
21 this point, because there's not even cost data for ASCs.
22 So, anyway.

1 DR. CROSSON: Okay. So I think the approach here
2 will be to add robustness to the text, based on the
3 discussion, and we will come back in January with an
4 attenuated presentation, as we have. Because I think I see
5 now support for that, so that's what we'll do.
6 Okay. Thank you, Dan and Zach. I appreciate it.
7 Don't go far. You're up for the next one as well.
8 [Pause.]
9 DR. CROSSON: Okay. We are going to move along
10 now to a discussion about hospital update for inpatient and
11 outpatient services. I will presage a little bit by saying
12 that, particularly for some of our guests who are
13 interested in hospital payment, this particular December we
14 will be addressing hospital payment overall in two parts:
15 in this discussion, and then in the discussion that
16 immediately follows lunch. However, this presentation will
17 be given by Zach, Stephanie, and Jeff, and Dan's name is
18 there, but I think he ran for the hills or something. I'm
19 not sure. So who's going to start? Zach?
20 MR. GAUMER: Yes, sir. All right. Well, good
21 morning again. This session will address issues regarding
22 Medicare payments for short-term acute-care hospitals. In

1 this session we'll cover both hospital inpatient and
2 outpatient payments, and we'll discuss whether payments are
3 currently adequate.
4 As a part of this, we'll provide you with the
5 Chairman's draft recommendation for updating hospital
6 payment rates for 2020.
7 In line with MedPAC's common framework, we
8 examine beneficiaries' access to care, providers' access to
9 capital, and the quality of care provided in hospitals. We
10 also examine hospital payments and costs, including
11 Medicare and efficiency provider margins in 2017 and
12 projected Medicare margins in 2019.
13 But before we jump into the adequacy structure,
14 we want to touch up a general trend in Medicare hospital
15 spending. As you can see on the bottom row of this table,
16 in 2017 Medicare fee-for-service hospital spending totaled
17 $190 billion, and from 2016 to '27, hospital spending per
18 beneficiary increased 4.3 percent.
19 The components of this growth include a 2.5
20 percent increase in inpatient spending, an 8.4 percent
21 increase in outpatient spending, and an anticipated decline
22 in uncompensated care payments.

1 For context, the growth observed in inpatient and
2 outpatient spending from 2016 to '17 was more rapid than
3 the average annual growth over the last decade.
4 Access to hospital care is good, and we do not
5 see any specific problems that would affect beneficiaries'
6 access to care.
7 On the inpatient side, service use per
8 beneficiary increased in 2017 by 0.7 percent, and this
9 follows several years of declining inpatient volume. One
10 driver of the inpatient growth was a relatively large
11 increase in inpatient cases with short inpatient length.
12 On the outpatient side, service use per
13 beneficiary also increased in 2017 by 0.7 percent. But
14 different from the inpatient side, this follows several
15 years of more rapid increases in outpatient service use,
16 and this slowdown is in part due to the flattening of
17 growth in ED and observation visits. However, two of the
18 drivers of outpatient growth this year were increases in
19 the number of clinic visits and Part B drug administration.
20 While the volume of Part B drugs increased,
21 spending related to Part B drugs was the largest source of
22 growth in the hospital outpatient setting this year. As we

1 told you earlier, overall hospital outpatient spending grew
2 in 2017 by 8.4 percent, and this amounts to a $4.9 billion
3 increase in one year. Approximately $2 billion of this
4 one-year increase was for separately payable outpatient
5 drugs.
6 In other terms, this is 40 percent of the total
7 increase in hospital outpatient spending. And over a
8 longer term, from 2012 to 2017, spending on separately
9 payable outpatient drugs increased by $6 billion. This
10 increase in drug spending is largely driven by two things:
11 higher prices on existing drugs such as cancer drugs and
12 growth in the use of new drugs, which are common referred
13 to as "pass-through drugs." From 2016 to '17, spending on
14 pass-through drugs increased by $1 billion.
15 While drug spending has increased, we also
16 observed that at 340B hospitals, outpatient drug revenues
17 exceeded costs, and what this means is that hospitals
18 profited from the increase in Part B drug spending.
19 Other measures also suggest access to hospital
20 care is good. The excess inpatient capacity observed in
21 prior years persists. In 2017, the number of hospital
22 closures declined, as did the number of hospital openings.

1 In a reversal of trends, more of the closures that did
2 occur in 2017 were urban rather than rural.
3 Hospital occupancy rates remain low, but did not
4 increase -- but did increase slightly, excuse me, in 2017.
5 The aggregate hospital occupancy rate in 2017 was 62.5
6 percent and in rural hospitals 40.2 percent. And, overall,
7 this means that many inpatient beds go unfilled and excess
8 capacity in rural areas is more pronounced.
9 We also believe hospitals maintain a financial
10 incentive to serve Medicare beneficiaries because the
11 average marginal Medicare profit or the profit made from
12 serving one additional Medicare beneficiary in 2017 was 8
13 percent.
14 Hospitals' access to capital remains strong, and
15 this is apparent in several different measures that we look
16 at.
17 The level of nonprofit hospital bond issuances in
18 2017 was consistent with the prior year, and relatively
19 high, suggesting that hospitals have reasonable access to
20 capital through the bond markets.
21 Construction spending in 2017 was also consistent
22 with the prior year. Hospitals spent $24 billion improving

1 facilities or expanding, and the hospital industry does
2 remain focused on building outpatient capacity right now.
3 Mergers and acquisition activity within the
4 hospital industry remains strong. In the reading
5 materials, we mention the private equity acquisition of
6 Lifepoint recently, but also large hospital systems that
7 are national are active in recent years acquiring smaller
8 hospitals.
9 Financial statistics pertaining the hospitals'
10 entire book of business may provide the strongest evidence
11 of the industry's general access to necessary capital.
12 In 2017, hospital all-payer margins were 7.1
13 percent, and both operating margins and a common measure of
14 cash flow, EBIDTA, increased from 2016 to 2017.
15 We have plotted these three all-payer financial
16 statistics on a chart so you can see the stability of these
17 three trends. Total all-payer margins, identified by the
18 green line in the middle, increased from 6.4 percent to 7.1
19 percent in the last year, and 7.1 percent is a relatively
20 high number compared to past years, as you can see.
21 The blue line on the bottom represents operating
22 margins, which includes revenues and costs from all

1 hospital operations, but excludes income from investments
2 and endowments. And operating margins were up slightly in
3 2017, but remain higher than levels observed earlier in the
4 decade.
5 The white dotted line at the top represents the
6 EBIDTA, the measure of hospital cash flow, as I mentioned.
7 And here we see a slight increase in 2017, and we interpret
8 this as generally improved stability.
9 So taken as a whole, the three measures
10 demonstrate sustained growth and indicate that hospitals
11 continue to grow their private sector revenues faster than
12 their costs.
13 Okay. So let's shift gears to quality of care
14 provided at hospitals. In 2017, we observed an improvement
15 in hospital quality. As you know, we view hospital quality
16 through the lens of patient experience, readmissions, and
17 mortality rates.
18 The share of patients rating their overall
19 hospital experience a 9 or 10, on a 10-point scale,
20 improved slightly, increasing to 73 percent in 2017.
21 All-condition 30-day non-risk-adjusted
22 readmission rates in 2017 remained lower than in 2012,

1 coming in at 15.8 percent. And then all-condition 30-day
2 risk-adjusted mortality rates are also declining. In 2017,
3 the mortality rate was 6.4 percent, lower than observed in
4 2012.
5 And I also want to note that we observed a
6 decline in raw or non-risk-adjusted mortality rates over
7 this period. And because inpatient volume was declining
8 over this period, too, and fewer people were using the
9 hospital, this may underscore the improvements we're seeing
10 in mortality rates.
11 And now to Stephanie.
12 MS. CAMERON: So let's talk about margins. We
13 assess the adequacy of Medicare payments for hospitals as a
14 whole, including Medicare payments across all patient care
15 services and uncompensated care. We compare these payments
16 to the allowable cost of providing services to Medicare
17 fee-for-service beneficiaries.
18 Using the most recently available data, we find
19 that the overall Medicare margin continues to trend
20 downward, falling from negative 9.7 percent in 2016 to
21 negative 9.9 percent in 2017. The decrease in the overall
22 Medicare margin starting in 2014 was not unexpected given

1 several payment adjustments required by statute. These
2 adjustments include: reductions to the annual payment
3 update; adjustments for documentation and coding
4 improvement; decreases in incentive payments for the
5 adoption of electronic health records; and decreases in
6 uncompensated care payments that correspond with increases
7 in the insured population.
8 While the average overall Medicare margin was
9 negative 9.9 percent in 2017, excluding critical access
10 hospitals, rural hospitals had a negative 8.2 percent
11 overall Medicare margin, which was 1.8 percentage points
12 higher than the negative 10 percent margin for urban
13 hospitals.
14 Major teaching hospitals had an overall Medicare
15 margin of negative 9 percent, which is higher than the
16 margin for the average IPPS hospital in large part because
17 of the extra payments they receive through IME.
18 As in prior years, for-profit hospitals had the
19 highest overall Medicare margins, well above the overall
20 Medicare margin for nonprofit hospitals, but still negative
21 at negative 2.6 percent.
22 Now let's turn to our relatively efficient

1 providers where we identify a set of hospitals that perform
2 relatively well on both quality of care and cost measures.
3 Looking at these hospitals' performance in 2017,
4 we find 7 percent lower mortality and 7 percent lower
5 readmissions, while keeping costs 9 percent lower than the
6 national median. Lower costs allow about half of these
7 hospitals to generate positive Medicare margins in 2017
8 with a median margin across all relatively efficient
9 providers of around negative 2 percent.
10 It is important to remember that when we talk
11 about efficiency, we are talking about quality and cost.
12 While these relatively efficient providers are spread
13 across the country and have a diverse set of
14 characteristics, they are more likely to be larger
15 nonprofit hospitals because these hospitals tend to have
16 better performance in the quality metrics we analyze.
17 We project margins for 2019 based on margins in
18 2017 and policy changes that take place during 2018 and
19 2019. We estimate that the overall Medicare margin will
20 decline from about negative 9.9 percent in 2017 to about 11
21 percent in 2019.
22 Although payment rate updates, increases in

1 uncompensated care payments, and case-mix growth will
2 increase payments, cost growth is expected to be larger
3 than the payment updates. The update is equal to the
4 expected input price inflation, less an adjustment for
5 productivity and an additional downward adjustment mandated
6 by the ACA. The net is a 2.7 percent increase from 2017 to
7 2019. We expect the margin to decline due to expected cost
8 growth of about 5 percent over two years on a case-mix-
9 adjusted basis.
10 In summary of our payment adequacy findings, we
11 find that access to care is good, access to capital remains
12 strong, and quality is improving.
13 Relatively efficient providers had a median
14 Medicare margin around negative 2 percent. There are
15 expected statutory and regulatory policy changes in 2018
16 and 2019 that reduce payments to hospitals. If current law
17 holds, we would expect negative Medicare margins in 2019.
18 That said, we expect hospitals to continue to
19 have a financial incentive to see Medicare patients because
20 we project that Medicare revenues will continue to exceed
21 marginal costs in 2019.
22 This slide shows the estimated update for

1 inpatient and outpatient rates for 2020, which would be 2.8
2 percent if the current estimates of the market basket and
3 productivity remain at 3.3 percent and 0.5 percent,
4 respectively. I want to note that the 2020 net update is
5 expected to be the highest in a decade as this will be the
6 first year since 2010 that hospitals have not received an
7 additional downward adjustment to the update factor that
8 was specified in law.
9 Based on this payment adequacy analysis, the
10 Chairman's draft recommendation seeks to balance several
11 imperatives. This includes maintaining pressure on
12 providers to constrain costs to improve long-term program
13 sustainability, minimizing differences in payment rates
14 across sites of care consistent with our site-neutral work,
15 rewarding high-performing hospitals, and moving Medicare
16 payments toward the cost of efficiently providing high
17 quality care.
18 Clearly, there are tensions between these
19 objectives that require a careful balance that is sought in
20 the Chairman's draft recommendation.
21 With this in mind, the Chairman's 2020 draft
22 hospital recommendation is in two parts. You will see the

1 update portion now and the second part, which includes
2 hospital value incentive payments, after lunch today.
3 With that, the Chairman's draft recommendation
4 reads: For 2020, the Congress should update the 2019 base
5 payment rates for acute-care hospitals by 2 percent. The
6 difference between this update and the amount specified in
7 current law should be used to increase payments in the
8 hospital value incentive program.
9 To be clear, this is the first part of the
10 Chairman's draft recommendation and is intended to be
11 implemented in a budget-neutral manner such that, in
12 aggregate, hospitals receive payment increases equivalent
13 in dollars to the entire current law payment update.
14 Therefore, from this part of the recommendation, we expect
15 no impact on program spending or on beneficiaries or
16 providers.
17 Beneficiaries maintained good access to care and
18 providers continued to have strong access to capital, while
19 quality improvement continued, despite negative Medicare
20 margins for most providers. The 2 percent update with
21 additional increases directed to the hospital value
22 incentive program balances the need to maintain fiscal

1 pressure on hospitals to control their costs and the need
2 to have payments high enough to maintain access to care at
3 high quality providers.
4 Because of the growing payment rate differential
5 between freestanding physician offices and offices on a
6 hospital campus, site neutrality for similar outpatient
7 services across settings should be a priority.
8 As I mentioned, Ledia's presentation after lunch
9 will discuss the implementation of the hospital value
10 incentive program in a manner that is intended to further
11 increase payments to acute-care hospitals. While you will
12 be discussing the Chairman's draft recommendation during
13 that session, if agreeable, we will anticipate both
14 portions of the recommendation be presented together in
15 January.
16 And with that, I turn it back to Jay.
17 DR. CROSSON: Thank you, Stephanie, Zach, Jeff.
18 We'll now proceed to clarifying questions. Bruce.
19 MR. PYENSON: A couple of questions. In the
20 introduction you note there's 4,700 hospitals. Are you
21 aware of any of those that in recent years have decided to
22 not participate in Medicare?

1 MR. GAUMER: No, I don't think we've had any
2 indication -- we all look at different stuff, but I don't
3 think we've had a big push on that at all.
4 MR. PYENSON: Thank you. My next question is on
5 Slide 12. This is the efficiency study. In the first row
6 of numbers there, the number of hospitals in this study is
7 about 2,151, adding the relatively efficient and the other
8 hospitals. And I realize that you've excluded about 54
9 percent of the hospitals that participate in Medicare from
10 the analysis. And I think one of the exclusions was
11 critical access hospitals and others.
12 It seemed as though rural hospitals had a higher
13 -- or the non-urban hospitals might have had a higher
14 margin. Do you think the excluded hospitals actually have
15 better financials than this sample?
16 DR. STENSLAND: They might have slightly better
17 financials, especially if you include the critical access
18 hospitals, but the critical access hospitals are paid on
19 their costs, and they're not paid on the rates that we're
20 discussing adjusting.
21 DR. PYENSON: Okay. Thank you. I recall that
22 you had explained that in the text as well.

1 My last question is on Table 6 of the reading
2 materials, and this is the risk-adjusted 30-day post-
3 discharge mortality rates. They've declined relative to
4 expected mortality.
5 Going from 2012 to 2017, the expected mortality
6 went up by about 25 percent, which is huge. What do you
7 think is going on with that? Why did expected mortality go
8 up that much in a few years?
9 DR. STENSLAND: I think the optimistic way to
10 look at it, there was about a 20 percent -- over a 20
11 percent decline in the number of admissions per capita. So
12 this would suggest that the easier cases probably aren't
13 being taken on an inpatient basis, and if you look at the
14 overall unadjusted, risk-adjusted mortality number, it's
15 about flat. So we have fewer people entering the hospital,
16 and amongst those that enter the hospital, about the same
17 percentage die. So the good news is fewer people are going
18 to the hospital and dying. So that's one reason. You
19 could say that maybe the people are getting sicker because
20 fewer cases are entering the hospital.
21 Part of it could also be coding. It would be
22 really difficult for us to try to distinguish exactly how

1 much would be coding and how much would be the easier case
2 mix because it depends on actually what goes in the medical
3 record and what does the physician put down. So that would
4 be a difficult task.
5 But I think the general direction, I think we can
6 be pretty comfortable with, given the flat un-risk adjusted
7 combined with the big decline of share of people going into
8 the inpatient setting.
9 DR. PYENSON: Thank you very much.
10 DR. CROSSON: Jon, Amy, Paul, Jonathan, Kathy.
11 DR. CHRISTIANSON: Okay. This is a question
12 clarification for Jeff because he looks disappointed that
13 he wasn't able to present today.
14 [Laughter.]
15 DR. CHRISTIANSON: So the data, again, sort of
16 raises the issue that clearly there's much higher profit
17 margins, if you will, retained earnings for the non-
18 Medicare business for hospitals, and we're often told by
19 hospitals that the reason those margins are so high is
20 because Medicare margins are low, and therefore, they need
21 to have higher margins from the non-Medicare sector.
22 But the Commission -- I think your work and also

1 the economic studies I'm aware of kind of come up with a
2 different logical sequence here, and this might be a good
3 time, since this data show up here again, to kind of run
4 through how the Commission views those differences.
5 DR. STENSLAND: Well, traditionally, what they
6 would call the other way of looking at it would be the
7 cost-shift model. They would say if commercial rates go
8 up, then the providers will ask -- or if Medicare rates go
9 up, the providers will ask less from their commercial
10 payers. If Medicare rates go down, they will ask more from
11 their commercial payers. That's the general cost-shift
12 idea. If we don't get it from Medicare, we have to get it
13 from somewhere else.
14 And one of the key factors in there is the idea
15 that there is some money left on the table. The idea is
16 that we do have the financial power or the market power as
17 a provider to demand higher rates, but we're not going to
18 do it because Medicare pays it enough. So we're going to
19 leave that money there.
20 I think mostly this is an empirical question,
21 which is the good thing. So then you look at, well, what's
22 happened when people have seen a decrease in their Medicare

1 rates or an increase in their Medicare rates. What
2 generally happens? What we generally see is that then
3 their costs move.
4 There was a recent study by Zack Cooper when he
5 looked at what happens when we see an increase in certain
6 hospitals' payment rates, and what we see is certain
7 hospitals got big increases through the 508 program when
8 that was implemented into law, and then we said, "Well,
9 what happened to them?" And they hired more staff and
10 bought more equipment, and there were some salary
11 increases.
12 So it looks like it wasn't a situation where they
13 said, "Okay. I got more for Medicare. I'm going to call
14 up Blue Cross and say you can pay me less this year." That
15 isn't what happened.
16 When we looked at our studies, when we looked at
17 the data before, we tried to look at, well, let's look at
18 these hospitals that appear to be getting strong rates from
19 their private insurers. How do they compare to the people
20 that tend to get lower non-Medicare revenue, which you talk
21 about in the report?
22 Generally, we see there's a cost differential

1 there. That those that are under financial pressure due to
2 having low non-Medicare revenues tend to have lower costs.
3 Those that have higher non-Medicare revenues, maybe strong
4 private payer rates or lots of private payers in the
5 commercial world, they tend to have higher costs. And
6 there's a limitation to how much that differential is, but
7 that's our general perspective in a nutshell is it looks
8 more like that we have payments following costs as opposed
9 to -- or costs following payments as opposed to having the
10 cost of the provider being immutable and then them
11 determining the payments.
12 DR. CHRISTIANSON: So, in that scenario, there's
13 a high strategic component to what the cost base is, which
14 plays into the large calculations as well?
15 DR. STENSLAND: That is the idea behind the
16 relatively efficient provider margin and the average
17 margin. What we also show in our report every year is what
18 is the margin for hospitals under pressure versus those
19 that are not under pressure, and we see that when the
20 hospitals are under financial pressure, they have lower
21 costs and better Medicare margins. They're still not
22 positive this year, but they are better.

1 DR. CHRISTIANSON: One more thing, didn't you do
2 some recent work too, or the staff, on the portion of
3 hospital costs that are in fact variable versus fixed?
4 DR. STENSLAND: Yeah. We did look at that a
5 couple of years and we looked at it a couple different
6 ways, through a cost accounting way and also through some
7 regression analysis, and what that generally showed was
8 that in terms of how much can the cost vary as volume
9 varies, and we said over a one-year period, it appears that
10 about 80 percent of the costs for an average size hospital
11 or a large hospital can vary with volume, meaning that if
12 the hospital knows our volume is going to go down over the
13 next year or they expect to have a lower volume, then they
14 can lower staffing, and they can reduce 80 percent of those
15 costs due to the lower expected volume. Twenty percent of
16 it is going to be fixed, things like your building and your
17 interest and stuff like that.
18 DR. CHRISTIANSON: So that's a larger number than
19 I think we were used to seeing in the literature?
20 DR. STENSLAND: I divide the literature into two
21 different groups. I think there's kind of the industry
22 literature, which is kind of more the hospital

1 administrator physician kind of perspective of saying these
2 costs are all fixed. And in their mind, sometimes they
3 say, "Well, I'm going to assume that all my labor is
4 fixed."
5 Then there is more kind of the economist-type
6 perspective of saying, "Well, look what happened, actually
7 happened to costs when volume changed." And we can say
8 when the volume changes, the costs go down, and it goes
9 down as much as you would expect if about 80 percent of the
10 costs were variable. So it's kind of an empirical
11 standpoint versus more of an intuitive standpoint, and it's
12 also a feeling of whether you want to assume that labor is
13 fixed or not. And I think we show empirically it doesn't
14 look like it really is.
15 DR. CHRISTIANSON: Okay. Thanks.
16 DR. PERLIN: May I on this point --
17 DR. CROSSON: On that point.
18 DR. PERLIN: Thanks.
19 Well, wearing a hat in each camp, health services
20 researcher as well as clinician administrator, both may be
21 true. The problem is that while things may be
22 theoretically variable, that's destabilizing.

1 I think that some more quality metrics, more
2 experience metrics, or staff experience metrics may
3 actually be more instructive in this area in terms of
4 understanding the destabilization.
5 Clearly, I published on those large-scale studies
6 of the variation between staff experience and patient
7 experience, and one of the biggest predictors of staff
8 experience is the volatility of the environment.
9 So I just want to note that because I think both
10 are potentially simultaneously true, and I think we
11 simultaneously have to be appreciative of the unintended
12 consequences in terms of the intent of our support of
13 Medicare.
14 DR. CROSSON: Jon, in this context, can I ask you
15 to explain destabilization?
16 DR. PERLIN: Yes. Let's play this out in a very
17 concrete manner. Let's say that -- take a hospital that
18 has seasonal differences. Take a hospital in an area of
19 the country where a factory has closed, et cetera, where
20 you begin to take staff, move them around all of a sudden.
21 Nurses, for example, the thing that is most
22 destabilizing to a constant nursing workforce is call-offs,

1 say, gee, our volume isn't just here, so all of a sudden --
2 and then inadequate shifts, and then all of a sudden, the
3 people who used to be your sort of fixed base of cost and
4 constant employees leave. Who leaves first? Best
5 employees.
6 What happens behind that is that you actually get
7 -- it would be interesting, the empirical data on this, but
8 I can tell you from some degree of experience that you
9 backfill them with alternative mechanisms like contract
10 labor, which tends not only to be more expensive but less
11 versed in the particular specialties of particular units.
12 All of a sudden, you have newborn intensive care nurses
13 cross-covering on adult intensive care, as an example, or
14 individuals who just don't know the hospital systems,
15 electronic records and the like.
16 So, in very practical terms, that's what I mean
17 by destabilization.
18 DR. CROSSON: Essentially, you're saying
19 workforce destabilization.
20 DR. PERLIN: Yes, indeed.
21 DR. CROSSON: Okay.
22 DR. PERLIN: Thanks.

1 DR. CROSSON: Thanks.
2 Amy.
3 MS. BRICKER: I wanted to chat a moment about
4 340B. It's referenced in the material, in the presentation
5 today. I'm curious as to our insight into the hospitals
6 that benefit under current 340B policy, not new proposed
7 policy from the 340B program, and the impact of the prior
8 policy on those margins and then, conversely, now with the
9 modifications to the 340B program and the impact to those
10 hospitals.
11 I know there's mention that there's some
12 offsetting associated with that policy to other services
13 and programs, but do we believe as a Commission that it is
14 a one-for-one or the impact to that?
15 Oftentimes, the benefit of the 340B program shows
16 up on the commercial payer less the Medicare payer, but
17 there's been a dramatic reduction in associated payments
18 associated with those products and therefore those
19 institutions.
20 So I'm curious as to the insight that you all
21 have on that change, current and then projected impact.
22 DR. STENSLAND: Okay. So the 340B, the data that

1 we're looking at is 2017 margin data, and at that point,
2 the GAO -- Dan can correct me if I'm wrong -- had estimated
3 something like a 30 percent discount. We're going to use
4 30 percent as a ball park.
5 If you're getting a new pass-through drug and it
6 costs $100,000 as the average sale price and you're getting
7 it for 70, so you have some margin there, and we're going
8 to see two things in the data you've been there. One,
9 you're going to see an increase in spending because you
10 have these new expensive drugs. Next, you're going to see
11 a little bit of improvement in the outpatient margin at the
12 hospital because they got that spread. That's the old
13 policy.
14 And the new policy is they were saying, "Well,
15 we're going to start paying people -- they're going to get
16 a rate of 22 percent below the average sale price." Is it
17 22? All right. Now they're going to get paid a lower rate
18 than they're used to. They're not going to get that full
19 spread of 30 percent. There still might be a little
20 spread, but it's not going to be so big.
21 So what you're going to see then is the
22 profitability of the drugs is going to go down a little bit

1 -- or down quite bit, but they did it in a budget-neutral
2 manner. They said, "We're going to pay this much less for
3 drugs, and we're going to take all this money. And we're
4 going to spread it out amongst all the other outpatient
5 services," whether that's a clinic visit or an x-ray or
6 whatever else. So the profitability of all those other
7 things is going to go up a little bit.
8 In essence, in the end, you're not going to see a
9 big change from that effect on the overall hospital margin
10 because that's really done budget-neutral in terms of what
11 the hospitals are getting, but you're going to see a little
12 bit of a shift in that the 340B hospitals will be getting a
13 little less. The non-340B hospitals will actually be
14 getting a little more because everybody is going to benefit
15 from that increased payment for the E&M visit or the x-ray
16 or whatever, where they're taking that 340B money and
17 spreading it amongst everything else.
18 MS. BRICKER: So I know in theory, that's how it
19 was crafted. I don't know if actually in practice if
20 that's how it played out, meaning that the hospital feels
21 budget-neutral, to use your word. Just given the reaction
22 in the market, it doesn't feel as though that's how the

1 hospital administration is sensing it play out.
2 In addition, what about the impact of 340B, not
3 on the Medicare program, but that of commercial? So that
4 when you're able to acquire a drug at a 340B rate, yet be
5 compensated at the commercial rate for your commercial
6 population, that's a tremendous value to those hospital
7 systems. We don't really talk about that.
8 So I think it was mentioned previously, if
9 there's a way for us to consider all of the value that a
10 hospital is receiving from a federal program, I think it
11 would be worthwhile. I don't know how hard. It seems kind
12 of hard, but if there's a way for us to bring that to
13 light, I think it allows the Commission some insight so
14 that we're making these recommendations with a full picture
15 of the value that many federal health care programs are
16 bringing to bear.
17 DR. CROSSON: Thank you, Army.
18 I want to make one point. This is a hospital
19 update session, but it probably is useful, since part of
20 our charge is beneficiary protection, to point out the fact
21 that this change is going to dramatically reduce
22 beneficiary costs for these drugs because part of the

1 problem that we addressed as a Commission when we made our
2 recommendation, which is different from what's being
3 implemented right now, was concern that beneficiaries were
4 being charged co-payments based upon cost that the
5 hospitals were not paying. And that will go away.
6 Paul.
7 DR. PAUL GINSBURG: I wanted to clarify the
8 Chairman's recommendation. The way I read it here, my
9 interpretation is that the current law is 2.8 percent
10 increase, and 2 percent of the increase is going to come
11 the usual way and .8 percent is going to come through the
12 revised value program we're going to be discussing after
13 lunch.
14 But I got the impression in talking with Jim just
15 before this public session started is that there was
16 perhaps more than the .8 percent funding the value program,
17 and I think it's important that we know about that now, so
18 that we can assess this recommendation.
19 DR. MATHEWS: Sure. As Stephanie said at the
20 outset, this is one of two hospital-related recommendations
21 that we're going to discuss today.
22 The effect of the update recommendation is that

1 given a current law projected update of 2.8 percent, we
2 would give an across-the-board update of 2 percent, with
3 the remaining .8 allocated to hospitals on the basis of
4 their performance under our revised quality incentive
5 program, the HVIP.
6 This afternoon, we are going to be talking about
7 a recommendation specific to the HVIP that incorporates the
8 Commissioners' comments from our previous discussion of
9 this proposal, and it also includes a change in how we are
10 going about funding the HVIP.
11 In the past when we've talked about consolidating
12 four existing hospital quality programs, we've contemplated
13 doing that in a budget-neutral way, and those four programs
14 collectively have the effect of taking roughly a billion
15 dollars out of the hospital payment bucket.
16 What we are now contemplating is an HVIP proposal
17 that would forego those savings and put that billion
18 dollars back into hospital payment, and so the net effect
19 of these two recommendations combined would be hospitals
20 would still get the full dollar value of a 2.8 percent
21 update, although that money would be distributed partly
22 through the update and partly through the HVIP. And there

1 would be an additional, roughly billion dollars of new
2 money put into the HVIP in addition to the .8 that is being
3 re-routed.
4 DR. CROSSON: Okay. Jonathan.
5 DR. JAFFERY: Thanks.
6 This conversation about variable cost, I think is
7 fascinating and actually much more than academic in terms
8 of a lot of the issues you're talking, probably beyond the
9 scope of today's discussion.
10 But I have a two-part question related to that.
11 One is I just want to verify that when the reports talk
12 about Medicare payments covering the variable costs of a
13 patient and so continuing to be desirable for the hospital
14 to admit those patients, the first part, is that using the
15 80 percent as the variable cost? So that's 80 percent
16 variable cost. Okay. So that's good to know.
17 Then you talked a lot about the different
18 capacities. I think the average hospital capacity was 62.5
19 percent, and in rural hospitals, it was about 40 percent.
20 The benefit of Medicare payments covering variable costs is
21 dependent, to some degree, on capacity issues. So is there
22 any empirical data about hospitals that have much higher

1 capacity -- or much lower capacity, whose capacity is at 85
2 or 90 percent, and what happens as Medicare payments change
3 in those settings?
4 DR. STENSLAND: I'm not aware of any empirical
5 studies of looking at those kind of markets, like
6 Rochester, New York, where there's really high-occupancy
7 rate kind of markets, what's happening there. I think what
8 we would have to say is, on the one hand, the financial
9 incentive is not there to admit a Medicare patient if your
10 beds are all full and you could admit a commercial patient
11 rather than the Medicare patient. So the financial
12 incentive wouldn't be there.
13 But there is other concerns, certainly just good
14 practice. I think they're going to want to admit the
15 Medicare patients, and to the extent that they're a
16 nonprofit facility, if they didn't admit the Medicare
17 patients, they might lose their nonprofit status. So we
18 don't see that happening in terms of the beneficiaries not
19 receiving access. I think the only places that we've heard
20 of that weren't taking Medicare is an occasional -- there's
21 a for-profit chain of cancer hospitals, and in some cases,
22 in some places, they don't take Medicare patients.

1 DR. CROSSON: Okay. Kathy and then Jon on this
2 point.
3 DR. PERLIN: I'm just wondering how you're
4 accounting for the sort of incremental nature of variable
5 costs? I mean, you know, this strikes me as one of those,
6 in theory, theory and practice are the same, and in theory
7 and practice they're not. And the challenge here is that
8 while I would stipulate, in the long run, all costs are
9 variable, in practical terms, you know, if you discharge a
10 patient a little bit earlier, if you have patients that are
11 discharged you don't get savings until you actually have
12 one less staff member there, but don't have one less person
13 on the unit unless, you know, you've had that as a run for
14 a while, and that creates a problem.
15 So there is this sort of step-wise nature that is
16 not continuous, that's more of -- using the language from
17 our earlier discussions -- cliffed than continuous. I'm
18 just wondering if we take that into account in our
19 contemplation.
20 DR. STENSLAND: I don't think that we're saying
21 that this is all continuous. It's not like you're going to
22 get rid of one third of a nurse that day. You know, you're

1 going to have to reduce your nurse staffing by a whole
2 number.
3 But if you look at the data for the hospitals
4 where they actually saw a big drop in their volume or a big
5 increase in their volume, what happened to their overall
6 costs from one year to the next? They moved so that it
7 looks like they were able to either eliminate 80 percent of
8 their costs when their volume went down, or they moved so
9 that the cost increases for their increased volume was like
10 80 percent of what the cost was for the average cost. So
11 over that period of -- you know, you've got lots of little
12 steps but it adds up to a fixed amount.
13 DR. PERLIN: I'm sorry to ask this question.
14 This is the main question I'm going to ask. So you're
15 aware of a hospital that flexed downward by some
16 significant proportion of staff, right? I mean,
17 theoretically, as a basis for this discussion, in
18 theoretical terms, right?
19 DR. STENSLAND: Yes. When you look at the cost
20 reporting and you look at what the reported costs were, in
21 your X versus your X plus 1, and then you look at their
22 volume.

1 DR. PERLIN: Is that the first place you want to
2 send your mom?
3 DR. STENSLAND: I probably would -- I would have
4 some other indicators that I would look at besides that. I
5 would not say, "Oh, my indicator of quality is volume
6 change."
7 DR. PERLIN: Yeah.
8 DR. STENSLAND: But I wouldn't say that we have
9 any evidence to show that a lower-volume hospital -- say if
10 you have discharges of 200 patients, that you're
11 necessarily a worst hospital than someone that has 250
12 discharges.
13 DR. PERLIN: I'm not arguing the volume outcomes
14 relationship. I mean, I think there's pretty good
15 literature on that. What I am arguing is that an entity
16 that has had to reduce variable costs substantially, in a
17 unit period of time, probably is not performing at top
18 level. And for me, personally, that would not be my first
19 choice.
20 That's the nuance I'm trying to get at behind
21 these data, and that's why I say, I agree that, in theory,
22 both ends are accurate. But I think there is a sort of

1 incrementalization that, in practical terms, is
2 problematic. I see a number of heads nodding, and I think
3 those of us who have been in that clinical environment
4 understand that challenge.
5 DR. CROSSON: Okay. Let me make two points.
6 First of all, generally speaking, mothers are off the
7 table. Secondly, we'll take Kathy and then we've already
8 run out of time for the whole discussion so I'd like to
9 move on to the discussion.
10 Kathy.
11 MS. BUTO: This will be fairly quick. I was
12 trying -- on page 13 of the mailing materials we're talking
13 about the greatest factor in increased spending for
14 observation stays is the packaging of ancillary care.
15 Although we point out that that's offset by, or there is a
16 decrease in spending for those services that were packaged
17 in. Does that mean net-net, that overall spending has gone
18 up for outpatient care because of the packaging, or is it
19 just for observation stays?
20 DR. STENSLAND: I think that's generally just
21 observation stays.
22 MS. BUTO: Okay. So you'd expect that.

1 DR. STENSLAND: In large part it's an offset.
2 Yeah, you package more stuff in, you're going to expect it
3 to go up.
4 MS. BUTO: I was just trying to figure out
5 whether were against more packaging, but it doesn't sound
6 like it. Thanks.
7 DR. CROSSON: Okay. I think it's time to move on
8 to the discussion. We'll put up the recommendations. I'm
9 going to ask, as we have before, for people to express
10 their opinion about the recommendation -- in favor, not in
11 favor, why not, other ideas?
12 I will point out, though, that, as Stephanie
13 pointed out, because we're going to be combining this and
14 the second one, this will be brought back for full
15 discussion in January.
16 So comments on the recommendations?
17 [No response.]
18 DR. CROSSON: This perhaps is suggestive of
19 hunger -- I'm not sure -- or perhaps respect for our guests
20 because they haven't had a chance to make their comments
21 yet. But I will take it as it stands. We'll have more
22 discussion, as was pointed out, after lunch, and then

1 again, we'll be coming back to this total package in
2 January.
3 So thank you, Stephanie, Jeff, and Zach.
4 DR. CROSSON: We now are open for public comment.
5 Those of you who would wish to comment on the business
6 before us this morning, please come to the microphone so we
7 can see who you are.
8 [Pause.]
9 Not seeing any movement towards the microphone we
10 are adjourned until 1:30.
11 [Whereupon, at 12:31 p.m., the meeting was
12 recessed, to reconvene at 1:30 p.m. this same day.]
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2 AFTERNOON SESSION

3 [1:30 p.m.]

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

5 Okay. This afternoon we are going to continue our

6 discussion about payments to hospitals, and we're going to

7 have a discussion about the hospital quality incentive

8 program. Ledia and Jeff again -- Jeff is again here. Jeff

9 has done a lot of work today. I like to see that.

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

11 MS. TABOR: Good afternoon. In this session we

12 will continue discussions about the Hospital Value

13 Incentive Program, or HVIP. The HVIP aligns with the

14 Commission's principles for quality measurement, is simpler

15 than the current hospital quality programs, focuses on

16 outcomes, and promotes the coordination of care.

17 Today we will review the HVIP design, and a draft

18 Chairman's recommendation to implement the HVIP.

19 As a reminder, the Commission has identified

20 several issues with current hospital quality programs.

21 Primarily, aspects of the current hospital quality programs

22 do not align with the Commission's principles for quality

1 measurement. The Commission believes there are too many,
2 overlapping hospital quality payment and reporting
3 programs, which creates unneeded complexity in the Medicare
4 program and for hospitals. Also, the current programs
5 currently use condition-specific readmissions and mortality
6 measures, as opposed to all-condition mortality and
7 readmissions measures, which are more stable.
8 Some of the programs include process measures
9 that are not tied to outcomes and provider-reported
10 measures that may be inconsistently reported.
11 Finally, the programs score hospitals using
12 "tournament models," meaning hospitals are scored relative
13 to one another and not on clear, absolute, and
14 prospectively set performance targets.
15 Over the past cycle and a half, the Commission
16 has discussed replacing current quality payment programs
17 with the HVIP. In September 2017, the Commission discussed
18 key design elements of the HVIP, for example, what measures
19 to score and how to set scoring scales. In April 2018, the
20 Commission reviewed results modeling the HVIP using current
21 hospital quality data. In the June 2018 report to the
22 Congress, we published results of the modeling as well as

1 reiterated the Commission's principles for quality
2 measurement.
3 The Commission asked to continue to refine
4 aspects of the design of the HVIP, for example, the
5 weighting of measures, which we discussed this past
6 September. I will highlight the results of this discussion
7 on the next slide.
8 Throughout the past year, Commissioners have
9 supported the HVIP and asked that we continue to move
10 forward with a recommendation to the Congress. That brings
11 us to today's discussion.
12 Based on the Commission's September discussion,
13 we updated the design of the HVIP and modeling to
14 incorporate three substantive changes. First, we added
15 hospital-acquired infection rates as a measure domain,
16 based on the Commission's discussion of the importance of
17 tying infection rates to payment.
18 Second, consistent with the VBP Program, we
19 scored all 10 patient experience measures, including the
20 overall rating, as one patient experience composite rather
21 than only the overall rating of hospital care. When the
22 HVIP is implemented, CMS can refine the patient experience

1 measure domain using the federal rulemaking and comment
2 process.
3 Third, we modeled the HVIP based on both a 2
4 percent and a 5 percent withhold amount, reflecting the
5 September meeting discussion of transitioning to a higher
6 HVIP withhold over time or beginning with a withhold higher
7 than the current VBP's withhold of 2 percent.
8 In September, the Commission also discussed
9 various approaches to weighting the HVIP measure domains.
10 We presented analysis that showed small weighting changes
11 didn't have large effects on groups of hospitals.
12 Consistent with the current VBP Program, in the models
13 presented in this paper, we continued to use equal
14 weighting. When the HVIP is implemented, CMS can solicit
15 input through the federal rulemaking process regarding
16 specific weighing of the measures.
17 This brings us to the current HVIP design. To
18 improve focus and clarity, the new HVIP would be one
19 program as opposed to separate programs. As illustrated on
20 the left hand side of the slide, the HVIP would combine the
21 current HRRP, VBP, and HACRP into one program, and
22 eliminate the IQRP, which is an obsolete pay-for-reporting

1 program.

2 Looking at the right-hand side of the slide, we

3 would incorporate five existing, all-condition quality

4 measure domains into the HVIP: readmissions, mortality,

5 spending, patient experience, and hospital-acquired

6 conditions, or infection rates. Per the Commission's

7 principles, the HVIP would translate quality measure

8 performance to payment using clear, prospectively set

9 performance standards. The HVIP also accounts for

10 differences in provider populations through peer grouping.

11 Similar to the current VBP, the HVIP would

12 redistribute a pool of dollars to hospitals based on their

13 performance.

14 I will briefly review the scoring methodology we

15 used to model the HVIP, starting with how measure

16 performance is converted to HVIP points.

17 One of the Commission's principles is that

18 Medicare quality programs should reward providers based on

19 clear, absolute, and prospectively set performance targets.

20 So hospitals will know ahead of time what performance they

21 need to achieve on each measure to receive HVIP points and

22 payments. In our HVIP modeling, hospitals earn points for

1 their performance on quality metrics based on a continuous
2 scale, starting at 0 points and gradually increasing to 10
3 points. All hospitals are scored on the same scale.
4 Medicare can define the performance scale using
5 different methods. For our modeling we set the scale along
6 a broad distribution of historical data so that most
7 entities have the opportunity to earn credit for their
8 performance. A hospital's total HVIP score is the average
9 of all of its points earned across the five measure
10 domains.
11 The Commission believes that the Medicare program
12 should use peer grouping to take into account differences
13 in a provider's population social risk factors of a
14 provider's population. Based on these principles, we
15 modeled the HVIP where quality-based payments are
16 distributed to hospitals within ten different peer groups.
17 Each peer group has about the same number of hospitals and
18 those hospitals have about the same share of Medicare
19 beneficiaries that are fully dual-eligible.
20 We use the same performance-to-points scale
21 across all groups, but each peer group has its own
22 "percentage adjustment to payment per HVIP point" based on

1 the group's pool of dollars and HVIP points. Like the
2 performance-to-points scale from the previous slide, each
3 peer group's percentage adjustment to payment per point is
4 prospectively set and known by hospitals.
5 Each peer group has an enhanced pool of dollars
6 with is distributed to hospitals within the peer group
7 based on the HVIP points each hospital earns. The pool of
8 dollars will be made up of two sources. First, as we have
9 discussed, the HVIP would be built on a withhold amount
10 from each of the hospitals in the peer group. The VBP
11 currently uses a 2 percent total base payment withhold. In
12 September, the Commission discussed that the HVIP can begin
13 with a 2 percent withhold and transition over time to a
14 larger withhold, such as 5 percent. Some Commissioners
15 also supported beginning with the higher withhold amount.
16 As Stephanie discussed earlier, the second source
17 for the pool of dollars is including part of the current
18 law payment update. For modeling the HVIP, we assumed that
19 0.8 percent of the total hospital payment update, which
20 applies to both inpatient and outpatient, would be added
21 the HVIP pool. This 0.8 percent roughly translates to a
22 little more than 1 percent of inpatient spending. So for

1 your discussion we modeled hospital performance using a
2 pool of dollars based on a 2 percent withhold plus the 1
3 percent of total base inpatient spending, or a 3 percent
4 pool, as well as a 5 percent withhold and 1 percent of
5 total base spending, or a 6 percent pool.
6 In modeling hospital performance under a 3
7 percent pool of dollars, most hospitals, 95 percent, will
8 receive a reward relative to their withhold. The
9 unweighted, average net HVIP increase in payments is about
10 1.07 percent, meaning that 2 percent is withheld from the
11 hospital and that, on average, 3.07 is redistributed to a
12 hospital.
13 Under a 6 percent pool of dollars, less hospitals
14 will receive a reward but still the vast majority, at 82
15 percent. The unweighted, average net HVIP increase in
16 payments is about 1.13 percent, meaning that 5 percent is
17 withheld from a hospital and that, on average, 6.13 is
18 redistributed to the hospital. Under the 6 percent pool,
19 the higher-quality hospitals will receive more of a reward,
20 compared to the 3 percent pool, because the percentage
21 adjustment to payment per HVIP point is higher in this
22 larger pool.

1 Both average adjustment values are greater than
2 the 1 percent added to the pool because they are
3 unweighted, and different categories of hospitals have
4 different HVIP performance. For example, on average,
5 smaller rural hospitals will have slightly higher HVIP
6 adjustments because they perform better than large urban
7 hospitals on readmissions, patient experience, and MSPB
8 measure domains.
9 In summary, consistent with the Commission's
10 principles, the HVIP links payment to quality of care to
11 reward providers for offering high-quality care to
12 beneficiaries. It also rewards hospitals that efficiently
13 deliver high-quality care. The HVIP is simpler than the
14 current four, overlapping programs. HVIP uses a small set
15 of population-based outcome, patient experience, and value
16 measures that encourage providers to collaborate across the
17 delivery system. A benefit of these measures is that
18 Medicare could use these measures to compare across fee-
19 for-service, accountable care organizations, and Medicare
20 Advantage.
21 Overall, the HVIP reduces the differences in
22 payment adjustments between groups of providers serving

1 populations with different social risk factors.

2 I will now review the Chairman's draft

3 recommendation for your discussion.

4 The Congress should replace Medicare's current

5 hospital quality programs with a new HVIP that includes a

6 small set of population-based outcome, patient experience,

7 and value measures; scores hospitals based on absolute and

8 prospectively set performance targets; and accounts for

9 differences in patients' social risk factors by

10 distributing payment adjustments through peer grouping.

11 The implications for this recommendation is that

12 it would increase inpatient spending relative to current

13 law due to eliminating current quality incentive programs.

14 During previous meetings, we had discussed that the HVIP

15 would be budget neutral to current quality incentive

16 programs, but this recommendation would eliminate the

17 penalty-only quality programs and therefore increase

18 Medicare spending compared to current law. This is in

19 response to the Commission's desire to move Medicare

20 payments toward high-quality care and a simplified quality

21 program.

22 From the beneficiary perspective, the

1 recommendation may also improve their care by creating
2 incentives for higher quality and more coordinated care.
3 The HVIP would be less burdensome for providers and may
4 increase their willingness and ability to furnish services.
5 The HVIP would give higher Medicare payments to hospitals
6 providing higher-quality care.
7 This brings us to your discussion. After
8 reviewing your questions and comments, we would like your
9 thoughts on the Chairman's draft recommendation for a
10 potential vote in January.
11 DR. CROSSON: Thank you, Ledia. We are now open
12 for qualifying -- clarifying questions. Brian.
13 DR. DeBUSK: First of all, thank you for a
14 fantastic chapter. I mean, I really like the work and it's
15 very impressive, some of the examples you worked us
16 through.
17 My question is on page 21 of the reading
18 materials. And if you look at the total HVIP points, I
19 notice it goes from 6.3 to 4.7, the third column over, but
20 it's remarkably flat in the middle. And I noticed that in
21 the reading. You could walk me through that and maybe help
22 me understand that. Why the flatness? Does that say

1 anything about our choice of deciles and how those
2 intervals are constructed?
3 MS. TABOR: So I will just reiterate that it is
4 the same performance-to-point scale across all the
5 different peer groups, so what you're seeing is that the
6 peers groups that have the lowest share of fully dual
7 eligibles are doing much better than the peer groups -- the
8 tenth decile, which has the highest share of fully dual
9 eligibles. So just by nature that are not performing as
10 well in the measured domains.
11 It is very true that there is not a lot of
12 distinction kind of in the middle. We chose the 10 peer
13 groups because we thought that it was important to
14 distinguish between the 9th and 10th, for example, because
15 there is quite a difference between the number of dual
16 eligible in those groups. But, you know, perhaps using
17 quintiles or another number of peer groups could be more
18 appropriate.
19 DR. CROSSON: Other questions. Yeah, Bruce.
20 MR. PYENSON: Thank you very much. Could you
21 describe the issues for including the fully dual eligibles
22 as opposed to the partial dual eligibles and some of the

1 thinking around that?

2 MS. TABOR: We chose -- you know, we chose, for

3 this modeling, just to use the fully dual eligible. We

4 thought it was a little clearer. But again, that would be

5 -- you know, you can argue to also do it with the partial

6 included.

7 MR. PYENSON: Could you talk a little bit about

8 the pros and cons of that?

9 MS. TABOR: There could be -- if you did include

10 the partial there could be differences within states,

11 because of the differences in the Medicaid programs across

12 states. That would probably be more obvious if you

13 included the partial dual population.

14 DR. CROSSON: Marge.

15 MS. MARJORIE GINSBURG: Just a quick question.

16 You referenced, in the slides, the inclusion of hospitals,

17 those within Medicare Advantage, yet it's not often that

18 I've heard the term "Medicare Advantage" come up in this

19 group. So it doesn't appear that we have done much

20 evaluation of the programs within the MA plan. So could

21 you explain both why that is added and how getting that

22 information may be more or less challenging than the

1 information from non-MA plans?

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

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

13 DR. CROSSON: Okay. I've got Jonathan, Jon,
14 Jaewon, and Pat.

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

19 MS. TABOR: Yeah. So we did use the CMS
20 specification here and also their data that's available on
21 Hospital Compare, and it basically measures Part A and B
22 spending for three days before inpatient stay, during the

1 inpatient stay -- or actually it's three days before
2 admission and 30 days after admission, so all Part A and B
3 spending.
4 DR. JAFFERY: Total spending, but episodic.
5 MS. TABOR: Yes.
6 DR. JAFFERY: Okay. Thank you.
7 DR. CROSSON: Jon.
8 DR. PERLIN: Thanks. Let me add my thanks for a
9 terrific chapter. You made a statement on page 11 that for
10 low-volume hospitals you used three years of data, and I
11 assume that would park everybody into three years of data
12 for comparability. And if one of the intents is to promote
13 performance improvement then you're using data that are
14 three years, some number of quarters in arrears, a la the
15 readmission, then it would strike me as it would be
16 somewhat difficult for the hospitals to do two things. One
17 is to actually use those data as a signal for improvement,
18 because it's kind of driving in the rear-view mirror. The
19 second, by virtue of the thing, so incredibly a trailing
20 indicator, to be able to have much mobility even if they
21 were improving, say, for something that was mobile over a
22 period of three more years, at a minimum.

1 MS. TABOR: Yeah, that would be an issue with
2 using the three years of data. The Commission -- I think
3 it was Dana, actually mentioned in the past, perhaps last
4 year, that if we are going to use three years of data we
5 could perhaps weight the most recent year more, so that if
6 you did improve over the past year you perhaps -- you'd get
7 more credit for it. So we could, you know, use the three
8 years of data to kind of conquer the statistical problem of
9 we need more numbers, especially for small or low-volume
10 providers, but then also still continue to drive
11 improvement and not penalize as much for the first year.
12 DR. PERLIN: What would you envision the HACs
13 being, as they're now sort of rolled up into a sort of
14 metric of a number of different acquired conditions?
15 MS. TABOR: Yeah. So the way that we modeled it,
16 I will say, is that we took the six infection rates and
17 averaged them, their standardized infection rates, and
18 averaged them for our domain score.
19 DR. PERLIN: The reason I ask is, you know, Rich
20 Platt has done some work. Here's the problem. You don't
21 want these low-frequency bad events to occur. On the other
22 hand, they are low frequency. And by virtue of the fact

1 that they're low frequency, especially in low volume, means
2 that, you know, in terms of either accountability or
3 interpretation, it's difficult because they may not be
4 predictive of future performance. That's really what Rich
5 Platt published on, that, you know, it operates more --
6 with more of a random characteristic than a predictive
7 characteristic. Thanks.
8 DR. CROSSON: Okay. Jaewon.
9 DR. RYU: Yeah, I had a question on Table 4 on
10 page 22. You give some range of under the 2 percent
11 withhold and under the 5 percent withhold, what would the
12 range of the payment adjustments be. And I was wondering
13 how those ranges stack up against what current state looks
14 like, as far as those ranges. Do you have any sense of
15 that?
16 MS. TABOR: Yes. Well, I wouldn't be able to
17 totally compare Table 4 to current programs because the
18 peer grouping idea is new. But I will say, in general, the
19 peer group 10, the highest share of fully dual eligible
20 beneficiaries are performing worse, or getting penalized
21 more under current programs than the top peer group.
22 DR. RYU: And when it's worse, I mean, do you

1 have a sense, is it -- here it says negative 1.4 to
2 positive 2.1 percent would be the range under a 2 percent
3 withhold. But what does that look like for that group
4 today under the four or five programs we have?
5 MS. TABOR: So for the peer group one, which is
6 the lowest share, right now they're being penalized 0.54
7 percent, and because of the peer grouping, they would now
8 get 1 percent adjustment, on average.
9 DR. RYU: Thank you
10 DR. CROSSON: Pat.
11 MS. WANG: So combining the two recommendations
12 under consideration, particularly pulling in money from the
13 update to fund this new program, what is the sustainability
14 model for that kind of funding going forward? So this
15 year, you know, the update is larger than it has been, or
16 the recommended update is larger than it has been in past
17 years. What happens when the recommended update goes down?
18 Is this viewed as kind of an ongoing funding mechanism for
19 the HVIP? Or is this like a one-shot?
20 DR. STENSLAND: Yeah, I think you can think of
21 the update, we talked about taking eight-tenths of 1
22 percent out of the update and putting it into the HVIP.

1 And if it was left in the update, it would be in the
2 baseline, and that eight-tenths would continue forever in
3 the base payment rate. So the way we would envision this
4 would be a permanent increase in the HVIP, amount of
5 dollars in the HVIP program. So there would permanently be
6 more dollars in the HVIP program than just the withhold.
7 Does that make sense?
8 MS. WANG: Why -- oh, withhold from the update
9 factor every year?
10 DR. STENSLAND: It wouldn't -- you think of the -
11 - once you have this eight-tenths of 1 percent increase in
12 your update in this year, then you kind of think of, well,
13 wherever this -- the parallel lines would be that much
14 higher if you had an extra eight-tenths of a percent in one
15 year, because this update just moves the whole line up, and
16 it continues on forever. So think of this --
17 DR. MATHEWS: So, Jeff, if I could get in, the
18 0.8 percent represents a one-time infusion of additional
19 dollars, which results in the higher baseline going
20 forward. But on an ongoing basis -- and correct me if I'm
21 wrong -- the program would still operate under a withhold
22 that would be reallocated plus or minus based on the

1 hospital's performance under the HVIP.
2 MS. BUTO: Can I just add a question to her
3 question? But on an ongoing basis, we could contemplate in
4 a future year taking an additional amount out of the
5 update, legislated update, to put into this fund if we
6 wanted to. In other words, yes, the whole pool goes up,
7 but you could increase it even more going forward if you
8 wanted to take another increment from the update. Is that
9 right?
10 DR. STENSLAND: Yeah, you could think of it in
11 that way, but I would think of it as we're taking what was,
12 you know, the equivalent to, say, a billion and a half
13 dollars in base payments that was going to increase base
14 payments from here in perpetuity. And now we're saying
15 let's take that billion and a half dollars and put it in
16 the HVIP every year from here in perpetuity.
17 MS. BUTO: But you could take another $500
18 million and --
19 DR. STENSLAND: Yes, in future years you could
20 move it up from what we're proposing.
21 DR. CROSSON: Okay. Pat still has the floor,
22 then Jon. Oh, I'm sorry. Go ahead.

1 DR. JAFFERY: So maybe I'm not thinking through
2 the math right, but I get that one-time payment would
3 maintain these being those parallel differences as the
4 future updates happen. But over time, wouldn't that erode
5 such that the extra amount that's going into HVIP might be
6 less and less significant?
7 DR. STENSLAND: I think it would just always be
8 that you would always be taking eight-tenths of a percent
9 of what your base payments would have been and adding that
10 to the HVIP every year.
11 DR. CROSSON: It's not a dollar amount. It's a
12 percentage.
13 DR. STENSLAND: Yeah.
14 MS. WANG: Thanks. To Marge's question about
15 Medicare Advantage and the importance now that, you know,
16 this program is going to, I think, make it easier for
17 hospitals to focus on specific quality measures, there's
18 going to be more money in it, and so it kind of just
19 underscores the importance, I think, of trying to
20 rationalize and bring the quality metrics of the program --
21 all of the programs together as much as possible, so
22 everybody's working on the same thing. The only one in

1 here that really overlaps with the Medicare Advantage star
2 measure that I can see is readmissions. Do you know
3 offhand whether this is the same measurement of
4 readmissions that is used in the Medicare Advantage
5 program? Because, again, you don't want plans to be, like,
6 saying -- you know, working with hospitals on one
7 definition of a readmission measure and having the
8 hospitals focused on this, which is a different definition
9 of the readmission measure. So I'm curious if you --
10 MS. TABOR: I would say that the measure is close
11 enough. I think the biggest difference is that the current
12 hospital quality programs for fee-for-service use the
13 condition-specific measures; whereas, MA uses an all-cause.
14 So by us going to an all-condition measure here, we are
15 moving us much closer to aligning to the MA.
16 MS. WANG: The only thing that I'd point out is
17 that fee-for-service is now going to be ahead of MA in
18 having, you know, an adjustment for socioeconomic status
19 through the peer grouping, and MA doesn't have that, not
20 really. It's theoretically in the measure specification,
21 but not really. So that's a gap that should be brought
22 together.

1 The final thing, to Bruce's question about
2 partial duals, I would assume -- and I'd just ask if you
3 have a comment -- that there is a correlation between the
4 proportion of full duals and the sort of proportion of
5 partial duals. The people live in the same community.
6 They're either technically below the poverty level that,
7 you know, makes them eligible for full, or they have $10
8 more a month which gives them eligibility for partial. But
9 do you have a feel for that?
10 MS. TABOR: Mr. Rollins?
11 MR. ROLLINS: [Off microphone].
12 MS. WANG: Probably a pretty good proxy then for
13 low-income.
14 MS. TABOR: Yeah. We can look into that, though.
15 DR. CROSSON: Kathy.
16 MS. BUTO: This is on HACs. I know we struggled
17 with the idea that the HAC data are self-reported. Is
18 there anything like an infection-sensitive adjustment in
19 the payment system that might help us validate or help
20 somebody validate, CMS validate the veracity of reporting
21 from the hospitals on HACs? Do you know? Anything in the
22 DRG claim -- anything at all that would help us provide

1 some measure of how valid the self-reported data are?
2 MS. TABOR: Yeah. I will say that the CDC
3 National Health Safety Network that is the tool that's used
4 to collect all the self-reported data does have a
5 validation protocol developed. It's just unclear how much
6 CMS uses it.
7 I know some states have used it. I've done some
8 reading that the State of New York was very interested in
9 the infection rates among hospitals, and they actually did
10 some of their own audits and found that the results were
11 actually not as surprising. I mean, there were some
12 imperfections in the reporting, but it wasn't so bad.
13 And I will say with the claims data that there is
14 a small amount of literature that has said when you compare
15 infections or other patient safety issues that are reported
16 by claims to the CDC system that the CDC system is more
17 reliable than the claims. It's a small amount of
18 literature, but I think that is meaningful to show that if
19 you want to do infection rates, kind of the CDC system is
20 the best way to do it.
21 MS. BUTO: Okay. Is there any value to mentioning
22 some kind of audit, a look behind for some of these self-

1 reported data?

2 MS. TABOR: Yeah. We can definitely write about

3 that in the paper.

4 DR. CROSSON: David.

5 DR. GRABOWSKI: Thanks for this work.

6 I wanted to ask you about the patient experience

7 measures, and as you note in the chapter, there are

8 different ways to construct this measure from an overall

9 score to a subset of scores to using a composite measure of

10 all the different domains. You opted for the third, kind

11 of using all the different domains, yet there was a line --

12 and I just wanted to clarify -- that said the overall score

13 was highly correlated with the composite, so why not just

14 use the overall score that seems simpler to kind of --

15 MS. TABOR: Yeah. I think you could argue kind

16 of the pros and cons, the different approaches. We

17 initially went with the overall rating because we thought

18 that was simpler, but there were also comments that you are

19 kind of missing some other key factors like communication

20 with the nurses, communication with doctors. So the more

21 comprehensive measure may be a better approach to go.

22 DR. MATHEWS: David, you might not have been here

1 for that discussion.

2 DR. GRABOWSKI: Okay.

3 DR. CROSSON: Okay. Seeing no further questions,

4 we'll move on to the discussion.

5 I would like to make a couple of points in part

6 for our guests. I think you heard this referred to in the

7 presentation, but this recommendation is one of two

8 recommendations. The first one, we had this morning with

9 respect to the hospital update.

10 It is our intention to -- in January, when we

11 come to our final vote, to -- I think. We'll see how the

12 discussion goes, but combine these into one set of

13 comprehensive recommendations for the hospital update.

14 It's of note, and I think particularly for our

15 guests, that for the last 20 years or so, MedPAC has made

16 one hospital update that apply to all categories of

17 hospitals, all hospitals for that matter. This is a

18 departure that we're intending to take here based on the

19 support of the Commission, and it is essentially directed

20 towards, in this case, using the hospital update process to

21 promote a very central and important Commission goal, and

22 that is to reward hospitals, which have proven that they

1 can efficiently develop high-quality, deliver high-quality
2 care to Medicare beneficiaries, as Ledia presented in her
3 discussion.
4 This is not a small issue. It's a departure, as
5 I said, from what we've done in the past, but it's a policy
6 departure that we feel very strongly about because, again,
7 if we are able to bring this forward successfully in
8 January, it will bring a very strong message to the
9 hospital industry that we information fact are very
10 supportive of hospitals, and we are particularly supportive
11 of hospitals who can prove over time that they can in fact
12 manage both the quality and cost of the care that they
13 deliver.
14 So let's open it up for discussion. Brian.
15 DR. DeBUSK: I would support the draft
16 recommendations as written on Slide 11, as written. I
17 think this is fantastic work. It's a major step forward in
18 consolidating the different value-based purchasing systems
19 that we have.
20 I also think your incorporation of peer grouping
21 is -- I'd really like to see us -- I'd like to see us in
22 this three-tier model for looking at peer group hospital

1 and then ultimately patient-level characteristics.
2 We've had this conversation before. I hope that
3 when we publish in the March report that we can have a
4 discussion around the mathematics behind some of these
5 calculations, particularly around the fixed effects versus
6 random effects models, but I would see that just as a
7 detail in implementing a solution that has a much grander
8 vision.
9 Hopefully, we'll see solutions similar to this in
10 other venues in the future, so thank you.
11 DR. CROSSON: Jon.
12 DR. PERLIN: Let me add I think this is a really
13 elegant way of bringing a number of disparate programs
14 together, and that conceptually is extraordinarily
15 appealing. Thank you for that.
16 Let me also acknowledge that -- and I've shared
17 this before that, full disclosure, as vice chair of the
18 National Policy Forum, we've wrestled with the notion of
19 socioeconomic status adjustment, and so I think this
20 approach is probably the best I've seen in terms of being
21 able to do that in some sort of reasonable manner.
22 Just a sort of asterisk on our discussion about

1 full versus partial dual eligibles, if the intent is
2 actually better support for hospitals with a
3 disproportionate burden because of adverse payer mix, then
4 expanding to partial dual eligible, they may actually be
5 retro or counter to the intent because, of course, you have
6 more partials in Medicaid expansion states, and that
7 obviously tempers some of the adverse payer mix that's
8 there, so just note that.
9 The broader construct I want to move to is that
10 we incorporate in this consolidated approach five domains,
11 readmission mortalities, medical spending -- Medicare
12 spending per beneficiary experience, and hospital-acquired
13 conditions. And I really, as I say, like the consolidation
14 and the composite. As the saying goes, the devil is in the
15 details.
16 I think we need to also offer some commentary
17 about the inadequacies of our measurement with respect to
18 the reality that we may not have better at the moment, but
19 we really need to acknowledge the inadequacies.
20 I think it's noble to say that we aspire to
21 health systems managing the continuity of care, but I've
22 got to tell you with full candor, I mean, I can take full

1 responsibility or credit for this first seven to ten days
2 after hospitalization, and despite best intent, it's
3 sometimes difficult to create the continuity that would be
4 ideal to prevent readmissions.
5 Nevertheless, is the construct of readmissions
6 good? Yes, it is.
7 What are potential adverse consequences? When I
8 ran the VA health system, I actually did not have a 30-day
9 readmission metric because I worried about the patient
10 being excluded until Day 31 in conjunction with Medicare
11 spending per beneficiary and the table that's in there that
12 show the potential for dollars from those two metrics. I
13 just worry that it not be a recipe for things that are
14 counter to our intended high-quality care.
15 In the area of mortality, I know we looked at --
16 there is an argument in the chapter for all-cause
17 mortality. Again, I think we need to be circumspect in
18 realizing there may be utility in all-cause mortality that
19 smooths variation. On the other hand, the really
20 interesting signal might be in the particular clusters of
21 disease. How do hospitals do and how do patients fare in
22 areas of heart disease or stroke or cancer or whatever

1 other particular area?

2 But that same sort of concern applies in the area

3 of spending, Medicare spending per beneficiary. One looks

4 at the average. Just think about the difference between

5 two theoretical hospitals, which I could actually give you

6 absolute representatives of, one that specializes in

7 orthopedic and joint surgery, and even with a somewhat

8 adverse patient mix, very different from a hospital that

9 has high constellations of patients with complex, multiple

10 comorbidities, medical diseases, et cetera, that are really

11 so highly covariate with the social determinants.

12 On patient experience, we've had good

13 conversation on -- my own assessment is that there's no

14 best metric. There are internal issues as well with

15 composite, the discharge planning. Quite rightly, it

16 should vary and in fact does with readmission, so you get a

17 little bit of a double signal, and we just have to look for

18 internal cross-correlation between the different domains as

19 they're apt to co-vary.

20 Finally, in the hospital-acquired conditions, I

21 think these are an absolutely imperative bucket to have,

22 but I come back to the issue in the proposal to have

1 multiyear assessment because I have concern that -- I
2 hadn't heard the concept of weighting the most recent year.
3 I think that may ameliorate it to some degree, but again,
4 you would want good measures being really qualified as good
5 by virtue of, one, that they're valid and reliable in terms
6 of reporting, to measure what they intend to measure; two,
7 that they're based on strong evidence because the measure
8 is essentially the interrogative of what should be an
9 evidence-based recommendation; and three, that they're
10 measures that help providers make improvement. That means
11 they have enough recency to be able to provide direction in
12 terms of what to change; and fourth, that they have enough
13 currency that there is the capacity for providers to shift
14 their relative position, unless they sort of arrest in
15 progress because the mathematics just make it impossible to
16 do that.
17 So, with those caveats, I absolutely like the
18 overall construct and consolidation. I think it's elegant
19 and thoughtful. Devil in the details. Thanks.
20 DR. CROSSON: Okay. Other comments? Draft
21 recommendations. Support? Don't support? Have another
22 idea?

1 Jonathan.

2 DR. JAFFERY: That's a lot.

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

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

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

22 And that may mitigate some of the -- one of the

1 concerns that Jon just mentioned around how do you keep
2 somebody out for 30 days and not 31.
3 DR. CROSSON: Thank you.
4 Bruce.
5 DR. PYENSON: I also support the recommendation
6 on Slide 10.
7 What I would seek a little bit of clarification
8 on is which hospitals would be exempt from this program, if
9 any, with the goal of having the program apply to as many
10 hospitals as possible.
11 MS. TABOR: Some thoughts on it now. I think it
12 would not apply to -- it would just be hospitals paid with
13 IPPS, and then I think we would have to do something about
14 the low volume. I think by using the three years of data,
15 we're fixing a lot of the low-volume issues. But there
16 still are -- even in our modeling found that there were
17 just some hospitals that didn't have enough discharges for
18 us to calculate any of the measures.
19 But I think, again, this three-year approach
20 really does help include as many hospitals as possible.
21 DR. CROSSON: Marge.
22 MS. MARJORIE GINSBURG: I have a question about a

1 comment in the report where it said these actions would
2 actually require legislation, which I haven't been on the
3 Commission that long to know how many things have we
4 proposed that actually require legislation, and whether you
5 all have given any thought to how we make that happen and
6 is there kind of a step-by-step process. It's a bigger
7 hurdle than I think going to CMS.
8 Is that sort of the next phase? If we come to
9 agreement on this, then there's the implementation plan,
10 which is how do we actually get it to legislation and move
11 on from there? So I don't know whether this is too early
12 to ask the question about how do you do it.
13 DR. MATHEWS: Sure. So, Marge, I'll take a stab
14 at this one. Once you've been around for a couple more
15 years, you'll realize that a lot of what we do by way of
16 recommendations are recommendations that are directed at
17 the Congress because much of what we do will require a
18 change in law.
19 The second thing I want to say is that you are
20 not the first Commissioner to have expressed a little bit
21 of impatience with the Congress at the rate of take-up of
22 our recommendations, and I sense that. But at the same

1 time, our role is advisory, and we go where the analysis
2 leads us. We recommend what we think is the best policy,
3 and sometimes the recommendations lie fallow for a bit.
4 But then as we continue to provide technical support to the
5 Congress as they consider legislation, we are able to bring
6 up these ideas and remind them of recommendations that we
7 have made. And every once in a while, every several years,
8 there is an opportune time when many of our recommendations
9 get enacted into legislation.
10 So we play the long game here, but we are very
11 cognizant of our role as advisory and support rather than
12 proactive pushing -- "agenda" is too strong a word, but
13 trying to make things happen.
14 DR. CROSSON: In the longer term, by way of
15 examining what we do and the impact of it -- and this is
16 rough, rough, but we end up with either Congress or the
17 Secretary picking up our ideas or recommendations about 50
18 percent of the time. Sometimes it's not often, not
19 exactly, but generally speaking -- and we're going to come
20 up later in our update discussions with one very good
21 example of that recently.
22 So, yeah. First of all, Congress does have to do

1 the updates, some update, and they either take our
2 recommendation or they come up with a different idea, but
3 in the policy arena, over a period of time, we think we're
4 about one for two, something like that.
5 MS. MARJORIE GINSBURG: This one is very
6 exciting. I mean, this is a biggie.
7 DR. CROSSON: I agree. Absolutely.
8 MS. MARJORIE GINSBURG: I don't know how else to
9 say it, and so whatever we can do to foster its acceptance,
10 I'm sure we will think of ways to do that.
11 DR. CROSSON: Absolutely.
12 Yes, Pat.
13 MS. WANG: I just want to sort of acknowledge Jon
14 and Jonathan's comments because I really agree with them.
15 I think the devil being in the detail and making sure that
16 we have an open mind and don't just put pens down after
17 this but continue to do work on quality -- the details of
18 the quality metrics is very important -- and to try to help
19 the government continue to refine that.
20 There are a lot of things that I like about this.
21 We talked about the HVIP last time, and I think it's very
22 elegant. I think that the peer grouping is terrific. We

1 mentioned all of that.

2 The precedent I think that we are kind of talking

3 about here is to look at the update discussion differently

4 by sort of breaking apart, as Jae mentioned, portions of

5 what would otherwise constitute a straight across-the-board

6 update and seeing if there are certain policy goals that we

7 think are paramount, where the money should be, more

8 directed and more focused.

9 I would like us to consider if this path is a

10 good one that we consider in the future, trying to

11 encourage the development of value-based organizations

12 along the lines of ACOs or what have you using similar

13 mechanisms. The Commission is really on record as saying

14 that we think that this is critically important for the

15 fee-for-service system and for the future viability of

16 Medicare. So I think that that is a gigantic policy

17 priority that we should keep track of.

18 The final thing, though, is I don't want to

19 completely detach it from the conversation that we had just

20 before lunch. The analysis of the efficient hospital

21 margins, I think does need to be addressed, the

22 relationship between what we saw there and what we're

1 proposing here. One of the thoughts was is there a way of
2 sort of modeling how the hospitals that were in that
3 efficient hospital category would perform in the HVIP
4 because if the money is somewhat related or targeted, then
5 I think we're kind of solving a couple of problems at the
6 same time.
7 DR. CROSSON: Right. Two birds with one stone or
8 something to that effect.
9 So, Jim, that is something we can address?
10 DR. MATHEWS: Yes.
11 DR. CROSSON: Try to address. It may not be
12 perfect, but I think we can get more information on that
13 between now and January.
14 Paul.
15 DR. PAUL GINSBURG: I just want to praise the
16 work that was done to develop this comprehensive approach
17 to value, and I think it's a big improvement over what we
18 have now.
19 And I also like the idea of integrating this with
20 the update recommendation. I think we'll have to decide
21 each time, but I think it's promising as a way to go in the
22 future to increase the richness and to really provide a

1 source of funding for new directions and policy that
2 promote quality and efficiency.
3 So I support the recommendations.
4 DR. CROSSON: Paul, thank you. I'd like to
5 second that in terms of compliment to Jim and the staff
6 because not only is this an exemplar of the good work that
7 the staff does, but I watched them doing this in a
8 relatively short period of time and very intensely. I know
9 there were some people not getting a full night of sleep as
10 a consequence, and we're very grateful for that.
11 Okay. I think we've come to the end of this
12 discussion. As we have mentioned several times, because
13 we're combining this with this morning's discussion, we
14 will be bringing this entire package back for a discussion
15 and vote in January.
16 Thanks very much, Ledia and Jeff. Appreciate it.
17 [Pause.]
18 DR. CROSSON: Okay. We're now going to take on
19 the question of payment adequacy for skilled nursing
20 facilities. Carol is here to take us through that
21 discussion.
22 DR. CARTER: Great. Good afternoon, everyone.

1 Before I get started, I wanted to thank Carolyn San Soucie
2 for her help with this chapter.
3 First, a sketch of the industry. In 2017, there
4 were about 15,000 SNF providers, and about 1.6 million fee-
5 for-service beneficiaries used these services. Fee-for-
6 service spending was $28.4 billion. Fee-for-service
7 Medicare makes up about 11 percent of days but 19 percent
8 of revenues.
9 I will be using our update framework to assess
10 the adequacy of Medicare's payments shown on the slide.
11 Access to SNF services is adequate. In 2017,
12 supply was steady at about 15,000 providers, and 89 percent
13 of beneficiaries lived in counties with at least three SNFs
14 and less than 1 percent lived in a county without a SNF.
15 Occupancy rates were down slightly but remained high, at 85
16 percent.
17 Between 2016 and 2017, covered admissions
18 decreased, consistent with a small decline in inpatient
19 hospital stays that were three days or longer, which is a
20 requirement for Medicare coverage. SNF stays were shorter,
21 so total days declined. These changes are consistent with
22 expanded participation in ACOs and alternative payment

1 models and are not a signal about the adequacy of
2 Medicare's fee-for-service payments.
3 The marginal profit, a measure of whether
4 providers have an incentive to treat Medicare
5 beneficiaries, was very high, over 19 percent, a positive
6 indicator of patient access.
7 For years we've reported on the growing intensity
8 of therapy provision and how this trend reflects the biases
9 of the payment system and not changes in patient
10 characteristics. Since 2002, the share of days classified
11 into the intensive therapy case-mix groups increased from
12 27 percent to 83 percent in 2017.
13 Changes in patient characteristics do not explain
14 this growth. Rather, this growth reflects the design
15 feature of the payment system, which uses the amount of
16 therapy to assign patients to case-mix groups. Our work
17 has found that as more therapy is furnished, providers'
18 costs increase but payments increase even more, so
19 providing more therapy is more profitable than providing
20 less. The Commission first recommended revising the PPS in
21 2008.
22 CMS plans to implement a revised PPS in fiscal

1 year 2020. The redesign will base payments on patient
2 characteristics, such as comorbidities, functional status,
3 and cognitive impairment. CMS estimates that the new
4 design will redistribute payments from high-therapy
5 patients to medically complex patients. In response to the
6 new PPS, providers are likely to change their mix of cases,
7 service provision, and cost structures. The Secretary will
8 need to recalibrate the relative weights of the case-mix
9 groups to keep payments aligned with the cost of care.
10 CMS's redesign is consistent with MedPAC's
11 recommended design and estimated impacts. CMS also noted
12 in its final rule this year that the redesign will bring
13 the SNF PPS closer to an eventual PAC PPS.
14 Turning to quality measures, performance was
15 mixed, with small changes from 2016. We track three groups
16 of risk-adjusted quality measures: discharge to community,
17 potentially avoidable readmissions (both during and after
18 the SNF stay), and changes in function. Because the
19 function measures are provider-reported, the Commission is
20 concerned that the information may not be reliable.
21 Between 2016 and 2017, the average facility rates
22 of discharge back to the community improved. The

1 readmission rates were mixed. The during-stay rate
2 remained the same as in 2016, but the rate of readmissions
3 after discharge from the SNF worsened, and the function
4 measures were essentially the same. Material in the
5 chapter shows the variation in the rates, which suggests
6 that there is plenty of room for improvement.
7 Because the vast majority of SNFs are also
8 nursing homes, we assess the adequacy of capital for
9 nursing homes. Industry analysts report that capital is
10 generally available and expected to remain so in 2019.
11 Buyer demand remains strong, fueled by aging demographics
12 and the setting's lower costs compared to other
13 institutional PAC.
14 Some lender wariness reflects three factors: low
15 total margins -- that is, the margin across all payers and
16 all lines of business are low; declining SNF use; and the
17 increasing share of facility revenues from lower-paying
18 payers, such as MA plans.
19 Investor reluctance does not reflect the adequacy
20 of Medicare's payments; Medicare continues to be a payer of
21 choice.
22 In 2017, the average margin for freestanding SNFs

1 was 11.2 percent, the 18th year in a row that the average
2 was above 10 percent. These margins illustrate why
3 Medicare is a preferred payer.
4 Across facilities, margins vary substantially.
5 One-quarter of SNFs had margins of 0.8 percent or lower,
6 and one-quarter had margins of at least 20.2 percent.
7 There continues to be more than a 10 percentage point
8 difference in Medicare margins between nonprofit and for-
9 profit facilities, due in part to differences in their
10 patient mix and therapy practices, but also differences in
11 their economies of scale. Nonprofit facilities are
12 typically smaller and have higher costs per day. Also in
13 recent years, nonprofits have had higher cost growth
14 compared with for-profit facilities.
15 To understand differences in performance and to
16 evaluate the level of Medicare's payments, we identify a
17 set of relatively efficient providers and compare them to
18 other SNFs. Efficient providers are those that perform
19 relatively well on both cost and quality metrics for three
20 years in a row. The metrics are: standardized cost per
21 day, rates of readmission during the SNF stay, and rates of
22 discharge to community. In 2017, 987 SNFs, or about 9

1 percent of the over 11,000 providers that were included in
2 the analysis, were relatively efficient.
3 Compared to other SNFs, relatively efficient
4 providers had better outcomes: higher community discharge
5 rates and lower readmission rates. Because relatively
6 efficient SNFs were typically larger and had higher daily
7 census, they achieved greater economies of scale. Their
8 standardized costs were 8 percent lower than other SNFs.
9 On the revenue side, revenues were 11 percent
10 higher, in part reflecting their higher share of the most
11 intensive therapy case-mix groups. The combination of
12 lower costs and higher revenues per day results in an
13 average Medicare margin of over 18 percent, an indication
14 that Medicare's payments are too high relative to the costs
15 of treating beneficiaries.
16 We also look at the payment rates that some MA
17 plans pay for SNF care. In three publicly traded companies
18 that operate SNFs, fee-for-service payment rates averaged
19 21 percent higher than MA care payment rates. A survey of
20 over 1,400 SNFs conducted by the National Investment Center
21 for Senior Housing and Care found slightly higher
22 differences between fee-for-service and MA rates. I think

1 it was 22 percent.

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

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

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

17 In considering how payments should change for
18 2020, indicators including access to care, access to
19 capital, and quality are stable. The level of Medicare
20 payments remain too high. For years, the Medicare margin
21 has been among the highest of any sector. The wide
22 variation in Medicare margins reflects differences in

1 patient selection, service provision, and cost control.
2 The PPS has historically favored the provision of therapy
3 and needs to be revised. CMS's proposed revisions are long
4 overdue and should prompt providers to better align therapy
5 with patient care needs and increase providers' willingness
6 to admit medically complex patients.
7 This leads to the Chairman's first draft
8 recommendation, and it reads: The Secretary should proceed
9 to revise the skilled nursing facility prospective payment
10 system in fiscal year 2020 and should annually recalibrate
11 the relative weights of the case mix groups to maintain
12 alignment of payments and costs.
13 The implementation of a revised SNF PPS will
14 increase the equity of Medicare's payments by increasing
15 payments for medically complex care and decreasing payments
16 for intensive therapy care that is not related to a
17 patient's condition. The redesign would narrow disparities
18 in financial performance across SNFs. The recommendation
19 also calls for the Secretary to recalibrate the relative
20 weights of the case-mix groups. The redesigned PPS is
21 likely to alter the mix of cases treated, providers' cost
22 structures, and the relative costs of different types of

1 stays. To keep payments aligned with the cost of care, the
2 Secretary should recalibrate the relative weights each
3 year.
4 In terms of implications, the recommendation
5 would not affect spending; the revised PPS would be
6 implemented to be budget neutral to the current level of
7 spending.
8 For beneficiaries, access should increase for
9 medically complex patients. Given the level of Medicare
10 margins, we expect providers should continue to be willing
11 and able to care for beneficiaries. A revised PPS should
12 reduce the variation in Medicare margins across providers.
13 The impact on individual providers will depend on their mix
14 of cases and their current practice patterns.
15 The second recommendation addresses the level of
16 payments, and it reads: The Congress should eliminate the
17 fiscal year 2020 update to the Medicare base payment rates
18 for skilled nursing facilities.
19 The level of Medicare's payments indicates a
20 reduction to payments is needed to more closely align
21 aggregate payments to aggregate costs. However, we expect
22 the SNF industry to undergo considerable changes as it

1 adjusts to the redesigned PPS.

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

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

15 As required by PPACA, we report on Medicaid
16 trends in nursing home spending, their spending, their
17 utilization, and financial performance, and that
18 information is in the chapter, and I won't go over it now.

19 I'll put the Chairman's draft recommendations up,
20 and I look forward to your discussion.

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

22 Clarifying questions? David.

1 DR. GRABOWSKI: Thanks, Carol. This is great
2 work. I wanted to start by asking you about this big
3 change we're going to see in fiscal year 2020, the patient-
4 driven payment model. Do you have any sense -- it's like
5 pressing "reset" for the sector, shifting from paying for
6 therapy to paying for patient characteristics. Do you have
7 any sense what that's going to do to margins? I know it's
8 going to totally change incentives, but I'm trying to just
9 think about going forward, what does that look like in
10 terms of --
11 DR. CARTER: Well, the margin should change --
12 should remain the same because it is going to be budget
13 neutral. At least that was what was in the proposed rule
14 and final rule for this year, but it's to be implemented
15 next year. I haven't heard discussions about whether it
16 will continue to be implemented budget neutral, but I think
17 that's the expectation.
18 There will be some redistribution, and I would
19 suspect that the difference between for-profits and
20 nonprofits will narrow, and between freestanding and
21 hospital-based. So the narrowing of the distribution --
22 but it won't eliminate it. I should emphasize the cost

1 differences are real between nonprofits and for-profits.
2 So this payment system's not going to correct that, but the
3 narrowing will happen.
4 DR. GRABOWSKI: That was going to be my second
5 question, so let me get to my third and final question,
6 which was: Have you ever calculated the all-payer margins?
7 Medicaid is such an important payer in this sector --
8 DR. CARTER: Yes.
9 DR. GRABOWSKI: -- and it differs quite a bit
10 across states in terms of its generosity.
11 DR. CARTER: Yes.
12 DR. GRABOWSKI: Have you ever calculated sort of
13 state-by-state margins and show they're much higher in
14 these high-payment states --
15 DR. CARTER: No, I haven't done that.
16 DR. GRABOWSKI: No? Okay. That might be
17 interesting --
18 DR. CARTER: Yeah, I would expect them to differ.
19 DR. CROSSON: I'm sorry. For SNFs or nursing
20 homes?
21 DR. GRABOWSKI: For SNFs that also care for these
22 long-stay nursing home residents.

1 DR. CARTER: Right.
2 DR. GRABOWSKI: So they do both. These aren't
3 only caring for Medicare --
4 DR. CROSSON: No, but which -- okay.
5 DR. GRABOWSKI: I wanted to look at the all-payer
6 margins for SNFs.
7 DR. CROSSON: For the facilities, or for the SNF
8 patients?
9 DR. GRABOWSKI: For the facilities. Sorry, for
10 the overall nursing home --
11 DR. CARTER: For the facility, so it includes the
12 nursing home business, and actually our total margin also
13 includes if they have a home health business and
14 outpatient, sort of all business, all payers, yeah.
15 DR. CROSSON: Okay. Kathy.
16 MS. BUTO: Carol, do you know why the total
17 margins went down -- are lower for for-profits versus not-
18 for-profit nursing homes? Apparently, they were pretty
19 comparable until 2017, but something happened. Do you know
20 what that --
21 DR. CARTER: I haven't looked at that. It's
22 possible just given what's happening with their payer mix

1 for MA plans that there's different mixes across for-
2 profit/not-for-profit, so you would see that in the total
3 margin. I haven't looked at that, though.
4 DR. CROSSON: Okay. Seeing no more questions,
5 we're going to move on to the discussion. The
6 recommendations are there. We'll hear discussion about
7 support or lack thereof or other ideas with respect to the
8 recommendations. Yeah, David?
9 DR. GRABOWSKI: I'll just say very quickly I'm
10 very supportive of these recommendations. I'm also struck
11 both in this discussion and our hospital discussion how
12 Medicare doesn't pay in a vacuum, and we pay alongside
13 other payers in these sectors. And when it comes to
14 hospitals, the dollars run from commercial payers to
15 Medicare. Here Medicare is cross-subsidizing Medicaid, and
16 I think that's a really important point, and there is some
17 text in the chapter around that's not the most efficient
18 way to cross-subsidize Medicaid. I very much agree with
19 that, yet these are all Medicare-eligible individuals.
20 They're dually eligible. They're Medicaid. But I just
21 want to make that point, that Medicare's not just an
22 important payer in this sector for kind of post-acute care;

1 it also is an important payer for Medicaid. And I'm not
2 advocating that we kind of incorporate that into how we
3 make our decisions going forward, only that there's some
4 interdependence there, and we've got the good side of that
5 with hospitals. Here we're seeing the other side of that
6 coin that dollars are flowing the other direction. So I
7 just wanted to make that point. But I'm very supportive of
8 the recommendations.
9 DR. CROSSON: Okay. Paul.
10 DR. PAUL GINSBURG: I also support the
11 recommendations. You know, following up on what David was
12 saying, we just have a very complex thing that -- I mean,
13 unlike hospitals where commercial payers and Medicare and
14 Medicaid are paying different prices for pretty much the
15 same thing, here we have a situation where the Medicaid is
16 paying for different services, lower-acuity, custodial
17 services, but still, you know, the reality -- and I was
18 talking to Carol during the break about this -- is that it
19 seems as though SNF and the custodial Medicaid services
20 seem to really go in the same nursing homes, and that few
21 have been successful in separating out the SNF and having a
22 SNF-only business. So that makes it complex.

1 I have a sense that, Medicare being the better
2 payer, as long as Medicare continues to be the better
3 payer, states likely will respond by paying even less for
4 their patients because they can. And if Medicare, you
5 know, pays less generously, I think states will ultimately
6 have to pay more. And it's important to keep this in mind
7 as we contemplate this decision.
8 DR. CARTER: I guess the one thing I would follow
9 on to that is people often look at the Medicaid rate and
10 the Medicare rate, and they are really buying different
11 packages of services. When I look at the relative weights
12 of the Medicaid patient versus the Medicare patient,
13 they're sort of orders of magnitude different. So if
14 Medicare were paying for that same package of services, its
15 average payment would be much lower also.
16 DR. CROSSON: Good point. Okay. Thank you. I'm
17 looking around. I'm not seeing any signs of objection to
18 the recommendations, so we will bring this forward in
19 January in the expedited mode. And, Carol, thank you once
20 again.
21 [Pause.]
22 DR. CROSSON: Okay. We'll move on to the next

1 presentation. Welcome back, Craig. Craig and Dana are
2 going to take us through the update for inpatient
3 rehabilitation services.
4 MR. LISK: Good afternoon. Glad to be back.
5 So after illness and injury or surgery, many
6 patients need intensive rehabilitation care, including
7 physical, occupational, and speech therapy. Sometimes
8 these services are provided in inpatient rehabilitation
9 facilities. Today I will briefly review Medicare's payment
10 system for IRFs, including some concerns we have about the
11 payment system, and then I will present our payment
12 adequacy analysis.
13 In 2017, Medicare spent $7.9 billion on care
14 provided in about 1,180 IRFs nationwide. There were about
15 380,000 Medicare fee-for-service IRF stays in 2017, and on
16 average, Medicare paid a little more than $20,300 per case.
17 Per case payments to IRFs vary depending on
18 patient's condition, level of impairment as measured by the
19 IRF, age, and comorbidity. Medicare accounted for about 58
20 percent of IRF discharges in 2017. The average length of
21 stay in an IRF was 12.7 days.
22 To qualify for an IRF, facilities must meet

1 Medicare's conditions of participation as well as several
2 additional requirements outlined in your paper. In
3 addition, for a stay to be covered, there are certain
4 patient requirements that must be met as well. We will be
5 happy to discuss these on question.
6 The Commission has made two observations about
7 the IRF payment system that raise concerns. First, we have
8 observed that high-margin IRFs have a different mix of
9 cases than other IRFs do. This suggests that some case
10 types may be more profitable than others.
11 Second, the Commission has found evidence to
12 suggest that patient assessment may not be uniform across
13 IRFs. We, for example, found that patients in high-margin
14 IRFs were less severely ill during the preceding hospital
15 stay compared with patients in low-margin IRFs. But once
16 patients were admitted to and assessed by the IRF, the
17 patients were coded as being more impaired on average.
18 At any level of severity in the acute-care
19 hospital, high-margin IRFs consistently coded for a higher
20 level of impairment than did low-margin IRFs. What is
21 important to remember is how IRFs code affects payments and
22 that we currently rely on IRFs to assess patients'

1 functional status that helps determine their payments.

2 I'll turn now to our review of payment adequacy

3 for IRFs. We've used our established framework that you

4 have seen in earlier presentations today. We will start by

5 considering access to care.

6 We first looked at the supply of IRFs. In 2017,

7 there were just under 1,180 IRFs nationwide, a slight

8 decrease from 2016. However, despite this decline in

9 number of facilities, the total number of IRF beds edged up

10 slightly, with a little more than 37,000. As you can see

11 in the facilities column on the chart, only 24 percent of

12 IRFs were freestanding, but freestanding IRFs tend to be

13 bigger, so they accounted for slightly more than half of

14 Medicare discharges in 2017. And even though the total

15 number of facilities declined in 2017, the total number of

16 freestanding facilities actually continued to grow.

17 Overall, 33 percent of IRFs were for-profit, accounting for

18 54 percent of Medicare fee-for-service cases. The number

19 of for-profit IRFs also continues to grow steadily.

20 We next move on to beneficiaries' access to care,

21 and in 2017, we find a slight dip in the volume of Medicare

22 cases and the number of cases per fee-for-service

1 beneficiary. However, payments per case continue to rise
2 along with Medicare expenditures for IRFs. If we look at
3 marginal profit, we see that it is a robust 40.9 percent
4 for freestanding IRFs and 19.4 percent for hospital-based
5 IRFs, meaning that both sets of providers have an incentive
6 to serve additional Medicare beneficiaries, assuming that
7 they qualify for IRF-level care.
8 We also looked at the quality of care furnished
9 in IRFs using risk-adjusted measures developed for MedPAC.
10 Overall, we find some improvement since 2012 in our quality
11 measures. The risk-adjusted rate of potentially avoidable
12 readmissions during the IRF stay was 2.6 percent in 2017
13 and was 4.7 percent during the 30-days after discharge,
14 both improving slightly from 2012.
15 Now, these rehabilitation rates -- these
16 rehospitalization rates are low compared with those of
17 other PAC settings, in part because IRF patients must be
18 able to tolerate and benefit from intensive therapy, which
19 means they tend to be less frail than, say, SNF patients.
20 In addition, IRFs are certified as hospitals, so they may
21 be in a better position to handle cases that have problems
22 during the stay.

1 We also saw improvements in the share of patients
2 discharged to the community, rising from 74.3 planning in
3 2012 to 76 percent in 2017. And we also saw improvements
4 on gains in motor function and cognitive function over this
5 period. But remember that function scores are provider-
6 reported and affect payments, so should be viewed with some
7 caution.
8 Turning now to access to capital, as I noted
9 earlier, more than three-quarters of IRFs are hospital-
10 based units which access needed capital through their
11 parent institutions. As you heard this morning, hospitals
12 maintain good access to capital. Hospitals with IRF units
13 also had a strong all-payer margin which stood at 7.0
14 percent in 2017. Please note that we cannot calculate an
15 all-payer margin just for the hospital's IRF line of
16 business.
17 But if we look at hospitals with units and we
18 look at their Medicare margins, we see their relative
19 Medicare inpatient margins and overall Medicare margins
20 were higher than for hospitals that did not have IRF units.
21 As for freestanding IRFs, close to half of the
22 providers in the freestanding IRF category are owned or

1 operated by one large chain. Market analysts indicate that
2 this chain had good access to capital, the company has
3 continued its pursuit of vertical integration by expanding
4 its business to include the purchase of home health
5 agencies and hospice providers, and entering into joint
6 ventures with acute-care hospitals to build new facilities.
7 The all-payer margin for freestanding IRFs is a robust 10.4
8 percent.

9 We now move on to discuss payments and costs. As
10 this next slide shows, the green line -- shows payments,
11 the green line had been increasing faster than costs since
12 2009 with payments rising a cumulative 20.8 percent and
13 costs rising a cumulative 14.5 percent. You will note that
14 the cost growth was particularly low from 2009 to 2015,
15 averaging just 1.5 percent per year.

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

21 Financial performance continued to vary widely
22 across IRFs. The aggregate Medicare margin for

1 freestanding IRFs was 25.5 percent in 2017. In contrast,
2 hospital-based IRFs had an aggregate margin of 1.5 percent.
3 We also see wide differences in margins for for-profit and
4 nonprofit IRFs. The primary driver in these differences in
5 margins is costs, which tend to be lower in freestanding
6 and for-profit IRFs.
7 So why do we see such a disparity in margins and
8 costs as one of those factors between hospital-based and
9 freestanding facilities? We think there are a number of
10 factors.
11 First, hospital-based IRFs are more likely than
12 freestanding IRFs to be nonprofit, and so they may be less
13 focused on reducing costs to maximize returns to investors.
14 They also may have fewer economies of scale.
15 Hospital-based IRFs tend to be much smaller than
16 freestanding IRFs, and they have fewer total cases. Their
17 occupancy rates are also somewhat lower.
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 a larger share 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 move on to our analysis that
5 examines relatively efficient IRFs. This is the first year
6 the Commission has completed an analysis to look at the
7 financial performance of relatively efficient IRFs.
8 Efficient provider analysis had been part of the update
9 framework for many of the other sectors, such as hospitals
10 and SNFs, for many years. The approach we take for
11 examining efficient providers in IRFs is similar to what we
12 do for the other sectors. We examine IRFs with
13 consistently low costs and high quality. In our analysis,
14 we used three years of data -- 2014 to 2016 -- to
15 categorize IRFs as efficient. We required that over the
16 three-year period they be in the top third performance on
17 costs or quality every year for one of these metrics and
18 that they do not have poor performance, bottom third, on
19 any of these metrics over the three-year period. We then
20 assess the efficient hospital groups' performance using
21 2017 data and compare it to other IRFs.
22 What we find is that the relatively efficient

1 IRFs had better performance on quality metrics with
2 readmission rates that were 9 percent lower and discharge
3 rates to skilled nursing facilities that were 35 percent
4 lower than for other IRFs.
5 Relatively efficient IRFs also were larger and
6 had higher occupancy rates than other IRFs, leading to
7 lower costs.
8 Payment rates, however, were similar between both
9 groups but, as I mentioned before, with large cost
10 differences. Medicare margins were much higher in the
11 relatively efficient group, 16.5 percent in 2017 compared
12 with 1 percent for other IRFs.
13 The mix of cases was also different, and as we
14 have discussed before, relatively efficient IRFs had a
15 smaller share of stroke cases and a higher share of other
16 neurological condition cases. Freestanding and for-profit
17 IRFs were disproportionately represented in the relatively
18 efficient hospital group here, but there were hospital-
19 based facilities in the efficient group, and they
20 represented about half of the facilities in that group.
21 With that, we will move on to discuss our
22 projected margin for IRFs in 2019. We expect that cost

1 growth is likely to exceed payment growth in 2018 and in
2 2019, and so we have projected that aggregate margin will
3 fall to 11.6 percent. Payment growth will be limited
4 because payment updates for fiscal year 2018 and '19 were
5 set in statute at below market basket levels, 1 percent and
6 1.35 percent, respectively. And though cost growth in the
7 industry was low from 2009 to 2015, cost growth was higher
8 in 2016 and 2017, and we expect this higher cost growth to
9 continue with costs rising faster than the payment updates
10 in both '18 and '19.
11 So, to summarize, we observed capacity that
12 appears to be adequate to meet demand and that providers
13 should have an incentive to take more Medicare
14 beneficiaries that qualify for IRF-level care given the
15 strong marginal profits for both freestanding and hospital-
16 based facilities. Our risk-adjusted quality outcome
17 measures have improved slightly over time. Access to
18 capital appears adequate. In 2017, the aggregate Medicare
19 margin was 13.8 percent and the projected margin for 2019
20 is 11.6 percent.
21 And so that brings us to the update for 2020. We
22 have started from the Chairman's draft recommendation from

1 last year, and it reads: The Congress should reduce the
2 fiscal year 2020 Medicare payment rate for inpatient
3 rehabilitation facilities by 5 percent.
4 To review the implications on spending relative
5 to current law, Medicare spending would decrease. Current
6 law would give an update of 2.7 percent, for your
7 information.
8 On beneficiaries and providers, we anticipate no
9 adverse effects on Medicare beneficiaries' access to care.
10 The recommendation may increase financial pressure on some
11 providers.
12 The Commission's standing recommendation to
13 expand the outlier pool may increase payments to providers
14 that treat more high-cost cases, which would tend to go to
15 hospital-based and nonprofit facilities.
16 So, with that, I'd be happy to answer any
17 questions. We'd be happy to answer any questions, and I'll
18 look forward to your comments.
19 DR. GRABOWSKI: Thanks for this work and
20 presentation. Could I ask you about Slide 9, the relative
21 growth in payment and cost? What happened? What sort of
22 took off and changed? Was there a policy change in there?

1 I just want to better understand --

2 MR. LISK: I think cumulative cost growth was

3 being held down substantially, and I think profits had gone

4 up so much they probably felt -- even in hospital-based

5 facilities, the profits had started going up a little bit,

6 even though it's relatively low compared to the

7 freestandings. And so probably cost pressure wasn't there

8 to hold down costs as much, so costs went up a little bit.

9 DR. GRABOWSKI: Maybe I'm not reading this

10 correctly, but in 2009-2010, payments and costs per case

11 are pretty tight there, right? Am I -- cumulative growth -

12 -

13 MR. LISK: This is cumulative growth.

14 DR. GRABOWSKI: Got it, okay. So this is

15 relative margins.

16 MR. LISK: Yes, yes.

17 DR. GRABOWSKI: Thank you.

18 DR. CHRISTIANSON: Jon.

19 DR. PERLIN: Let me add my thanks for a terrific

20 presentation. I just have a couple clarifying questions.

21 First, we're talking about fiscal year 2020 in

22 terms of the recommendation, but we also have

1 simultaneously something in motion, if my recollection is
2 correct, that we're switching in terms of the risk
3 adjustment or case-mix methodology from FIM to IRF PAI.
4 And I was just wondering what your assessment of how that
5 impacts this going forward is and how should we view that
6 in terms of our deliberations?

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

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

20 MS. KELLEY: So MA -- IRFs are required to submit
21 IRF PAI assessment forms for their MA patients. We don't
22 know -- however, since there's no connection with payment

1 on the fee-for-service side, there's no way of knowing how
2 complete those reports are. But assuming we do have
3 complete data, when we look at MA use of IRFs, what we see
4 is generally lower use and much -- patients tend to be in
5 particular case types. There's more use of IRFs for
6 patients with stroke as opposed to neurological conditions,
7 and the lengths of stay tend to be shorter. But we have
8 not -- when we do that analysis, we have not controlled for
9 -- what's not clear is whether or not areas that have IRFs
10 are more or less likely to have high MA penetration, so
11 that's something we haven't controlled for in that
12 analysis.
13 So it's something we looked at in the past, but
14 we don't have complete confidence in our findings.
15 DR. PERLIN: Thank you very much.
16 DR. CHRISTIANSON: Brian and then Paul.
17 DR. DeBUSK: First of all, thank you for a great
18 report. It read really well. I had a question on page 3
19 of the presentation. You mentioned that the patient
20 assessment may not be uniform across IRFs. This has a
21 little bit of the whole MA coding issue feel to it in that,
22 you know, are these patients at least in certain situations

1 being upcoded to realize larger payments. Do you have a
2 feel and can you get your hands around the upcoding effect?
3 And could you speak to the -- maybe focusing on program
4 integrity and getting the coding right, or properly coded,
5 versus the 5 percent payment cut? Could we realize the 5
6 percent cut or even more if the assessments were done
7 correctly? That's what I'm trying to get a feel for.
8 MR. LISK: So there are some issues about how the
9 assessments are done and some talking -- it was discussed I
10 think last year and stuff where we looked at -- and some of
11 it's a question whether some of the requirements to just do
12 the assessment at the greatest level of impairment the
13 person has. And so that's one -- kind of maybe one of the
14 tricks that may go on, but it's kind of what focus places
15 really have in learning how to do the assessments, too. So
16 it's kind of like if everyone's assessing consistently,
17 that would be an issue, but I think there's kind of a
18 question of whether people are assessing fully how impaired
19 a person is and what level of effort they put into it and
20 what effort they learn to those assessments, too. So it
21 can go both directions.
22 So some of the issue is whether hospital-based

1 facilities, for instance, are not putting as much effort
2 into judging that assessment and the training. On the
3 other cases, you know, they may be waking the patient up
4 where an assessment will not be as productive for the
5 patient, too.
6 DR. DeBUSK: That is what I was just trying to
7 get at because, again, something needs to be done. I think
8 there's no question you've made that case.
9 I was just wondering if you did the 5 percent cut
10 and then, say, program integrity worked on this and we
11 tried to get the assessment right, if the people who were
12 doing the coding correctly in the first place, we're going
13 to disproportionately suffer from the cut, and I just
14 wondered how much emphasis we should put on adjusting the
15 rate versus ensuring that the assessment is done correctly.
16 MS. KELLEY: So I think there's probably room for
17 both things to be done.
18 About the assessments, I will say that I think
19 Craig characterized correctly that it's not clear exactly
20 what is going on. In a way -- well, from the sort of
21 10,000-foot view, it doesn't really matter what's going on.
22 If we can't rely on the assessments, the payment system is

1 not moving money around to the patients who need or who
2 have the higher resource needs.
3 When we dig down and try to think about how to
4 fix the problem, I think there's a great deal of research
5 about the reliability of the IRF PAI assessment tool, but I
6 think a lot of that research was done before Medicare
7 started paying on it. And I think as a payment tool, what
8 we have seen or what we are starting to wonder about is
9 whether or not we can rely on how much a provider's
10 assessment of a patient really can vary and whether or not
11 there's enough in the medical record that can actually
12 support particular assessments, whether the medical record
13 can provide the background information that one would need
14 to check.
15 And Carol and Ledia are going to come back to us
16 in the spring to talk about this issue of patient
17 assessment and how reliable it is and whether or not -- to
18 what extent we need it to make appropriate payment for
19 post-acute care cases.
20 DR. CROSSON: Okay. I have Paul and then Kathy.
21 DR. PAUL GINSBURG: Yeah. Well, a really good
22 job on this report. I learned a lot.

1 On Slide 14, it struck me as tautological saying
2 that this efficient group of IRFs had better than average
3 quality and lower than average cost, but that's how you
4 chose them for that list. I suspect that that's not what
5 you did, but that's what it seemed to me.
6 MR. LISK: I mean, in some ways, that is because
7 we are requiring them to have two of the quality measures
8 to be better on quality for those here. So, in some ways,
9 yes, we're looking at places. We have had consistently low
10 cost and consistently low quality, but we're looking at
11 that at an earlier period, and we're looking to see how
12 they're doing in 2017.
13 So they are performing well, and I think there's
14 a lot of consistent -- in this group compared to even other
15 groups, there's a lot of consistency. When we do this
16 analysis, we have a large share of IRFs actually in a
17 relatively efficient group compared to other settings.
18 Even though we're requiring a third, we have about --
19 almost a quarter of the IRFs are in that efficient --
20 relatively efficient group.
21 But I think what's actually important to remember
22 about that analysis too is that what we're finding now is,

1 even though we see the low margins in hospital-based IRFs,
2 we are finding that half of those hospitals in the
3 efficient group are hospital-based units. So we do know
4 that hospital-based units can be relatively efficient in
5 making those lower cost --
6 DR. PAUL GINSBURG: An idea is that you might
7 do the analysis a little differently. First of all, look
8 at the group that qualified based on low costs, and look at
9 their quality compared to the other IRFs. And then do the
10 same thing, the ones that qualified through your filter on
11 high quality. Look at their costs. I think that might be
12 meaningful.
13 MS. KELLEY: So that would be interesting. That
14 might be something we could take a look at. We've tried to
15 keep our approach to the efficient provider analysis
16 consistent across the different sectors, and so maybe
17 that's something we could consider, a change in the future.
18 But for this first attempt at this analysis, we kept it
19 consistent with what we've done in other sectors.
20 DR. PAUL GINSBURG: It's possible, then, that my
21 question really applied to all the analyses, then.
22 [Laughter.]

1 DR. CROSSON: Kathy.
2 MS. BUTO: So I have a question about the
3 Chairman's draft recommendation to reduce the 2020 payment
4 rate update by 5 percent. I have two thoughts. One is, is
5 some of that money being used to fund the outlier pool? Is
6 that the reason that you went for 5 percent?
7 And then I looked back on SNFs, and I realized
8 that for SNFs, which have a similar, not quite as high -- I
9 guess it's a 10 percent Medicare margin projected for 2019,
10 and this is 11.6. That we essentially recommend no
11 increase or no payment updates.
12 So I'm just trying to understand the difference,
13 and maybe this is partly a question for Carol. It might
14 have to do with the transition they're going through in
15 2020, but it struck me that we for a long time said SNFs
16 were really needed to face a reduction as well, maybe to
17 keep the pressure on. I just wondered why this disparity.
18 DR. CROSSON: Kathy, it is exactly what you said,
19 which is what Carol.
20 MS. BUTO: Transition.
21 DR. CROSSON: Yeah, transition.
22 MR. LISK: And the only other thing I want to say

1 is that for IRFs -- and we didn't put this slide in -- that
2 when we look at what the Commission has done from 2009
3 through 2015, the Commission recommended zero update. For
4 2017 and 2018, the Commission had recommended -- in our
5 2017 and '18 reports, we recommended a minus 5. So this is
6 consistent. This recommendation is consistent with what
7 the Commission recommended last year too.
8 MS. BUTO: This looks out of whack with SNFs, I
9 guess, in my view.
10 MS. KELLEY: Right. And so the change that we're
11 anticipating in the SNF case-mix system will.
12 The other thing you asked about, the outlier
13 pool. No, this would be separate from -- our standing
14 recommendation is to increase the outlier pool from 3
15 percent to 5 percent. This would be separate.
16 DR. CROSSON: Jon.
17 DR. CHRISTIANSON: That is actually what I was
18 going to ask about. It seems odd to have that sentence in
19 there, "As an implication of the Chairman's
20 recommendation." It's not an -- it would be true, no
21 matter what the Chairman's recommendation is, right, this
22 outlier pool in effect?

1 MS. KELLEY: That is true, and our discussion in
2 the report will reflect it in that way.
3 This was a way for us to remind you that we have
4 that standing recommendation out there and that if the two
5 recommendations were done simultaneously, this is what
6 would happen.
7 DR. CHRISTIANSON: Yeah. I think that's probably
8 better in the chapter than in the implications of this
9 particular recommendation, if it isn't.
10 MS. KELLEY: Okay.
11 DR. CROSSON: Okay. Seeing no further questions,
12 we'll move on to the discussion period. We have a draft
13 recommendation before you. The discussion should focus on
14 the recommendations, support, not support, other ideas, et
15 cetera.
16 Seeing one.
17 [Laughter.]
18 DR. JAFFERY: So let me make sure that I
19 understand because this is to Congress, right?
20 DR. CROSSON: Yes.
21 DR. JAFFERY: So this is a little bit different
22 than some of our other recommendations?

1 DR. CROSSON: No. We've only had one
2 recommendation that goes to the Secretary. That's the next
3 one.
4 DR. JAFFERY: Okay. So that's the outlier.
5 All right. I'm going to withdraw my questions.
6 DR. CROSSON: Okay. The reasons is -- and
7 everything except for -- what is it? IRFs? Long-term care
8 hospital. Sorry. We have a standing congressional current
9 law that we react to, and in the case of long-term care
10 hospitals, there is none, although it's a little more
11 complicated than that because it's actually the Secretary
12 that sets the rate, but there is some guidance in MACRA as
13 well. So it's kind of a mixed case, but it still goes to
14 the Secretary.
15 DR. JAFFERY: Okay.
16 DR. GRABOWSKI: Jay?
17 DR. CROSSON: Yeah, David.
18 DR. GRABOWSKI: So I'll say I support the draft
19 recommendation. I wanted to make one small comment, which
20 is after reading this chapter, it really reaffirmed my
21 support of site-neutral payment for post-acute care. That
22 really came across in reading this. I'll leave it at that.

1 DR. CROSSON: Okay.
2 DR. GRABOWSKI: I think this would be Exhibit 1
3 and why we need site-neutral payment.
4 Thanks.
5 DR. CROSSON: Okay. I'm getting a sense that
6 there is a consensus in support of the recommendation.
7 Thank you very much.
8 We'll bring this through expedited voting in
9 January.
10 Craig, thank you, and Dana.
11 We'll move on to the final presentation for the
12 day.
13 [Pause.]
14 DR. CROSSON: Okay. The last one for today's
15 session is an assessment of the payment adequacy and
16 recommendation for update for long-term care hospitals.
17 Stephanie, you've got the mic.
18 MS. CAMERON: Thank you. Good afternoon. Today
19 we are here to discuss how payments to LTCHs should be
20 updated for fiscal year 2020. Using the established
21 framework, we will evaluate the adequacy of Medicare
22 payments in LTCHs. As you will recall from our September

1 and November meetings, the Commission has been asked to
2 assess changes in response to the implementation of a dual-
3 payment structure for LTCHs, which is due in June. We plan
4 to incorporate any relevant information from today and our
5 January presentation into this report, as applicable.
6 Today I start by summarizing some background
7 information that was included in your mailing materials.
8 To qualify as an LTCH under Medicare, a facility must meet
9 Medicare's conditions of participation for acute care
10 hospitals and have an average length of stay for certain
11 Medicare cases of greater than 25 days. Care provided in
12 LTCHs is expensive. The average Medicare payment in 2017
13 was over $38,000 across all cases and close to $46,000
14 across the cases meeting the criteria specified for payment
15 under the LTCH perspective payment system that I will
16 discuss momentarily.
17 As you will recall, the Pathway for SGR Reform
18 Act of 2013 changed the way LTCHs are paid, and established
19 a dual-payment rate structure. Cases meeting the criteria
20 are those that are preceded by an acute care hospital
21 discharge and either spend three or more days in the ICU of
22 the referring acute care hospital or receive prolonged

1 mechanical ventilation in the LTCH. These cases are paid
2 under the LTCH PPS and will be the focus of a lot of the
3 analysis I will walk through. All other cases, those not
4 meeting the criteria, are paid a lower site neutral rate.
5 The policy began in fiscal year 2016 and is being phased-in
6 over four years. Until 2020, cases that do not meet the
7 criteria are paid a rate equal to 50 percent of the site-
8 neutral rate and 50 percent of the much higher standard
9 LTCH payment rate.
10 I will now turn to the question of how payments
11 to LTCHs should be updated for fiscal year 2020. To
12 determine the update recommendation, we review payment
13 adequacy using our established framework consistent with
14 what you've seen in other sectors throughout the day today.
15 While we apply this framework on the prior slide
16 in the same manner for LTCHs, we expect substantial changes
17 from the implementation of the dual-payment rate structure
18 given the financial disincentive for LTCHs to continue
19 taking Medicare beneficiaries not meeting the criteria.
20 Because of the reduction in payment, the extent to which
21 LTCHs are better able to alter their admission patterns
22 toward cases meeting the criteria will determine

1 facilities' financial performance under Medicare.
2 Because some LTCHs have dramatically altered
3 their admission patterns in response to the policy
4 consistent with the goals of the dual-payment rate
5 structure, we isolate some of our analyses to the LTCHs
6 with more than 85 percent of their cases meeting the
7 criteria. I will specify when we consider this subset of
8 providers during this presentation.
9 Now with that, we have no direct indicators of
10 beneficiaries' access to needed LTCH services so we focus
11 on changes in use, capacity, and occupancy. As you will
12 recall, most beneficiaries receive this level of care in a
13 short-term acute care hospital.
14 We are going to start with use. We find the
15 number of LTCH cases declined starting in 2012. The
16 reduction in volume has not been consistent across case
17 types over the last six years. Although the volume of
18 cases meeting the criteria decreased slightly from 2012 to
19 2015, which is before the policy started, starting in 2016,
20 following the implementation of the policy, the volume of
21 cases meeting the criteria increased, as expected.
22 In contrast, cases not meeting the criteria

1 declined more rapidly from 2015 to 2017, compared with
2 prior years. As a result, the share of LTCH discharges
3 meeting the criteria has increased since 2012. Just over
4 half of LTCH cases met the criteria prior to the
5 implementation of new dual-payment rate structure and
6 aggregate. However, this share increased to about 64
7 percent in 2017.
8 As you know, historically, this product has not
9 been well defined and the absence of LTCHs in many areas of
10 the country and the variation in availability of LTCHs
11 across markets makes it particularly difficult to assess
12 the adequacy of supply. Although the number of LTCHs has
13 been decreasing since 2012, there was more than a 4 percent
14 reduction in supply from 2016 to 2017, with additional
15 closures occurring in 2018.
16 In 2017, LTCH occupancy rates averaged around 64
17 percent, a 2 percentage point drop from 2016. This
18 suggests that LTCHs have excess capacity in the markets
19 they serve.
20 Medicare marginal profit across all LTCHs was 14
21 percent in 2017, down from close to 20 percent in 2016.
22 The marginal profit for LTCHs with a high share of Medicare

1 beneficiaries meeting the criteria was 16 percent.
2 Therefore, we contend that LTCHs have a financial incentive
3 to increase their occupancy rates with Medicare
4 beneficiaries who meet the criteria.
5 Moving to quality, not unexpectedly, given
6 differences in patient severity, unadjusted rates of direct
7 LTCH to acute care hospital readmissions, death in the
8 LTCH, and death within 30 days of discharge from the LTCH
9 varied depending on whether or not the case met the
10 criteria, but were all stable over time.
11 In 2017, for cases meeting the criteria, 10
12 percent were readmitted to the acute care hospital directly
13 from the LTCH, 16 percent died in the LTCH, and 13 percent
14 died within 30 days of discharge from the LTCH. This means
15 that, combined, close to 40 percent of LTCH cases meeting
16 the criteria in 2017 were readmitted or died within 30 days
17 of LTCH discharge. By comparison, cases not meeting the
18 criteria have lower rates of readmission and mortality.
19 CMS has published two years of data for several
20 outcomes measures including new or worsening pressure
21 ulcers, 30-day all-cause unplanned readmissions, catheter-
22 associated urinary tract infection, and central line

1 bloodstream infection.

2 In 2017, the pressure ulcer rate was relatively

3 low, around 1.3 percent. The risk-adjusted 30-day

4 readmission rate was about 25 percent in 2016. This rate

5 differs from the unadjusted rate I previously mentioned

6 because of differences in methodology. The standard

7 infection ratios for catheter-associated urinary tract

8 infection and central-line associated bloodstream infection

9 were lower than expected after adjustments for certain risk

10 factors.

11 Moving now to access to capital. Access to

12 capital allows LTCHs to maintain and modernize their

13 facilities. However, given the last decade of policies

14 that have limited industry growth, including moratoria on

15 new facilities, and the implementation of the dual payment

16 rate structure, the availability of capital is limited

17 across the industry. Major chains have been diversifying

18 their portfolios and have been strategic in their purchase,

19 sales, and closure of LTCH facilities in more competitive

20 LTCH markets, also reducing the need for capital.

21 LTCHs' access to capital also depends on their

22 all-payer profitability which was 0.2 percent in 2017, down

1 from 3.1 percent in 2016, resulting from reduced payments
2 for cases not meeting the criteria. LTCHs with more than
3 85 percent of their Medicare cases meeting the criteria had
4 an aggregate all-payer margin of 4.2 percent in 2017.
5 LTCH cost per case increased by about 2 percent
6 per year from 2012 through 2015 across all LTCHs, including
7 those with a high share of Medicare beneficiaries meeting
8 the criteria as of 2017. However, after the phase-in of
9 the dual-rate payment structure began, the trend in cost
10 growth diverged. In aggregate, growth in cost per
11 discharge was low from 2015 through 2016, and negative from
12 2016 to 2017.
13 However, cost growth remained robust for LTCHs
14 with a high share of Medicare cases meeting the criteria.
15 Cost per case increased by 5.4 percent from 2015 to 2016,
16 and by 5.6 percent from 2016 to 2017. These increases in
17 costs are expected, given the increase in case mix and
18 patient acuity associated with treating the higher severity
19 of patients meeting the criteria. For this group of LTCHs,
20 the share of cases meeting the criteria grew tremendously,
21 by close to 30 percentage points in aggregate. We expect
22 changes in cost growth over time will become increasingly

1 stable.

2 In 2017, the aggregate Medicare margin fell to -
3 2.2 percent, down from 3.9 percent in 2016. However, the
4 aggregate Medicare margin for LTCHs with more than 85
5 percent of their Medicare cases meeting the criteria was
6 4.6 percent, reflecting a 1.6 percentage point reduction
7 from 2016. Consistent with LTCHs' financial performance in
8 aggregate, differences still exist by facility ownership,
9 even across LTCHs with a high share of cases meeting the
10 criteria. We see a 13 percentage point difference in the
11 margins between for-profit and nonprofit facilities, with
12 for-profit LTCHs accounting for 87 percent of Medicare
13 cases in this group.

14 Looking more closely at the characteristics of
15 established LTCHs with the highest and lowest margins, this
16 slide compares LTCHs in the top quartile for 2017 margins
17 with those in the bottom. More than half of the LTCHs with
18 the highest Medicare margins in 2017 also had more than 85
19 percent of their Medicare cases meeting the criteria.
20 Therefore, many, although not all, of the attributes of the
21 highest-margin facilities overlapped with those of LTCHs
22 with a high share of cases meeting the criteria.

1 As you can see, high margin LTCHs tend to be
2 larger and to have higher occupancy rates, so they likely
3 benefit more from economies of scale. Low margin LTCHs had
4 standardized costs per discharge that were 30 percent
5 higher than high margin LTCHs. High margin LTCHs have
6 fewer high cost outlier cases and are more likely to be
7 for-profit.
8 We project that the 2017 Medicare margin for
9 LTCHs with a high share of cases meeting the criteria will
10 decline in 2019. Our projection of the LTCH margin for
11 fiscal year 2019 focuses on LTCHs with more than 85 percent
12 of Medicare cases meeting the criteria. This includes
13 about 30 percent of LTCHs and aligns with the goals of the
14 dual-payment rate policy, encouraging LTCHs to admit the
15 most medically complex cases requiring specialized
16 services.
17 We expect significant changes in LTCHs' costs as
18 the dual-payment rate structure is fully implemented and
19 continue to increase their Medicare admissions toward cases
20 that meet the criteria. However, once an LTCH has reached
21 a threshold of Medicare cases that meet the criteria, we
22 expect the changes in cost will become increasingly stable

1 and reflect cost growth levels consistent with those prior
2 to the implementation of this policy in 2016. Using
3 historical levels of cost growth, we project a 1.2 percent
4 Medicare margin for LTCHs with a high share of cases
5 meeting the criteria for 2019.
6 In sum, occupancy rates across the industry have
7 decreased by 2 percentage points. Although growth in the
8 volume of LTCH services per beneficiary declined, this
9 decline is in large part from the implementation of the
10 dual-payment rate structure and LTCHs admitting more
11 patients meeting the criteria, which aligns with the goals
12 of the policy.
13 In terms of quality, unadjusted mortality and
14 readmission rates appear to be stable. While certain
15 adjusted measures appear to be better than expected, it is
16 likely too soon for a time-series analysis for other
17 publicly reported measures. The effect of fully
18 implementing the dual-payment rate structure will continue
19 to limit industry growth and access to capital in the near
20 term. Our projected Medicare margin for LTCHs with a high
21 share of cases meeting the criteria in 2019 is 1.2 percent.
22 CMS historically has used the market basket as a

1 starting point for establishing updates to LTCH payments.
2 Therefore, we make our recommendation to the Secretary.
3 And with that, the Chairman's draft recommendation reads,
4 The Secretary should eliminate the fiscal year 2020
5 Medicare payment update for long-term care hospitals.
6 Eliminating this update for 2020 will decrease
7 federal program spending relative to the expected
8 regulatory update.
9 We anticipate that LTCHs can continue to provide Medicare
10 beneficiaries who meet the criteria with access to safe and
11 effective care.
12 And with that, I will turn it back to Jay.
13 DR. CROSSON: Thank you, Stephanie. Actually, I
14 have a question myself. So in this particular case does
15 the 1.2 percent projected 2019 margin, does that assume
16 something about like a market basket update? It does.
17 MS. CAMERON: Yes. So the Secretary has
18 historically provided a market basket update for LTCHs,
19 and, in fact, there an LTCH-unique market basket that is
20 produced annually. However, the Secretary is not under
21 statute required to use that. The expectation is that he
22 or she will apply it and then that market basket is

1 subsequently reduced by what's in statute, and right now,
2 for 2018 and 2019, that is a productivity adjustment
3 downward, an additional adjustment that was mandated by the
4 ACA. In 2020, that additional adjustment goes away and
5 then it would be -- what would be expected is the market
6 basket minus productivity. However, that is not in
7 statute. The market basket piece is not in statute, and
8 therefore, technically up to the discretion of the
9 Secretary.
10 DR. CROSSON: Right. But that's built into the
11 1.2.
12 MS. CAMERON: That's correct. Yes.
13 DR. CROSSON: Okay. All right. Thanks.
14 Okay. Questions. Amy?
15 DR. BRICKER: What do you believe is driving the
16 facilities to get out of the business, given the margins
17 that we've highlighted? What's the driver? There's so
18 few, right? Is it 398 now?
19 MS. CAMERON: Yes.
20 DR. BRICKER: So few.
21 MS. CAMERON: So few that have left?
22 DR. BRICKER: No. In total facilities.

1 MS. CAMERON: Oh.
2 DR. BRICKER: I mean, the same expenditure, when
3 you look at the surgery centers, right, the same exactly
4 expenditure. There are 5,800 of those. There's only 400
5 of these. I'm just curious, if the margins are as rich as
6 I believe I understood them to be, then what's driving them
7 to get out of the business?
8 MS. CAMERON: So I think in the past the margins
9 have been significantly higher. So last year the margins
10 for all facilities for Medicare were 3.9 percent, and this
11 year they're down to -2.2 percent. And a lot of what we
12 focused on today were the facilities that were taking a
13 large share of cases meeting the criteria, thinking about
14 the underlying goals of the policy and wanting to kind of
15 transition to think, for the LTCHs that are aligning with
16 those goals, what is their payment adequacy and thinking
17 about it in that manner.
18 I think for the other LTCHs they've had quite a
19 large reduction in their margin and they've seen a fairly
20 large reduction in payment. And for LTCHs that have, you
21 know, lower rates of admissions for patients meeting the
22 criteria, their Medicare margins are quite low. And we

1 have found that because Medicare accounts for often more
2 than half of an LTCH business, if that Medicare margin is
3 quite negative the all-payer margin also goes down
4 considerably.
5 And I think there have been a significant number
6 of closures, although it's less clear based on the
7 methodology we use in this report. You know, a gross
8 number of closures is about over 40, and that's kind of
9 using the most up-to-date data. That's not thinking about
10 kind of the timeline of just up through 2017 that we
11 typically use for this report. And that's 10 percent of
12 the industry. So I think when you look at it that way,
13 there have been a significant number of closures, and those
14 closures did have fairly low Medicare margins before they
15 closed.
16 DR. BRICKER: Yeah. I don't want to bleed into
17 round two. I just -- I know we've had robust discussions
18 about the role of these facilities. I think that there's
19 not a consensus that I've felt overwhelmingly that the
20 Commission holds about then. But if you have seen that
21 they do serve, you know, a specific purpose around the most
22 complex and critically ill, although only 100,000

1 beneficiaries, based on this information, why we would not
2 give them an update to payment, why we would recommend a
3 zero percent update.
4 MS. CAMERON: So is your question why is the
5 Chairman's draft recommendation zero?
6 DR. BRICKER: I guess I should turn --
7 MS. CAMERON: I think -- well --
8 DR. CROSSON: Yeah. So I think the thought here
9 is that -- and actually I was going to say something. I'll
10 say it now. Marge asked the question earlier, which is,
11 you know, does anybody listen to us, and I think this is a
12 good example of not only a recommendation of ours, with
13 respect to the dual payment system having been picked up
14 and passed into legislation, but once that happened then
15 the industry itself began to be reformatted in a way that
16 we see, where the facilities that were treating patients,
17 who arguably didn't need the expertise of the facility, are
18 now unprofitable. And so facilities who were, you know,
19 kind of using that as a business model are the ones who
20 appear to be dropping out. And those who are focusing, as
21 we would have wished, more appropriately on patients who
22 meet the criteria and who really need that type of care,

1 those facilities are doing much better.
2 So I think that transition is expected to
3 continue and has led us to the recommendation that at least
4 at this point extra money is not needed. But that's for
5 this Commission to decide.
6 MS. CAMERON: And if you will recall, there has
7 been a long history of very rapid growth in this sector,
8 especially following the implementation of the PPS, where
9 really, since 2002, we've seen costs skyrocket. We've seen
10 payments increase. We've seen the use of the facilities
11 grow quite rapidly, and we've seen the facilities grow
12 quite rapidly. So I think there is kind of a long history
13 to go along with what you said, Jay, that kind of supports
14 wanting to maintain a certain level of cost pressure on
15 these facilities, given their relative responsiveness to
16 payment policy, historically.
17 DR. CROSSON: Right. And again, I think the
18 other piece of it is the recognition that these services
19 can also be supplied, and are being supplied in many parts
20 of the country, by acute care hospitals quite well. So
21 it's not, you know, that if we see some facilities who are
22 basing a business model on inappropriate provision of

1 services fall out that there's no other option for Medicare
2 beneficiaries. At least that's the logic.
3 Paul.
4 DR. PAUL GINSBURG: To continue this discussion,
5 I think the fact that there are a lot of departures from
6 the industry, you know, I think we're comfortable with
7 that, because of the change in structure of payments, what
8 it was trying to achieve. But was still surprised with
9 projecting a 1.3 percent margin for the types of long-term
10 care hospitals that we want to keep, presumably the ones
11 where most of their patients meet the criteria, why we
12 would be recommending such a low margin for them.
13 You know, everything we've talked about today
14 either had a margin that was very high -- you know, 10
15 percent or in that area -- or something that was negative,
16 and we haven't really had occasion to discuss, well, what
17 should an appropriate margin be, somewhere between negative
18 and 10. And, you know, I guess the key thing is that we
19 understand that this industry is still shaking out. There
20 should be departures, but isn't there a subclass of long-
21 term care hospitals that we want to keep, and it seems as
22 though with a 1 percent margin we're not supporting that.

1 DR. CROSSON: Okay. Marge.
2 MS. MARJORIE GINSBURG: This information raises,
3 to me, the question, are these facilities dinosaurs? Are
4 we holding onto them because they still do serve some
5 purpose somewhere, for some people, and they are providing
6 some value? But looking ahead, do we really think we're
7 going to have them? Are they still going to be here 5, 10
8 years from now? And if we think they shouldn't be
9 dinosaurs, that we really -- regardless of how many there
10 are, they plan an important role, then perhaps we should
11 send the message that we value them and want to continue to
12 see them function.
13 So, anyway, my main comment was really the
14 dinosaur one.
15 MS. CAMERON: And so one of the things to keep in
16 mind as we move forward, and this goes into the work that
17 we've done and the Commission has done on the unified PPS,
18 is looking at these services being provided, and, you know,
19 the question of down the road, transitioning toward a much
20 more kind of patient-centric payment model that is across
21 all setting. You would see patients who may now currently
22 be in an LTCH perhaps seen in different settings, but all

1 the payment would be kind of leveled out across those
2 settings for that same patient.
3 So I think, you know, maybe, Marge, you're
4 thinking more ahead of, you know, are the silos, maybe is
5 that the dinosaurs and it's moving towards a unified PPS
6 that we're really after.
7 DR. CROSSON: Yeah. Thank you. But in that
8 interim period of time we still have these facilities, and
9 I think it's our responsibility to decide whether we think
10 this is an update that's adequate or not. And I want to
11 hear more discussion about that.
12 Jonathan and then Kathy.
13 DR. JAFFERY: Yeah. So I think generally I am
14 supportive of the draft recommendation. I have a concern
15 about the criteria, and I think that actually may be very
16 relevant if we go to a unified system and where patients
17 have the opportunity to go to other places.
18 But I recall that there was something -- it might
19 have been in some previous reading from a prior meeting,
20 but it also drives as my own personal experience with these
21 organizations -- that they have increasingly tried to
22 increase their catchment area in order to improve the

1 number of -- you know, fill their beds, which is
2 understandable. But, you know, that means that they're
3 reaching out to smaller -- likely reaching out to smaller
4 hospitals, community hospitals and other places, in a
5 broader area.
6 And when I think about these two criteria -- so
7 mechanical ventilation while in the LTCHs, prolonged
8 mechanical ventilation seems like a pretty clear proxy for
9 severity -- it's not as clear to me that three days in an
10 ICU, from the referring acute care hospital, is always a
11 mark of very high severity, especially as you're getting
12 into different facilities. ICU stays in a small community
13 hospital can look very, very different from other
14 facilities.
15 And so if we're baking those criteria into what
16 will be a significantly higher payment for LTCHs, or
17 potentially for other post-acute settings, or even acute
18 care settings, as outlier payments or whatnot, I wonder if
19 we should be thinking about a different proxy for severity,
20 or if that one, in particular, is adequate.
21 DR. CROSSON: Okay.
22 MS. CAMERON: So the Commission, in their

1 recommendation on our recommendation in March of 2014, we
2 actually had an eight-day criteria, to partially get at the
3 issue that you're talking about. I think three days in an
4 ICU, the Commission has been, in the past, and obviously
5 continues to be concerned with, given that it almost
6 comprises about a quarter of current acute care hospital
7 users have at least a three-day stay in an ICU. So I think
8 there is a fairly large pool of potential LTCH candidates,
9 if you're only looking at ICU use, whereas if you moved to
10 an eight-day you're getting 5, 6 percent-ish of patients
11 instead, and that's obviously a much higher severity, I
12 think, type of patient who would be eligible for LTCH care.
13 So the Commission remains on record with an eight-day ICU
14 stay recommendation.
15 There has been a significant amount of work
16 trying to distinguish LTCH patients or patients appropriate
17 for LTCH, and how do we define the most chronically
18 critically ill. The literature, you know, has provided a
19 wide range of descriptions, but I think the difficulty is
20 finding that data and having descriptions that also match
21 claims data, or data that can be used to define the patient
22 in a clear way. And the ICU days has been one of the

1 actual data points that does seem to distinguish patients.
2 Now whether 3 days is too little, I think the Commission
3 has been in agreement, but I think the measure itself seems
4 to be one of the more solid ones that's out there.
5 DR. GRABOWSKI: So just to follow up, I
6 appreciate that. The length of the ICU stay doesn't really
7 change this potential issue of what an ICU stay looks like
8 in different kinds of acute care facilities. And so it
9 also appears that there is a particular expertise that
10 comes on LTCHs often, which is around prolonged ventilation
11 and difficult-to-wean patients and patients who are on
12 ventilators with other conditions, for whatever reason, so
13 that they become prolonged. And so I'd encourage us to
14 think about looking at the criteria more in the future.
15 DR. CROSSON: Kathy and then David.
16 MS. BUTO: So, Stephanie, remind me what the
17 number is again of individuals who are discharged from an
18 LTCH, the mortality rate. Is it 30 percent, 40 percent,
19 within 30 days, something like that?
20 MS. CAMERON: Right. The measure you're looking
21 at -- so I think I mentioned almost close to 40 percent and
22 that was a readmission plus a death in the LTCH, plus

1 mortality within 30 days of discharge.
2 MS. BUTO: Thirty days.
3 MS. CAMERON: So it's kind of the adverse event
4 that occurred between being in the LTCH and 30 days post-
5 discharge.
6 MS. BUTO: Okay. So I think it's probably 29
7 percent, 30 percent, something like that, for death, as I
8 recall.
9 MS. CAMERON: Yes. I think that's right.
10 MS. BUTO: And so when I was reading this
11 material I started thinking, the LTCH feels lot like a
12 hospice for people with respiratory failure. There are a
13 lot of individuals on ventilators in the LTCH, and those
14 clearly are not as easily, I guess, treated, or there's not
15 as much a specialization in maybe other settings. So at
16 least in my mind, there was that issue. But I wanted to
17 just check that with you, since we're in round one, before
18 drawing any conclusions. Is that right? Are they a lot of
19 respiratory failure patients?
20 MS. CAMERON: Absolutely, and as you look toward
21 the facilities that take a larger share of patients meeting
22 the criteria, the ventilation, you know, obviously you

1 would expect those to be more respiratory in nature. And
2 so, you know, the LTCHs have been experts, I think, in a
3 lot of ways, at vent weaning, and for the respiratory
4 population, the population that has respiratory needs, a
5 place for treatment.

6 That said, I don't have offhand, but I could
7 provide additional information on certain respiratory
8 conditions and the mortality and readmission rates for
9 those specifically, if you think that would be a helpful
10 statistic to have, thinking about just kind of the
11 respiratory DRGs and how that looks.

12 MS. BUTO: I just think it would be helpful to us
13 as we think about the unified PAC to think about what is
14 the niche that LTCHs may or may not be able to play in that
15 post-acute care unified PAC world, to know a little bit
16 more about that set.

17 MS. CAMERON: Right, and I think the LTCHs,
18 because they have an average length of stay requirement,
19 they are not looking -- their preference is not trying to
20 find patients they think are going to die in their facility
21 or soon thereafter. I mean, death is very, very hard to
22 predict. I think even under the best circumstances it's

1 very difficult. But the LTCHs, you know, have to make
2 sure, or do their best to ensure that patient is strong
3 enough to make it, because, you know, these are not large
4 facilities. They have very long lengths of stay. And if
5 there are a handful of patients that die within a week of
6 their stay, their average length of stay can really be
7 reduced, and I think then there's a problem on the facility
8 with its certification.
9 So, you know, it's not -- I worry about thinking
10 of them as a hospice, with all due respect, because they're
11 doing a lot of interventional care and their goal is to,
12 you know, to provide --
13 MS. BUTO: To prolong life --
14 MS. CAMERON: -- curative care.
15 MS. BUTO: -- et cetera. Yeah. No, I wasn't
16 actually trying to label them as hospices. I was just
17 trying to understand, you know, because they are among the
18 most expensive, you know, institutional settings that
19 exist. In fact, the downside for them is being paid at a
20 DRG level. So it just helps to think about where they fit
21 in the overall continuum.
22 MS. CAMERON: Sure.

1 MS. BUTO: Thanks.
2 DR. CROSSON: Okay. I'm not sure who was first.
3 I had Pat and then Sue. Sorry. On this point, Sue?
4 MS. THOMPSON: On the point, and I think the
5 comment that Kathy made about this feels like we're talking
6 about pre-hospice. If we just step back, this whole
7 business -- and I need my clinical friends here to help me
8 with this discussion -- but it strikes me that the fact
9 that we have Medicare patients that end up in need of LTCH
10 care, in many cases could be addressed if we were more
11 proactive and intentional to have conversation about folks'
12 intentions, what they would want. I can assure you, when
13 you look at the kinds of quality measures, pressure ulcers
14 and urinary tract infections and bloodstream infections,
15 these all end up in sepsis, and that is not -- and
16 ventilator dependency, that is not the way -- and I know we
17 weren't going to bring Mom up again, but that would not be
18 the way I would want my mom to see her demise.
19 And I think the fact that we are in this
20 conversation about LTCH is a comment on our ineffectiveness
21 in a health care industry to address getting upstream here
22 a bit, and having the conversation with folks about their

1 intentions, so that they don't, in many cases -- and in
2 some cases they do. This is their intention and it is
3 their want. But in many cases they would not desire to be
4 in this situation.
5 So the comment that you make about hospice,
6 Kathy, I think it resonated with me and I would ask other
7 clinicians to comment on that. And I don't know that
8 there's anything to do with payment update, in terms of a
9 policy recommendation, but it just strikes me that it just
10 smacks of an inadequacy, and I'm guessing this is a round
11 two comment. But I had to comment while Kathy made that
12 question about hospice care.
13 DR. CROSSON: Okay. Thank you, Sue. Pat.
14 MS. WANG: Can you remind us what happens to this
15 class of providers under the unified PAC-PPS?
16 MS. CAMERON: I'm sorry, what?
17 MS. WANG: What happens to this group of
18 providers under the unified PAC-PPS --
19 DR. CROSSON: Go ahead, Carol.
20 MS. WANG: -- relative to the current -- if the
21 projected margin -- and I'm going to put you on the spot.
22 DR. CARTER: No, but I know the answer to this

1 question. Yeah. So there wouldn't be a specific payment
2 adjustment based on setting, but what we're trying to do
3 are define the types of patients and patient
4 characteristics that zero in on care needs. And so, for
5 example, payments would increase for severe wound care, for
6 medically complex, for patients with five or more body
7 system conditions, for ventilator dependence, and each one
8 of those adds payments.

9 So, I mean, those are patients that probably are
10 LTCH -- the poster child for an LTCH patient, but it's
11 defining the patient characteristics as opposed to the
12 setting.

13 Does that help?

14 MS. WANG: It does. Is it possible to say, under
15 the modeling that you did, that if you took one of these
16 efficient LTCHs that Stephanie has identified, whose
17 projected margin in 2019 is 1.9 percent, if the unified
18 PAC-PPS were fully in place, what would their margin be?

19 DR. CARTER: I don't know what their margin would
20 be but we did look at separating out the impacts on
21 payments between LTCH patients that meet the criteria and
22 patients who don't. And payments for all LTCH patients go

1 down because most of these patients are also treated in
2 other much lower-cost settings. But the payment reduction
3 for LTCH qualifying cases is much smaller than the
4 reduction for non-qualifying cases, and it's because the
5 non-qualifying cases are predominantly treated in SNFs,
6 which is a much lower-cost setting.

7 So we didn't -- and we might have done the
8 facility change in payments for LTCH that have a
9 preponderance of LTCH qualifying stays. I can't remember -
10 - criteria. But in general, the payments go down for all
11 LTCH patients, but for the qualifying they go down less.

12 MS. WANG: Okay.

13 DR. CARTER: And we are trying to capture
14 directing payments to patient criteria that are sort of the
15 heavy care, medically complex patients.

16 MS. WANG: Okay. I find that clarification
17 really helpful to put into context the transition of this
18 particular group of providers, so thank you.

19 DR. CROSSON: It was very helpful, because I
20 think it suggests -- and I'm not sure how this is going to
21 play out in the second part of this discussion, but it
22 suggests that LTCHs, even those who are caring for the

1 patients who meet the admission criteria, are going to be
2 in more financial straits as we move forward here.
3 So seeing no further questions, let's take a look
4 at the --
5 MS. CAMERON: Can I just make a quick
6 clarification?
7 DR. CROSSON: Yeah. Go ahead.
8 MS. CAMERON: I just want to be clear that the
9 providers that have greater than 854 percent of their cases
10 meeting the criteria, we have not classified them as
11 efficient or not. That is, we don't do that analysis for
12 LTCHs because of historical issues with some data, and now
13 this giant payment change that's occurring.
14 So, you know, we have not looked at them based on
15 quality. We do know their costs are actually a tad higher,
16 which could result from the different care that they are
17 providing. But just to be clear, that's not an efficiency
18 measure.
19 DR. CROSSON: So thank you, Stephanie. Without
20 putting you on the spot, because I realize that we're
21 talking about Secretary discretion, but you do have a track
22 record of what the Secretary has done in the past.

1 Realizing the fact that the Secretary is now dealing with
2 some requirements in law, can you make an educated guess as
3 to what the Secretary's decision might look like for 2020?
4 MS. CAMERON: Yes. I believe it's 2.8 percent.
5 I think it's similar to the hospital.
6 DR. CROSSON: And that includes the reduction for
7 -- okay.
8 MS. CAMERON: That's right.
9 DR. CROSSON: All right. Okay. So let's have a
10 discussion about the recommendation as it stands, and I
11 think the issue on the table is one of payment adequacy
12 pretty much. It's not a policy issue here per se.
13 Paul.
14 DR. PAUL GINSBURG: I'll start off and just say
15 that I haven't heard a case so far, you know, for not
16 having an update, and I'm open to hearing a case but I
17 haven't heard one.
18 DR. CROSSON: Other comments. Amy.
19 DR. BRICKER: Yeah. I think based on the
20 discussion thus far if we can focus on ensuring that the
21 criteria is there to promote this qualifying patient -- I
22 remember so many conversations that we've had, at least in

1 the last three years, around these facility types, and
2 specifically around mechanically ventilated patients and
3 their ability to wean. I'm just sitting here thinking if I
4 had a choice in a community between, you know, my hospital
5 or a facility like this for a loved one, you know, where
6 would I rather be, if that were my medical situation.
7 So I just want to make sure that we're thinking
8 about the value that these facilities, those that should be
9 in operation, if we have done a good job of ridding
10 ourselves of those that maybe shouldn't, I just want to
11 protect them, because I think that unless we can hear some
12 other rationale, they do serve a critical purpose in the
13 ecosystem, and I'd like to continue to protect them. So
14 I'm not as compelled, with this facility type, to not
15 provide the update.
16 DR. CROSSON: Okay. David.
17 DR. GRABOWSKI: I'm not opposed to giving them an
18 update but I think the argument -- just to respond to Paul
19 and Amy -- would be if you look at those LTCHs that are
20 treating 85 percent or greater of cases meeting the
21 criteria, they do have a margin here of 4.6 percent. And
22 so those are relatively healthy.

1 And to Carol's point, if those who don't meet the
2 criteria should really be receiving treatment in a SNF,
3 then these are exactly the LTCHs that we want to reward
4 with, you know, going down the road, and they do seem to be
5 fairly healthy. Once again, we can argue whether 4.6
6 percent is a good margin.
7 DR. PAUL GINSBURG: Well, actually, I think the
8 only difference between us, presuming you are on Slide 14 -
9 -
10 DR. GRABOWSKI: 12. Sorry.
11 DR. CROSSON: That's 2017 and we're talking about
12 projected.
13 DR. GRABOWSKI: Sure. Sure.
14 DR. CROSSON: We're talking about projected
15 margin.
16 DR. PAUL GINSBURG: Yeah, but the projection for
17 these is 1.2.
18 DR. CROSSON: Okay. Yeah, Pat.
19 MS. WANG: You know, I respect what people have
20 said, but then what does that -- does that call into
21 question our embrace of the unified PAC-PPS, because it
22 sound like that's going to make the situation worse for

1 these organizations. They're going to get cut. So if
2 there's concern about preserving them as part of the
3 infrastructure of the health care system, you know, how do
4 you reconcile these two things -- payment update and then
5 unified PAC-PPS, payment decrease?
6 DR. CROSSON: And remind me. Unified PAC-PPS is
7 2022? Carol, is that right, 2022? Okay. And we're
8 talking about -- sorry.
9 DR. CARTER: Do you mean what the Commission --
10 DR. CROSSON: Yeah, what we've recommended, 2022.
11 DR. CARTER: Yes. Right.
12 DR. PAUL GINSBURG: We don't know when it's
13 actually going to be implemented.
14 DR. CROSSON: Right. Right. You know, I have
15 the sense here that we're of two minds on this particular
16 issue, and I have some discomfort myself, to be frank,
17 after listening to the discussion. So I'm going to suggest
18 that we come back in January for reconsideration of this
19 issue, with perhaps -- can we do options in this regard?
20 DR. MATHEWS: Why don't we talk after the
21 meeting?
22 DR. CROSSON: Yeah. Kathy, go ahead.

1 MS. BUTO: Get a little more data on how some of
2 these prevalent conditions in LTCHs might be already being
3 managed in SNFs, for example, and maybe IRFs, but I don't
4 think IRFs because of the severity of illness. In other
5 words, it would help to know how much capability there is
6 in other settings, even as they move toward the 2020
7 changes, are SNFs going to be taking on more of these
8 patients? I think that would help us understand the
9 context.
10 DR. CROSSON: Yeah. I mean, my own sense, and
11 it's based on no data, is that there's plenty of
12 capability, because as Amy pointed out, there are not many
13 of these in the country. So we've got patients being cared
14 for in acute care hospitals and SNFs as well. If we could
15 get more quantitation of that.
16 DR. MATHEWS: Yeah. And, in fact, isn't the
17 strong majority of those kind of patients are being treated
18 in non-LTCH settings?
19 MS. CAMERON: That's right.
20 DR. CROSSON: Right. And the cost differential?
21 MS. CAMERON: It's quite significant. I mean,
22 the average LTCH payment, as I showed earlier, you know,

1 $40,000, close to. The SNF payment is $18,000, on average.
2 You know, we haven't adjusted that at all by condition,
3 but, you know, it's an order of magnitude difference.
4 DR. CROSSON: So this is a policy tension here,
5 because, you know, I understand the notion here of
6 providing an update that is adequate for the best of these
7 facilities to continue. On the other hand, one would say
8 what are we doing if, in fact, this is very much more
9 costly than other settings? Because I guess then the
10 argument comes down to whether or not the specialized
11 services, knowledge, expertise of these facilities is
12 sufficient to justify the extra cost.
13 DR. MATHEWS: And one other thing to add there,
14 and, Stephanie, this is memory refresh exercise. When we
15 made the original recommendation regarding eight days in
16 the ICU to identify qualifying cases, wasn't there a
17 companion part of that recommendation that said the savings
18 from this part of the recommendation should go to fund
19 outlier payments in acute care hospital, or am I missing
20 something?
21 MS. CAMERON: Nope. That's exactly right.
22 DR. MATHEWS: Yeah. So it was an explicit

1 recognition of the fact that acute care hospitals are
2 treating the majority of these cases and would benefit from
3 the additional money due to their high cost.
4 DR. CROSSON: Paul and then Jonathan.
5 DR. PAUL GINSBURG: Yeah. I mean, is it correct
6 that we have a report to Congress in June, due in June --
7 MS. CAMERON: Yes.
8 DR. PAUL GINSBURG: -- on long-term care
9 hospitals?
10 MS. CAMERON: It is correct.
11 DR. PAUL GINSBURG: So that might be a time to
12 consider, you know, do they really have a role in Medicare.
13 It seems to be premature starting to use no updates to sort
14 of getting there until we've actually come to the
15 conclusion and submit it to Congress, which, you know,
16 maybe will happen.
17 So, I think, I mean, it's one thing for us to
18 decide they shouldn't really have a role. We've been
19 working on them for a long time, and, therefore, this is
20 one of the things that should happen to diminish their
21 role. And then we'd have a justification for recommending
22 no update. But without doing that it's kind of hard to --

1 I don't see a justification for that at this point in time.
2 DR. CROSSON: I understand the point you're
3 making but I just want to be clear. That's not the point
4 we're making here, and the update recommendation is, you
5 know, let's make the update so small that all of these
6 facilities go out of business. That's not what we're
7 recommending. I think it's legitimate to contest whether
8 or not this particular recommendation of 0 versus 2.8 is
9 the right recommendation. I think that's fair enough.
10 DR. MATHEWS: Or any point in between those two.
11 DR. CROSSON: Right. Right. Right. Now I'm
12 lost. Where am I? Anybody? Yeah, Jonathan.
13 DR. JAFFERY: Yeah. I guess I just -- this has
14 come up a couple of times now and I want to emphasize this
15 point, a point. So we're talking about this moving towards
16 being an element of a unified post-acute care payment
17 system, and LTCHs are at one end of that, and it's not
18 clear to me -- and I think it's not clear to lots of people
19 all the time, because this keeps coming up -- that they're
20 always, or maybe predominantly, in the post-acute care
21 space. They may really be more in the acute-care space, in
22 fact. That's part of their name, right?

1 So, you know, and I'm thinking about Amy's
2 comment about if I needed this type of care I'd want this
3 in my community so I could go. Well, so maybe that depends
4 on if you're faced with there's a nursing home that doesn't
5 have great capacity for this or great experience, but not
6 comparing it to the acute care hospital that maybe could do
7 this more effectively or as effectively.
8 So I'm not sure, to me, this totally fits
9 entirely in the post-acute care space. And, you know,
10 that's not going to impact this recommendation right now,
11 but I think we need to think about that.
12 DR. CROSSON: Bruce.
13 MR. PYENSON: Yeah. I support the recommendation
14 as written, and I think what convinced me is some of the
15 discussion around the historical elasticity of this segment
16 to adjust. And I think that's an important characteristic
17 to look for in the transformation of the system. Thank
18 you.
19 DR. CROSSON: Okay. So I think it should be
20 obvious that this doesn't fit the criteria for coming back
21 with an expedited vote in January. So I think there have
22 been an number of good points here, and not just points but

1 values. We've got some competing values going on here,
2 which I think deserve some more explication. So I'm going
3 to suggest to Jim -- I already have -- and to Stephanie and
4 others that we come back in January and we lay out some of
5 these issues. How is this care provided? Where is it
6 provided? What's the financial impact on the Medicare
7 program of various sites? If we can, with some of the
8 implications of the recommendations on unified PAC, would
9 that take place? So we have a little bit better grounding.
10 And then as part of that, perhaps thinking again
11 of what the updated recommendation might be. I have to
12 talk to Jim about whether we can -- you know, in keeping
13 with our practices, whether we can actually have options
14 for, or we just need to bring forward a recommendation
15 based on some more thought.
16 Does that sound okay to everybody?
17 [No response.]
18 DR. CROSSON: Okay, good. Thank you. Thanks
19 very much.
20 So that's what we'll do, and that bring to the
21 end the discussions for today.
22 DR. CROSSON: We now have time for a public

1 comment period. If there are any of our guests who would
2 like to make a public comment, now is the time to stand up
3 and be recognized.
4 [No response.]
5 DR. CROSSON: Okay. Seeing no one come forward,
6 I would -- before we close I did neglect this morning to
7 ask about discussants for the Medicare Advantage chapter
8 tomorrow. Does anybody want to raise their hand on that
9 one? Pat, okay.
10 So we are adjourned then until 8:00 tomorrow
11 morning -- 8:00 tomorrow morning -- 8:00 tomorrow morning.
12 Thanks very much. Thanks you.
13 [Whereupon, at 4:05 p.m., the meeting was
14 adjourned, to reconvene at 8:00 a.m. on Friday, December 7,
15 2018.]
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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 7, 2018
8:00 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
BRIAN DeBUSK, PhD
KAREN DeSALVO, MD, MPH, Msc
MARJORIE GINSBURG, BSN, MPH
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
JONATHAN JAFFERY, MD, MS, MMM
JONATHAN PERLIN, MD, PhD, MSHA
BRUCE PYENSON, FSA, MAAA
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
29999 W. Barrier Reef Blvd.
Lewes, DE 19958
302-947-9541

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1 P R O C E E D I N G S

2 [8:00 a.m.]

3 DR. CROSSON: This morning, we have three updates
4 to do and then our annual review of the Medicare Advantage
5 program. We're going to start out with outpatient dialysis
6 services. Nancy and Andy are here.

7 Nancy, are you going to start out? Okay.

8 MS. RAY: Good morning.

9 Outpatient dialysis services are used to treat
10 most patients with end-stage renal disease. In 2017, there
11 were approximately 394,000 Medicare fee-for-service
12 dialysis beneficiaries treated at about 7,000 facilities.
13 Total Medicare fee-for-service spending was about $11.4
14 billion for dialysis services.

15 Moving to our payment adequacy analysis, as you
16 have seen, we look at the factors listed on this slide
17 which include examining beneficiaries' access to care,
18 changes in the quality of care, providers' access to
19 capital, and an analysis of Medicare's payments and
20 providers' costs.

21 We look at beneficiaries' access to care by
22 examining industry's capacity to furnish care, as measured

1 by the growth in dialysis treatment stations.

2 Between 2016 and 2017, growth in dialysis

3 treatment stations, at about 3 percent, grew faster than

4 fee-for-service beneficiary growth, at about 0.4 percent.

5 Between 2016 and 2017, more facilities opened

6 than closed. There was a net increase of about 250

7 facilities. Few facilities closed in 2016. There was a

8 net increase in for-profit freestanding facilities as well

9 as facilities located in rural and urban areas.

10 The roughly 40 facilities that closed were more

11 likely to be hospital-based and nonprofit compared to all

12 other facilities. Few patients, about 0.3 percent, were

13 affected by these closures. Our analysis suggests that

14 affected patients were able to obtain care elsewhere.

15 Another indicator of access to care is the growth

16 in the volume of services. We track volume growth by

17 assessing trends in the number of dialysis fee-for-service-

18 covered treatments and fee-for-service dialysis

19 beneficiaries.

20 Between 2016 and 2017, the total number of fee-

21 for-service dialysis beneficiaries, total Medicare-covered

22 treatments, and non-annualized treatments per beneficiary

1 remained steady. This is a little different than
2 historical trends that show small positive growth for these
3 measures.
4 There are a couple of reasons that may explain
5 this trend. First, overall ESRD incidence is decreasing.
6 Second, the share of ESRD patients in MA plans is
7 increasing; and third, there has been greater uniformity in
8 paying for three dialysis sessions per seek, as explained
9 in more detail in your briefing materials.
10 Looking at the marginal profit, the 17 percent
11 marginal profit suggests that providers have a financial
12 incentive to continue to serve Medicare beneficiaries.
13 We also look at volume changes by measuring
14 growth in the volume of dialysis drugs furnished. Dialysis
15 drugs are an important component of care.
16 Since the PPS was implemented in 2011, dialysis
17 drugs have been included in the payment bundle.
18 Consequently, providers' incentive to furnish them, in
19 particular the erythropoietin-stimulating agents, ESAs, has
20 changed. ESAs are the leading dialysis drug class in terms
21 of utilization.
22 Before start of the PPS in 2011, there were both

1 clinical and financial reasons for their overuse. As
2 anticipated, after the PPS, ESA use went down
3 significantly.
4 Between 2010 and 2017, the use of ESAs declined
5 in aggregate by 58 percent. This outcome was expected and
6 desired and has occurred, according to researchers with
7 some positive changes to beneficiaries' health status.
8 In early years of the PPS, 2011 and 2012, ESA use
9 per treatment declined substantially. In more recent
10 years, the decline has moderated somewhat. However, since
11 2015, we see substitution among ESAs for the lower-cost
12 product, which is also consistent with the goals of the
13 PPS.
14 Next, we look at quality by examining changes
15 between 2012 and 2017. One indicator that measures how
16 well the dialysis treatment removes waste from the blood,
17 dialysis adequacy, remains high. Mortality, admissions per
18 beneficiary, and the percent of hospitalized beneficiaries
19 with a readmission are trending down.
20 The percent of dialysis beneficiaries using home
21 dialysis, which is associated with improved quality of life
22 and patient satisfaction, has modestly increased. These

1 are all good trends. On the other hand, the percent of
2 dialysis beneficiaries with at least one ED visit in a
3 given month has increased under the PPS.
4 Regarding access to capital, indicators suggest
5 it is robust. An increasing number of facilities are for-
6 profit and freestanding. Private capital appears to be
7 available to the large and smaller-sized multi-facility
8 organizations.
9 Since the start of the dialysis PPS, the two
10 largest dialysis organizations have had sufficient access
11 to capital to each purchase other organizations. The 2017
12 all-payer margin was 23 percent.
13 Moving to our analysis of payments and costs, in
14 2017, the Medicare margin is negative 1.1 percent. The
15 biggest difference across freestanding facilities is based
16 on location.
17 The aggregate Medicare margin for rural
18 facilities, which accounts for about 20 percent of
19 facilities, is negative 5.5 percent. The lower Medicare
20 margin for these facilities is related to their capacity
21 and treatment volume.
22 Rural facilities are on average smaller than

1 urban ones. They have fewer stations, and they provide
2 fewer treatments. And smaller facilities have
3 substantially higher cost per treatment than larger
4 facilities, particularly overhead and capital costs.
5 So now let's review the factors that the 2019
6 projected Medicare margin is based on, the 2018 factors
7 include the statutory update to the base payment rate of
8 0.3 percent. Regulatory changes by CMS that are expected
9 to increase total payments, and a small estimated reduction
10 in total payments due to the ESRD quality incentive
11 program.
12 The 2019 factors include a statutory update to
13 the base rate of 1.3 percent, regulatory change by CMS
14 expected to increase total payments, and a small reduction
15 in total payments, again, due to the ESRD QIP.
16 Applying these factors, the 2019 projected
17 Medicare margin is negative 0.4 percent, a small increase
18 from the 2017 margin.
19 There are a couple of policy changes that will
20 occur in 2020. This includes the statutory update of the
21 base payment rate. There will also be an estimated small
22 reduction in total payments, again, due to the ESRD QIP,

1 and in addition, in 2020, CMS will begin to pay facilities
2 separately for all new dialysis drugs, including
3 biosimilars and generics for a two-year period without any
4 offset to the PPS-based payment rate. We expect this will
5 increase Medicare payments to dialysis facilities.
6 So here is a quick summary of the payment
7 adequacy findings. Access to care indicators are
8 favorable. Quality is improving for most measures. The
9 2019 Medicare margin is projected at negative 0.4 percent.
10 Here is the Chairman's draft recommendation. For
11 calendar year 2020, the Congress should update the calendar
12 year 2019 Medicare ESRD PPS base rate by the amount
13 determined in current law.
14 So with respect to the draft recommendation's
15 implications, in terms of spending, this draft
16 recommendation has no effect on spending relative to
17 current law. No impact to beneficiaries is expected.
18 Given that there is no change in current law, we would
19 expect no effect on providers' willingness and ability to
20 care for Medicare beneficiaries.
21 With that, I give it back to Jay.
22 DR. CROSSON: Thank you, Nancy.

1 I actually have one question myself. If we do
2 the math here, it looks like commercial margins are
3 relatively robust. Do you know is there as much spread in
4 commercial margins between urban and rural and between
5 large and small dialysis centers as there is with respect
6 to Medicare?
7 MS. RAY: I don't know that.
8 DR. CROSSON: Okay. Thanks.
9 Questions?
10 Bruce.
11 DR. PYENSON: Thank you very much, Nancy. I know
12 you're an expert in end-stage renal disease and have been
13 following it for a while.
14 Just a couple of questions, one of them taking up
15 from Jay's question. Do you know what portion of revenue
16 is commercial or is non-Medicare versus Medicare fee-for-
17 service? Because it's striking how the very healthy
18 margins of the industry compare to the Medicare
19 reimbursement.
20 MS. RAY: So I know that number, but it's back in
21 the office.
22 DR. PYENSON: Okay.

1 MS. RAY: I can definitely get that to you.
2 DR. PYENSON: A related question, in the
3 materials, it mentioned that 31 percent of all enrollees,
4 of Medicare enrollees, are in MA; 19 percent of people with
5 end-stage renal disease or classified as end-stage renal
6 disease in Medicare are in MA. Because they're not allowed
7 to enroll after beneficiaries are certified, this suggests
8 that people join either right before they get end-stage
9 renal disease or they've developed the disease while
10 they're a member.
11 DR. JOHNSON: I think that's right, but was there
12 a specific question? Or is that -- I think that assertion
13 is --
14 DR. PYENSON: Well, I'm leading to another
15 question. There have been suggestions in the oncology
16 world that individuals who know they will need cancer
17 treatment might disenroll from Medicare Advantage. There
18 have been suggestions on that.
19 I'm wondering if the opposite is true of people
20 who are going to need dialysis, and that's because the
21 Medicare Advantage plans are paying much, much more than
22 Medicare rates very often to the end-stage renal disease

1 providers, and I'm wondering if that's something that
2 you've looked at or could look at.
3 DR. JOHNSON: I don't think we've looked at. I
4 think a complicating factor is that the ESRD is a reason
5 for Medicare entitlement for people who are younger than 65
6 as well, so there's sort of a split in the population of
7 people who are on Medicare and are using dialysis.
8 DR. PYENSON: So do you think that's a
9 hypothesis, a reasonable hypothesis, that individuals who
10 are already enrolled in Medicare might be encouraged to
11 enroll in Medicare Advantage because the providers will be
12 much higher reimbursed?
13 DR. JOHNSON: I guess you would have to expect
14 that you might be heading towards end-stage renal disease,
15 that you have an earlier chronic kidney disease stage and
16 would plan in advance. We haven't looked at that, but I'm
17 thinking of ways that we might be able to.
18 DR. CROSSON: Marge, on this point?
19 MS. MARJORIE GINSBURG: Actually tied to this
20 question. First of all, it said in the report that people
21 with end-stage renal disease are not allowed to enroll into
22 Medicare Advantage plans, if this happens, but that that

1 law was changing and that they will be.
2 So that I think might be related to Bruce's
3 question. I'm curious why they were not allowed. My
4 theory -- and it may be wrong -- was that the cost is so
5 steep for caring for patients with end-stage renal disease
6 that in fairness to Medicare Advantage plans, they
7 basically gave them an out by saying, "Don't worry. We
8 won't have people enrolled," unless they were already
9 patients within that system, in which case they stay in the
10 system.
11 So was that true? Was it because they were
12 trying to -- and if that was true, then why is that now
13 flipping and people will be able to enroll with end-stage
14 renal disease now?
15 And I would question whether -- and this is pure
16 fantasy -- whether patients would be so forward-looking
17 that they would say which of these two systems is going to
18 treat me best. I don't think Medicare beneficiaries --
19 DR. PYENSON: Oh, for sure, but I think the
20 providers are so forward-looking.
21 MS. MARJORIE GINSBURG: The providers. But some
22 providers are both MA and fee-for-service. So you're

1 saying that you think a provider might encourage a patient
2 to move from original Medicare to MA that they're also a
3 part of? So they wouldn't be losing their physician
4 network? Is that what you're saying?
5 DR. PYENSON: And if not today, certainly when
6 the rules change, I think that's a real potential because
7 my understanding is that the market leaders are not
8 accepting Medicare rates from Medicare Advantage. They're
9 accepting commercial rates, which are much higher. So I
10 think there's sort of the flip side of what people have
11 talked about with oncology is potentially an issue.
12 MS. MARJORIE GINSBURG: Mm-hmm.
13 MS. RAY: I think one --
14 MS. MARJORIE GINSBURG: Well, so go back to the
15 original question, why did all this --
16 MS. RAY: Right. Just a couple of points, and I
17 hope this can help address your question.
18 Number one, for the under-65, if you're in a
19 state in which you're not permitted to buy Medigap and if
20 you're already in a plan, then you can stay in that plan.
21 Did I get that right?
22 DR. JOHNSON: If you're in the plan, you can stay

1 in the plan.

2 MS. RAY: Yes, yes, yes. So there's that working

3 here in this trend.

4 In terms of the background as to why there is a

5 statutory bar, I'm not sure of the exact history of that.

6 I do believe that the cost of these patients was a factor,

7 however; but on the other hand, there are other expensive

8 patients in MA plans who are permitted to enroll, patients

9 with multiple sclerosis and Parkinson's, et cetera.

10 The Commission has a longstanding recommendation

11 that the Congress lift the statutory bar and permit

12 Medicare ESRD patients to enroll.

13 MS. MARJORIE GINSBURG: Has there been a response

14 from MA plans about the right lifting of the bar? Have

15 they been happy or unhappy?

16 DR. JOHNSON: I don't know that there's a

17 consensus either way.

18 DR. CROSSON: Okay. Paul.

19 DR. PAUL GINSBURG: I just want to reimburse what

20 Bruce said about the very powerful role of the providers of

21 dialysis services to influence patients as to what they

22 enroll. It's been a major issue with marketplace plans set

1 up by the Affordable Care Act, of so-called foundations
2 paying the premiums for ESRD patients to enroll in private
3 coverage and allowing the providers to get much higher
4 commercial rates instead of Medicare rates. So this is
5 somewhat of a unique area.

6 DR. CROSSON: Yeah, Jonathan.

7 DR. JAFFERY: A little different type of
8 question. So in the meeting material there was some
9 discussion about the -- I forget what it was called --
10 kidney disease education payments, I think under MIPPA,
11 that doesn't sound like they had very much take-up. And
12 you mentioned a minute ago that obviously there's two ways
13 to get onto -- to get Medicare for dialysis. You can
14 already have Medicare and then be over 65 and develop
15 dialysis or be under 65.

16 And so I wondered, do you have any information
17 about other payers and if any of them have developed
18 similar education program type payments, because it does
19 strike one that it's hard for a clinic to set up -- it's
20 less easy or less straightforward from the setup of that
21 program to start charging people for that if it's just a
22 small subset of patients.

1 MS. RAY: I am aware of other payers that have
2 set up such programs and we could come back to you in the
3 future to discuss that. I'm also aware of some dialysis
4 providers who are, I think, working with payers to
5 implement such programs as well.
6 DR. JAFFERY: I just want to clarify one thing.
7 So we're talking about providers here.
8 MS. RAY: Facilities. I'm talking about dialysis
9 facilities.
10 DR. JAFFERY: Right, so that's come up a few
11 times. And so as we're getting into this idea of kidney
12 disease education and pre-end-stage renal disease.
13 MS. RAY: Right.
14 DR. JAFFERY: Ultimately if we want to save --
15 improve beneficiaries' lives and save money there's a
16 prevention opportunity here. So for those providers, we're
17 only talking about the nephrology community, dialysis,
18 although there are -- even the big dialysis centers are
19 starting to think about chronic kidney disease -- pre-end-
20 stage chronic kidney disease, but just for everyone to
21 recognize that there's a big distinction there between
22 providers and when and where they interact with patients.

1 DR. CROSSON: Karen.

2 DR. DeSALVO: Fantastic job on this chapter and
3 it sparked a lot of new things for me. So I just want to
4 get a little clarification about the outcomes and quality
5 measurement component to this, to make sure I understand.
6 What we know mostly is from the fee-for-service outcomes.
7 We don't know very much about the MA outcomes, or is that
8 included in what you all know?

9 MS. RAY: So mortality would be based on all
10 dialysis patients, regardless of payer. The hospital
11 admissions, readmissions, ED visits, adequacy hemoglobin
12 levels in the paper, that would be specific to the fee-for-
13 service population. Thank you. I apologize for that.

14 DR. DeSALVO: That's okay. And medication use as
15 well?

16 MS. RAY: Medication use is for fee-for-service.

17 DR. DeSALVO: Okay. And then just a follow-up
18 question about the strategy around moving this part of the
19 market to value, that looks like HHS is pretty active in a
20 few areas. And I think the reason I was interested in that
21 particularly was because of the hospitalization rates
22 starting to tick up, and I wondered if, Nancy, you all had

1 any perspective on what the cause of those hospitalizations
2 were and whether that was one of the drivers to try to
3 create ACO-type models or other models that are more
4 coordinated for dialysis patients.
5 MS. RAY: Right. Just to clarify. Admissions
6 per beneficiary has been trending down.
7 DR. DeSALVO: Okay.
8 MS. RAY: That is consistent, I think, with
9 overall decline in fee-for-service admissions going down.
10 All that being said, they are still hospitalized,
11 you know, more than non-dialysis beneficiaries, and I think
12 that that has -- and I don't have the exact percentage here
13 but a relatively large component of all of the costs of a
14 dialysis beneficiary -- dialysis, admissions, post-acute --
15 but admissions is a fair share. And I do believe that that
16 was a driving force in the creation of the ESCOs for
17 dialysis providers to take risk for these patients in
18 trying to decrease hospital admissions, ED visits, and
19 other -- and to improve outcomes.
20 DR. CROSSON: I have Kathy, Brian, Pat.
21 MS. BUTO: My question is about the -- remind me
22 whether last year we recommended the current law update for

1 ESRD. We did, right?

2 MS. RAY: Yes, we did.

3 MS. BUTO: And I'm looking at the new provision

4 that allows pass-through payments for new drugs. So we

5 can't estimate yet what the increase will be in terms of

6 revenue to dialysis centers as a result of that, but

7 clearly that's going to be additional revenue, assuming

8 there are new drugs that come along. And I just want to --

9 I'm looking to you for any sense of do we know anything

10 about projected new drugs in this space.

11 MS. RAY: I think there are a couple of new drugs

12 that are expected to come out, to be launched. I would

13 expect that after January 1, 2020. CMS, in their proposed

14 and final rule did not estimate the impact of this new

15 change, saying that, you know, they basically did not know,

16 you know, the pricing and the exact timing of the launch of

17 these products.

18 MS. BUTO: Okay. And are they ESAs, do you know?

19 MS. RAY: I believe that there is one ESA

20 biosimilar coming out. There is also a product for itching

21 of dialysis patients, which can be severe in certain

22 patients, and it's -- I think it is also expected to be

1 launched.

2 MS. BUTO: I know this is not the place to take

3 this on but this issue of pass-throughs for some drugs in a

4 category and not for others that are already in the base I

5 think is an issue we need to take a look at down the road.

6 But that's sort of a round two comment.

7 DR. CROSSON: Nancy, can you remind us what the

8 base -- what's the formula for payment for these pass-

9 through drugs?

10 MS. RAY: They will be paid at ASP, 100 percent

11 of ASP.

12 DR. CROSSON: Okay. With no add-on.

13 MS. RAY: No add-on.

14 DR. CROSSON: Okay. Thanks.

15 DR. JOHNSON: [Speaking off microphone.]

16 MS. RAY: And no adjustment to the base rate.

17 Thank you. No adjustment to the base rate.

18 DR. CROSSON: Right. Right. Right.

19 MS. RAY: They will be paid for two years at 100

20 percent of ASP, and then they will be included into the

21 base rate with no adjustment.

22 DR. JOHNSON: And all the --

1 DR. CROSSON: Is it reasonable to surmise, then,
2 that, once again, the larger facilities, particularly the
3 national chains with more negotiating power may have a
4 significant advantage here as well?
5 DR. BRICKER: I would just venture that you would
6 be incented to use the new products, not those that are
7 included in your bundles, right?
8 UNIDENTIFIED SPEAKER: Already paid for those.
9 DR. BRICKER: You paid for those. Then you get
10 additional value through the new products, whether or not
11 they're better products, or, yeah.
12 DR. CROSSON: And if -- okay. Well, I'm
13 speculating. Brian, on this as well as --
14 DR. DeBUSK: Yeah. To clarify one more time, and
15 this is part of where I wanted to go with my question but
16 then I have a separate one, so I could take an existing
17 patient, existing procedure, everything, quit using the ESA
18 that I've used for years, use a new ESA, receive an ASP
19 payment. Clearly it's in their economic best interest to
20 do a switch, even if the new ESA is more expensive than
21 what they're using. It seems like a huge hole in the
22 system.

1 DR. JOHNSON: And it would get the full base rate
2 bundle as well as the ASP rate.
3 DR. DeBUSK: Okay. And if I can ask a related
4 question on that too. I mean, first of all, that's sort of
5 glaring. The second question is, I know that -- and I
6 asked this two years ago so it hopefully may have changed.
7 You always want to ask. The ESAs that we have also are --
8 I think they're Part B drugs as well. They have codes --
9 MS. RAY: Yes.
10 DR. DeBUSK: -- they would have codes.
11 MS. RAY: Yes, they do have codes.
12 DR. DeBUSK: And do we have enough information,
13 say, from the cost report or from other information to
14 where we could crosswalk what the same drug, under the Part
15 B fee schedule, versus what it sells for to a dialysis
16 clinic?
17 MS. RAY: Yeah. You know, the way that -- that
18 would be a slightly tricky analysis, and I can talk to you
19 offline about it. But the way that the -- I'd have to go
20 back to the cost reports. And if all ESAs are reported in
21 one column then that would be -- and if a facility used
22 more than one ESA, that would be difficult to do.

1 DR. DeBUSK: Okay. I was just wondering, because
2 I know Kathy had advocated, when we had a Part B discussion
3 two years ago, was talking about packaging more drugs into
4 the procedures, and it seems like this would be a good
5 opportunity to test that.
6 MS. BUTO: We're going the other direction on
7 this one.
8 DR. DeBUSK: Yes.
9 MS. BUTO: Or unpackaging it.
10 DR. DeBUSK: Yes.
11 DR. CROSSON: Okay. Brian, was that your
12 question or do you have another one? Okay.
13 Pat.
14 MS. WANG: I just wondered whether there was any
15 information yet on the progress, I guess, or achievements
16 of the ESCOs or other efforts to coordinate. It was also
17 unclear in the written materials. Are these organizations
18 primarily being administered or initiated by the dialysis
19 providers or are some of them in coordination with like
20 hospital ACOs, et cetera?
21 MS. RAY: Okay. So the ESCOs are -- have been
22 developed by the dialysis organizations with nephrologists.

1 We have the first-year analysis of the results show that
2 they did save money. They were returned money from the
3 government, right?
4 DR. JOHNSON: All of the ESCOs saved money in the
5 first year and all but one saved enough to get a shared
6 savings payment back.
7 MS. RAY: Right. Thank you. And the
8 contractor's analysis show that admission significantly
9 decreased. And I think that was the biggest decrease in
10 terms of utilization of services.
11 DR. CROSSON: Jon.
12 DR. JAFFERY: It may be a related question. So
13 do you have any data of the Medicare fee-for-service
14 beneficiaries who, on dialysis, how many are either in
15 ESCOs or ACOs, separate ACOs?
16 MS. RAY: Right. I don't have the number that
17 are in ACOs. The number that are in ESCOs, I did not
18 determine it. It was based on what I found according to
19 CMS and in an article. And I'm looking for it. So
20 according to other sources, there are approximately 16,000
21 beneficiaries in the first performance year and it
22 increased to roughly 55,000 in the second performance year.

1 DR. JAFFERY: It might be interesting at some
2 point, if there are enough numbers, to compare performance
3 or outcomes between, you know -- you could have four
4 categories: MA, Medicare fee-for-service who are not part
5 of any value-based contract, Medicare fee-for-service in an
6 ESCO, and Medicare fee-for-service in some separate ACO,
7 and then even think about pushing out some shared learning.
8 MS. RAY: Agreed. I think that would be super
9 interesting.
10 DR. CROSSON: Karen.
11 DR. DeSALVO: And just as a follow-up, as you're
12 looking at it, is it possible to also look at geographic
13 for the beneficiaries, because I would imagine that those
14 in rural areas are less likely to have access to
15 coordinated care models through MA or ACOs or ESCOs. There
16 would be differential impact.
17 DR. CROSSON: Okay. Bruce.
18 MR. PYENSON: Nancy and Andy, I know you've used
19 the Medicare cost reports from the end-stage renal disease
20 facilities in your analysis, and that involved splitting
21 the Medicare costs from the non-Medicare costs. And that's
22 an issue of concern I have of how that's done and the

1 validity of the cost reports for some of the purposes that
2 we're using them.
3 I wonder if you have an opinion about that.
4 Yesterday we discussed a similar issue with the ASCs that
5 today don't have cost reports and how to do that right. So
6 I wonder if you have any thoughts on that and how that
7 might extend to other areas.
8 MS. RAY: I'd like to think about that question
9 and follow up with you in the future about that. What I
10 will say is that we recommended, I believe it was in 2014,
11 or 2013 or 2014, that CMS conduct audits of ESRD cost
12 reports. The statute -- Congress took up our
13 recommendation, appropriated money to CMS for this, and
14 we're still awaiting the results of that audit.
15 DR. CROSSON: Okay. I think we're ready to move
16 on to the discussion period. We've got -- put the
17 recommendation up. So we've got the recommendation there,
18 to the current law update. I'd ask you to comment on
19 support for the recommendation, no support, suggested
20 changes.
21 Kathy.
22 MS. BUTO: So I support the recommendation. I do

1 want to say that the pass-through for new drugs is
2 troublesome and we don't have enough data to say how
3 troublesome it is. But for next year -- and I think I
4 really urge that we put some language in this year's
5 update, saying that we're going to be looking at that --
6 maybe take us a year and a half to really look at it -- but
7 looking at the data on expenditures for new drugs to see
8 whether, number one, we would recommend that provision be
9 repealed, or two, we would recommend that updates
10 subsequently would be either no update or negative to
11 account for the inflation in costs.
12 So I'd like to see us take that on a little more
13 directly than just to lay out that this is an issue and da-
14 da-da-da-da.
15 DR. MATHEWS: Yeah, we can obviously do that and
16 we will track the effects of the pass-through payments
17 going forward. And I believe --
18 MS. BUTO: Will we have it for next year, though?
19 DR. MATHEWS: Pardon?
20 MS. BUTO: Will we have it next year?
21 DR. MATHEWS: Maybe not.
22 MS. RAY: It doesn't begin until 2020.

1 MS. RAY: Yeah.

2 MS. BUTO: Oh, okay. So we're not going to --

3 DR. MATHEWS: But one thing that we could do --

4 correct me if I'm wrong -- we took a fairly strong position

5 with respect to this proposed policy in our comment letter

6 this past summer. Is that correct?

7 MS. BUTO: Did you? Okay.

8 DR. MATHEWS: And so I think there was language

9 we can export from that comment letter --

10 MS. BUTO: Right.

11 DR. MATHEWS: -- and give it some prominence in

12 this year's chapter, just to put a marker down, if that

13 would help address your concern here.

14 MS. BUTO: I think that would help.

15 The other thing I would say is just -- speaking

16 of markers -- I think the Commission has to look at pass-

17 through payments, period, because these distortions that

18 we're talking about, a small change, not just for drugs but

19 for other things that are pass-through, a small change that

20 qualifies as a new whatever -- technology, procedure, drug

21 -- can really distort what's provided. And that can go for

22 imaging. There are a number of areas where I think we

1 haven't taken that on directly. I just think it's an
2 across-the-board issue that creates distortions in payment.
3 So I think it's totally within our bailiwick to look at
4 that.
5 DR. CROSSON: Other thoughts? Brian did you
6 raise your -- no. Okay. So Paul and then Bruce.
7 DR. PAUL GINSBURG: I support the recommendation.
8 I'm very glad that Kathy brought up this issue of pass-
9 through drugs. One word that we should be sure to use,
10 which hasn't come up in our conversation is the fact that
11 many of these drugs are substitutes for drugs in the
12 bundle, and that's what makes it so problematic.
13 DR. CROSSON: Bruce.
14 MR. PYENSON: I think we have an opportunity here
15 to encourage the coordinated care approach, that I want to
16 make sure we don't miss. So it's seems as though over 10
17 percent of end-stage renal disease beneficiaries are in --
18 have entered one of the new programs, and the evidence in
19 the first years is startling that everybody has saved
20 money, at least by how the benchmarks were set, and most of
21 those have saved enough to actually earn back. So I think
22 this is -- without -- of course, there could be distortions

1 in how that was calculated, but this suggests that that's
2 really, really powerful.
3 And so I would suggest that we provide no update
4 to the rates, that that be our recommendation, because we
5 see an alternative which is the coordinated care approach,
6 and that's been consistent with MedPAC's philosophy and
7 direction. So I think we have an opportunity to do that by
8 putting pressure on this sector. The margins are
9 impressive for the industry as a whole, and so given the
10 experience that we've seen with other sectors that pressure
11 encourages efficiency, and because we have a vehicle that
12 seems viable, I'd offer that as an alternative.
13 DR. CROSSON: Okay. Jon.
14 DR. PERLIN: You know, I'm glad Karen asked the
15 question earlier about quality measures. It strikes me
16 that across the different programs we ought to have a
17 coherent philosophy of how we measure quality. And, you
18 know, I liked the sort of rubric we invoked in HVIP, and
19 one wonders whether there isn't an analog here, where, you
20 know, there were a set of hospital-acquired conditions,
21 dialysis-acquired complications, admissions to hospital,
22 you know, things that were problematic there, spending per

1 beneficiary to help compare across programs, you know, a
2 direct correlation there. Infection, obviously, is a
3 consistent risk. And in terms of quality there are any
4 number of markers, including the adequacy of the dialysis.
5 You can dialyze a patient much faster and technically
6 complete the dialysis. It's absolutely miserable for the
7 patient and it leaves them with confusion and, you know,
8 some metabolic dysfunction after that.
9 So I just want to put a sort of placeholder
10 there. It doesn't have to be a bold-faced recommendation
11 but I think we should work toward a set of coherent,
12 balanced measure that are comparable across programs, and
13 particularly to Bruce's point, as we try to assess the
14 impact on patients across different arrangements of
15 reimbursement for these services.
16 DR. CROSSON: Yeah. And I think Jim may want to
17 comment but we do have kind of standing policy that that's
18 the direction we're trying to move across all payment
19 areas.
20 Karen.
21 DR. DeSALVO: So, first, I agree with Jonathan,
22 and it would be with Jon's recommendations about being more

1 structured including, as you all point out in the chapter,
2 that even within the dialysis program between the Stars and
3 the QIP, there's different ways that we're measuring
4 success. And that could be confusing. So there's
5 opportunity there.
6 I actually feel a little equivocal about the
7 recommendation for some of the reasons that Bruce mentions.
8 That it seems to have robust margins overall in the
9 industry, and that there seems to be opportunity when
10 pressed, when there's pressure, for savings.
11 In addition to these ACO models, with MA stepping
12 into the space and ACOs growing and taking on the total
13 cost of care longitudinally, there may be some
14 opportunities in the coordinated care, value-based care
15 world to really offset some of the negative outcomes for
16 the patients and maybe even, Kathy, some of the cost
17 choices about the drugs.
18 I mean, if you're responsible for total cost of
19 care, then it's not necessarily a pass-through. It might
20 encourage providers to be more thoughtful about not only
21 outcomes but also costs.
22 That's sort of a newbie thing for me about how we

1 look at total margin and Medicare margins, so I'll just
2 have to work my head through it, but it feels like there's
3 still opportunity to improve the total cost and outcomes
4 without an increase.
5 DR. CROSSON: And, truthfully, I think over the
6 years, we've been a little bit dualistic in this regard in
7 the sense that now we're about Medicare and we're
8 interested in what Medicare is paying and whether it's
9 equitable and adequate and the like.
10 On the other hand, sometimes -- and this is a
11 case, I think, in point here where it's kind of hard to do
12 that and totally ignore the other part of the equation,
13 particularly in a situation where it's undergoing change;
14 in this particular case, where there may be a new mechanism
15 coming in place, which could tend to exacerbate that
16 situation because I think -- I mentioned this already, but
17 I do think that the difference in Medicare margin between
18 the large commercial for-profit dialysis organizations and
19 some of the smaller organizations which serve certain
20 communities in the country, it may very well grow larger as
21 a consequence of this particular drug policy.
22 Let's see if there are more comments. Yeah. Jon

1 and then Pat.

2 DR. CHRISTIANSON: Yeah. I approve the

3 recommendation.

4 I'm wondering whether in the chapter there

5 couldn't be a little more discussion of the rural issue. I

6 don't know if we have an access problem for beneficiaries

7 living in rural areas. We do have lower margins on

8 Medicare, smaller facilities -- have a sense whether that's

9 adequate.

10 We worry about rural access issues for a lot of

11 things, and I would like to see something in the chapter

12 that would discuss whether that's an issue here, whether we

13 need to think more creatively about the need or not to

14 maintain access to dialysis for people living in remote

15 rural areas.

16 DR. CROSSON: Pat and then Jon.

17 MS. WANG: I agree with much of what has been

18 said, and again, if there needs to be further endorsement

19 of taking a really concerned look at the pass-through

20 payment policy, I would just add my voice to that.

21 I have to say I'm ambivalent about the update as

22 well, just because, Jay, as you point out, we just spent

1 time looking at negative margins for efficient providers,
2 and we're not really doing anything extraordinary there to
3 address that situation. I realize that it's an expensive
4 price tag when you're talking about hospitals.
5 But in this case, the fact that the overall
6 margin is so high and that the coordinated care approaches
7 have been so successful, whether it's because it's the
8 start of the program or benchmarks or what have you, when
9 ACOs started, the benchmarks were all over the place. And
10 there was varying levels of success -- suggest that there
11 is a lot more efficiency to be gained in providing these
12 services. It feels like the wrong approach just to
13 reflexively say here's a fee-for-service across-the-board
14 update when it seems like there's some other story lurking
15 behind there and opportunities to lower cost through a
16 coordinated approach. It seems like there's a lot of
17 opportunities there, actually.
18 So I'm a little ambivalent. It's like between
19 zero and the update that is in law.
20 I appreciate Jon's comment about it's going to
21 fall differently in different parts of the country. I
22 don't know what to do about that exactly, but I'm a little

1 uncomfortable about just kind of blasting an update out
2 there.
3 DR. CROSSON: Okay. I've got Jonathan, and then
4 I saw Amy and then Kathy and Marge.
5 DR. JAFFERY: So I'll also add I've got some
6 ambivalence, but I think on balance, I agree with Jon that
7 I support the recommendation for that particular reason.
8 It's not clear to me where this falls out for small
9 particular rural providers.
10 I think this issue around -- we've seen a clear
11 demonstration that organizations can move towards value and
12 have improvement. It is encouraging and exciting, but I'm
13 a little bit uncomfortable saying that means we should just
14 no longer give updates based on that because there is a
15 fair discrepancy in terms of where that exists in terms of
16 who the providers are that are delivering it.
17 I think the question of we've also got people on
18 ACOs -- I think there's a little bit of confusion about
19 who's getting the payments for this and where the
20 incentives are. So if you're running an ACO and you have a
21 substantial population of patients on dialysis, this
22 payment actually does not impact you at all, either way.

1 So I'm not sure that that's clear enough yet.
2 And I guess I ultimately -- I don't want to lose
3 sight of the fact that end-stage kidney disease is an
4 undesired outcome here for every conceivable reason, and
5 we've got -- I think it's beyond the scope of payment
6 update to dialysis providers. But we do have an
7 opportunity to think about, in going forward, are there
8 ways to use Medicare payment policies to incent better pre-
9 ESRD, chronic kidney disease care in order to prevent the
10 need for dialysis or transplantation.
11 DR. CROSSON: Amy.
12 MS. BRICKER: I want to just add additional
13 concern that other Commissioners have already mentioned
14 around the update.
15 Is there a mechanism for us to provide update
16 only to rural facilities versus all? Is that an option?
17 DR. CROSSON: Of course, it's up to us what we
18 do, but as we mentioned yesterday when we were talking
19 about hospitals, for the most part, we have made across-
20 the-board update recommendations. To develop a policy
21 which is different from that is something that we could do,
22 but it's not something we can do in the short term.

1 Just as you saw the complexity of what we were
2 doing yesterday with hospitals, my guess is it would
3 require us at least to think about this for a year and make
4 sure we've examined all the ramifications of departing from
5 our usual track.
6 I understand exactly what you're trying to get
7 at, and I have the same concern. But I don't think it's
8 something that we could do, let's say, by next month.
9 MS. BRICKER: Okay, that's fair.
10 So I think potentially -- and we're talking about
11 1 percent or 1.3 percent. The thing I wouldn't want us to
12 encourage is further consolidation of these types of
13 providers to those that are able to essentially drive the
14 all-payer margins that are in question, so continuing to
15 have those facilities that are servicing populations that
16 are underserved today. That's important.
17 And if we aren't able to -- and your point is
18 well taken -- make a shift to focus on those specific
19 facilities that are servicing those populations, I'm in
20 support of the recommendation for that sole reason.
21 I think this industry is presenting -- is leaning
22 into a number of tailwinds. I think that the margins will

1 continue to improve as a class, but as the individual
2 provider level, I'm not sure that that's the case,
3 especially these smaller facilities that aren't able to
4 have the leverage over the commercial payer MA market.
5 So I'm in support with -- come full circle.
6 Thanks.
7 DR. CROSSON: I understand. I kind of agree.
8 Okay. So, Kathy.
9 MS. BUTO: Yeah. And I could actually go either
10 way on this. I support the recommendation, but I am
11 sympathetic to the view that zero update might be the
12 stronger signal to send.
13 I do have a question, though, that I think we
14 should be aware of, both a question that Bruce originally
15 asked about the mix between commercial and Medicare because
16 I think the vast majority of payments is not -- in other
17 words, commercial margins are not a major source of payment
18 for ESRD, although I know over the years, Congress has
19 allowed more commercial payment because they've bumped up
20 the time you're eligible for ESRD. You have to stay on
21 private insurance for longer.
22 So I do think that's important as we consider

1 that issue, commercial versus Medicare.

2 The other thing I think is important to think

3 about is I believe the facility rate sets the ceiling for

4 how much home dialysis paid for. Is that still correct?

5 MS. RAY: For adults, for adult dialysis

6 patients, there is no difference in the payment rate for

7 in-center versus home dialysis.

8 MS. BUTO: Right. So anything we do on in-center

9 could impact the availability of home dialysis is my point.

10 We just need to be aware of that because there has been a

11 greater shift to home dialysis, and I think we're really

12 focusing on the facility aspect of this.

13 DR. CROSSON: Kathy, on the commercial margin

14 piece, I think that we'll find -- I think we're going to

15 come back on this in January. I think it's pretty clear.

16 I think we'll find that the number of Medicare

17 beneficiaries -- sorry -- the number of dialysis patients

18 who are on the commercial side may not be very large, but

19 the commercial margins are so large that when you're

20 looking at dollars, I think we'll be surprised at how large

21 that is.

22 MS. BUTO: I'd like to see that.

1 DR. CROSSON: Yeah. Okay.
2 DR. JAFFERY: Can you explain a little bit what
3 your concern was about the home dialysis payment?
4 MS. BUTO: I just want us to be aware that this
5 sets essentially a payment level for home dialysis as well,
6 and I think in people's minds, home should be cheaper than
7 facility. But it's really the opposite in many cases, not
8 all cases, but it can be more expensive.
9 I know this because some years ago, HCFA was sued
10 because it turned out the agency, Medicare, was paying a
11 lot more for home dialysis, and essentially, Congress put a
12 cap on that. And the reason it was there was a loophole,
13 paying based on charges.
14 So I'm just saying I think we ought to be aware.
15 There's a greater desire to have home dialysis be an option
16 and that anything we do on facility has an impact on what
17 payment rates are available for those services.
18 DR. JAFFERY: Thanks.
19 DR. CROSSON: Marge. I think that's it.
20 MS. MARJORIE GINSBURG: I share everyone's
21 ambivalence, and I appreciated Jon's comment and others
22 about the status of the rural programs, since those seem to

1 be the ones that are now more often falling by the wayside,
2 and their Medicare margins is so much worse than the
3 others. I worry that if we don't keep an eye on what's
4 happening with rural, we'll end up losing more and more of
5 them, and I really think that's unfair to Medicare
6 beneficiaries to have to drive 30 miles or more in order to
7 get their dialysis done.
8 I want us to be aware of those folks and sort of
9 keep an eye on what's actually happening there and if we
10 need to make adjustments in the recommendations that will
11 support the rural facilities.
12 DR. CROSSON: Okay. I agree with that.
13 We have a short-term and a long-term issue. The
14 short-term issue is we have to figure out what we're going
15 to do for this cycle, and I think we have a split opinion
16 here. In addition, a number of good thoughts have been
17 brought up. So we will be coming back for a fuller
18 discussion in January. Maybe I don't have all the issues
19 here, but I think the notion of what could be done to
20 encourage more value-based arrangements is one.
21 This question of access in smaller, particularly
22 not-for-profit, especially rural, more information there,

1 to the extent that it's possible. It may not be.

2 Perhaps a little more thought about the

3 differential impact of these pass-through drugs, but in the

4 end, we're going to need to come back with another

5 recommendation. We'd leave that to Jim and the staff to

6 absorb this commentary and come back with a recommendation

7 in January for the update.

8 Is everybody okay that? Okay. Thank you very

9 much.

10 We'll move on to the next presentation.

11 [Pause.]

12 DR. CROSSON: Okay. The next presentation for

13 this morning is on hospice services, recommended update,

14 and Kim is here.

15 MS. NEUMAN: Good morning. So next we'll be

16 talking about hospice services.

17 In 2017, nearly 1.5 million Medicare

18 beneficiaries used hospice services, including more than

19 half of beneficiaries who died that year. Approximately,

20 4,500 hospice providers furnished care to Medicare

21 beneficiaries, and Medicare paid those providers about

22 $17.9 billion.

1 So first I will review a couple of facts about
2 hospice. The hospice benefit provides palliative and
3 supportive services for beneficiaries with terminal
4 illnesses who choose to enroll. To be eligible, a
5 beneficiary must have a life expectancy of six months or
6 less if the disease runs its normal course.
7 At the start of each hospice benefit period a
8 physician must certify that the beneficiary's life
9 expectancy meets this criteria. There is no limit on how
10 long a beneficiary can be in hospice as long as they
11 continue to meet the life expectancy criteria.
12 A second requirement of the hospice benefit is
13 that the beneficiary agree to forgo conventional care for
14 the terminal condition and related conditions.
15 So before we walk through our indicators of
16 payment adequacy, I'm going to remind you about some recent
17 changes to the hospice payment system.
18 So first, back in 2009, the Commission reviewed
19 the hospice payment system and found that it was
20 misaligned, with long stays in hospice more profitable than
21 short stays. And this was because Medicare generally paid
22 a flat daily rate for hospice while hospice services tend

1 to be more frequent at the beginning and end of a hospice
2 episode. So the Commission recommended changing the daily
3 rate for routine home care, the most common level of
4 hospice care, from a flat payment per day to a payment
5 that's higher at the beginning and end of the episode and
6 lower in the middle.
7 In 2016, CMS changed the payment structure for
8 routine home care in a way that was directionally
9 consistent with the Commission's recommendation. There are
10 now two daily payment rates, one for the first 60 days,
11 which is higher, and a lower payment rate for days 61 and
12 beyond. In the last seven days of life, hospices receive
13 additional payments for registered nurse and social worker
14 visits on top of the regular daily rate.
15 CMS' new payment structure was designed to be
16 budget neutral in the aggregate but modestly redistribute
17 revenues across providers, so it was expect to increase
18 revenues for providers that had fewer very long stay
19 patients, that is, provider-based, nonprofit, and rural
20 hospices.
21 So this brings us to our payment adequacy
22 analysis, and like in the other sectors we use our standard

1 framework, shown on the slide.

2 First, we have a chart showing the growth in the

3 number of hospice providers. The green line is the total

4 number of hospice providers, and that total number of

5 providers has been going up for almost two decades, and it

6 increased by 2.4 percent in 2017. The other three lines

7 show the number of providers by type of ownership. Yellow

8 is for profit providers, and you can see that the net

9 growth in provider supply has been accounted for entirely

10 by for-profit entry. As of 2017, nearly 70 percent of

11 hospice providers are for-profit.

12 The next chart shows growth in hospice use among

13 Medicare decedents. The share of Medicare decedents who

14 used hospice crossed the 50 percent threshold in 2017,

15 reaching 50.4 percent. Over the years, hospice use has

16 grown most rapidly among the oldest beneficiaries. In

17 2017, more than 60 percent of decedents aged 85 and older

18 used hospice.

19 As we've seen in past years, minorities and

20 beneficiaries in rural areas continue to have lower hospice

21 use than other beneficiaries, but use has generally been

22 increasing for these groups as well.

1 So this next chart gives more details on
2 utilization growth. The number of hospice users grew about
3 5 percent in 2017, to nearly 1.5 million. With growth in
4 the number of hospice users, we also saw growth in the
5 total number of hospice days, reaching 106 million in 2017.
6 The bottom of the chart shows hospice length of stay among
7 decedents. Average length of stay among decedents
8 increased slightly in 2017, as we observed an increase in
9 length of stay at the 90th percentile, while median length
10 of stay was unchanged, at 18 days.
11 Another indicator of access to care is marginal
12 profit. Different from other sectors, for hospice we have
13 marginal profit in 2016 because the 2017 margin information
14 is incomplete. In 2016, marginal profit, which is the
15 amount Medicare payments exceed the marginal cost of
16 treating an additional Medicare patient, was 14 percent,
17 which is a positive indicator of access.
18 So next we have a chart showing that length of
19 stay varies by observable patient characteristics like
20 diagnosis and patient location, so that hospices that
21 choose to do so have an opportunity to focus on patients
22 likely to have long stays that may be more profitable.

1 Consistent with that, for-profit providers had
2 substantially longer lengths of stay than nonprofits in
3 2017, 109 days versus 67 days, on average. And as
4 discussed in the paper, over the years the Commission has
5 expressed concerns about very long stays and the
6 profitability associated with those stays. The Commission
7 has also expressed concern about very short stays in
8 hospice, which may not offer patients as much benefit as if
9 they had enrolled earlier. Your mailing materials discuss
10 what we know about early experience with a couple of
11 initiatives that might have potential to influence hospice
12 enrollment -- the CMMI Medicare Care Choice's model, and
13 the coverage of advanced care planning visits under the
14 physician fee schedule.
15 So next, on to quality. Limited data are
16 available on hospice quality. Currently, Hospice Compare
17 includes seven process measures that gauge whether hospices
18 performed certain activities appropriately at hospice
19 admission. Scores on the process measures are extremely
20 high for most hospices, and given that these measures
21 appear to be topped out, CMS may want to revisit the
22 measures and consider whether retirement is warranted.

1 In 2018, for the first time, Hospice CAHPS data
2 became available for individual hospice providers. CAHPS
3 surveys family members of hospice patients after their
4 death to get information about the care that was provided
5 to those patients. Scores were generally high on the
6 CAHPS measures but there was more room for improvement and
7 variation than the process measures.
8 Although not a traditional quality measure, live
9 discharge rates also are a potential indicator of poor
10 quality or program integrity issues. The rate of live
11 discharge has been stable over the last three years,
12 although as we note in the paper there is substantial
13 variation across providers.
14 So next we have access to capital. Hospice is
15 less capital intensive than some other Medicare sectors.
16 Overall access to capital appears strong. We continue to
17 see growth in the number of for-profit providers, which
18 increased about 5 percent in 2017, suggesting that capital
19 is accessible to these providers. Also, reports from
20 financial analysts suggest that the hospice sector is
21 viewed favorably by private equity investors and by other
22 health care companies seeking mergers and acquisitions. We

1 have less information on access to capital for nonprofit
2 freestanding providers, which may be more limited.
3 Provider-based hospices have access to capital through
4 their parent providers, who have adequate access to
5 capital.
6 Next, we have Medicare margins. As I noted
7 earlier, different from other sectors, we have the margin
8 data through 2016, because 2017 margin data are incomplete.
9 In 2016, the aggregate Medicare margin reached 10.9
10 percent, its highest level in more than 10 years.
11 A couple things to note. Consistent with other
12 sectors, we exclude non-reimbursable costs from our margin
13 calculation, which means we exclude bereavement costs and
14 the non-reimbursable portion of volunteer costs. If those
15 costs were included, it would reduce our margin estimates
16 by at most 1.7 percentage points.
17 Next we have margins by category of hospice
18 provider. In 2016, freestanding hospices have strong
19 margins, about 14 percent. Provider-based hospices have
20 lower margins than freestanding hospices. This was partly
21 due to their shorter stays and the allocation of overhead
22 from parent providers.

1 The chart also shows margins by type of
2 ownership. For-profit hospices have substantial margins,
3 16.8 percent. The overall margin for nonprofits is 2.7
4 percent. Looking just at freestanding providers, the
5 nonprofit margin is higher at 6.4 percent.
6 This table also shows, at the bottom, margins for
7 providers that are above or below the aggregate cap. As
8 you will recall, that the aggregate cap limits payments to
9 hospices with very long stays by capping the average
10 payment per beneficiary a hospice can receive. In 2016,
11 the cap was about $28,000 per beneficiary, and it applied
12 in the aggregate, not at the individual patient level.
13 Hospices that exceed the cap in 2016 had about a 20 percent
14 margin before the return of overpayments and a 12.6 percent
15 margin after the return of overpayments. Below-cap
16 hospices had a slightly lower margin, at 10.7 percent.
17 Next, we show what's underlying some of the
18 margin differences. Here we have the relationship between
19 length of stay and hospice margins. Providers with longer
20 stays had higher margins in 2016. Providers in the lowest
21 length of stay quintile had a -5 percent margin compared to
22 a 20 percent margin for providers in the 2nd highest length

1 of stay quintile. These margins include the effects of the
2 new payment system in 2016, and although the new payment
3 system narrowed the variation in margins by length of stay
4 modestly compared to 2015, there is large variation that
5 remains.
6 So next we have our 2019 margin projection. To
7 make this projection, we start with the 2016 margin, and we
8 take into account the net payment updates that occur in
9 2017 through 2019, and we assume cost growth consistent
10 with historic trends. With that, we project a margin of
11 10.1 percent in 2019.
12 Before we discuss the payment update it's worth
13 noting some broader concerns about the payment system.
14 First, the payment rates by level of care are out of
15 balance. Routine home care appears to be paid
16 substantially more than its costs, while the payment rates
17 for the other three less frequent levels appear to be below
18 providers' costs. Second, the new payment system has had
19 only a modest effect on the variation in profitability by
20 length of stay. Providers with the most long-stay patients
21 continue to have high profit margins. And third, the
22 percentage of hospices exceeding the aggregate cap has been

1 increasing, and for the first time in 2016, above-cap
2 hospices had higher margins than below-cap hospices, even
3 after the return of overpayments.
4 In light of these issues, the Commission could
5 consider approaches to rebalance the payment system in the
6 future.
7 So, in summary, our indicators of access to care
8 are positive and there are signs that the aggregate level
9 of payment for hospice care exceeds the level needed to
10 furnish high-quality care to beneficiaries. The number of
11 hospices increased, driven by entry of for-profit
12 providers. The number of beneficiaries enrolled in
13 hospice, the number of hospice days, and average length
14 stay increased. The rate of marginal profit was 14
15 percent. Access to capital appears strong. Limited
16 quality data are available.
17 The 1016 aggregate margin is 10.9 percent, and
18 the projected margin for 2019 is 10.1 percent.
19 So that brings us to the Chairman's draft
20 recommendation. It reads: The Congress should reduce the
21 fiscal year 2020 Medicare base payment rates for hospice by
22 2 percent.

1 Given the margin in the industry and our other
2 payment adequacy indicators, we anticipate that the
3 aggregate level of payments could be reduced by 2 percent
4 in 2020 and would still be sufficient to cover providers
5 costs. So this draft recommendation is not expected to
6 have an adverse impact on beneficiaries' access to care.
7 Consistent with the Commission's principle that
8 it is incumbent on Medicare to maintain financial pressure
9 on providers to constrain their costs, this draft
10 recommendation would increase financial pressure on
11 providers but it is not expected to affect their
12 willingness or ability to care for beneficiaries.
13 So that concludes the presentation.
14 DR. CHRISTIANSON: [Presiding.] Thanks, Kim. Do
15 we have clarification questions for Kim?
16 Jonathan.
17 DR. JAFFERY: Yeah, thanks for a great report.
18 Going back to the -- regarding the payment rates by level
19 of care being out of balance, and in the material Table 14
20 lays it out pretty nicely, and it's pretty striking,
21 actually, do you have any information about some of these
22 subcategories, the freestanding or the for-profit versus

1 not-for-profit and who delivers all these services? And am
2 I correct that not all facilities provide inpatient care,
3 for example?
4 MS. NEUMAN: So under the conditions of
5 participation, hospices are required to have the capacity
6 to furnish all four levels of care. What we see in the
7 data is that there are some hospices that do not appear to
8 provide, particularly the continuous home care. There is a
9 big chunk that don't seem to providing continuous home
10 care, and then there are some that also don't provide
11 general inpatient care. It's always been hard to know,
12 especially if a provider is small, whether they didn't have
13 a patient that needed that service or whether they don't
14 furnish it. But we definitely see providers who have, you
15 know, no days in these categories.
16 In terms of by category who's furnishing it
17 versus not, so I would say that freestanding providers --
18 let me just back up a second. For-profit providers provide
19 a little bit less of the higher acuity levels of care than
20 nonprofits, but it's not by much. I mean, the main level
21 of care is, on average, about 98 percent of the days across
22 the industry, and the for-profits are doing routine home

1 care at 99 percent of the days. So we're talking a
2 percentage point difference. But there are some
3 differences in that.
4 Also, the provider-based tend to provide a little
5 bit more, again, a percentage point or so more of high-
6 acuity care than the freestanding providers.
7 DR. CHRISTIANSON: Kathy, did you -- okay.
8 Anybody?
9 DR. GRABOWSKI: Yeah. Thanks, Kim, for this
10 work. I wanted to ask you about the access to capital, and
11 there's been a lot of media reports of kind of acquisitions
12 of hospice companies by private equity groups and other
13 health systems. And I'm just curious, is this just that
14 it's a really profitable sector? Is this part of trying to
15 move towards a greater system of care? I just wanted to
16 try to unpack a little bit of your understanding, because
17 it hasn't been clear to me from all the kind of different
18 media stories around all this activity that hospice is
19 really hot right now. It would seem, from these stories,
20 and I just wanted to get a little bit more color on that.
21 MS. NEUMAN: Yeah. So I think it's all of the
22 things you've mentioned. I think that the sector is viewed

1 favorably as having potential profit opportunities and
2 being stable, and the fact that the payment system changes
3 were quite modest. That is often cited. I also think that
4 there is sort of thoughts about, you know, sort of having
5 an ability to offer the full continuum of care and the idea
6 of moving to systems where we're less focused on inpatient
7 and more focused on treating people in the community, and
8 sort of changing how we care for people. And I think
9 that's part of it too. I think it's both things.
10 DR. GRABOWSKI: I can't help myself. I also have
11 to ask about it, that at the end of the chapter you have a
12 table on the margins that hospice delivered in assisted
13 living and nursing homes, and I wondered there, too. You
14 have some explanations about some of the economies around
15 potentially delivering hospice in an institutional setting,
16 or at least a facility-based setting.
17 I'm curious. Is that the whole story there? Is
18 there something about kind of ownership by nursing homes of
19 hospice? Is there more sort of going on, and is this
20 something we will want to think about going forward, about
21 payment hospice in the community versus hospice in kind of
22 these institutional settings?

1 MS. NEUMAN: So this is something that the
2 Commission has kind of looked at over time and something
3 that we could come back to if we look at the payment system
4 in greater detail in upcoming cycles. There are a few
5 things going on. As we've talked about, there are
6 potentially economies of scale, treating people in a
7 facility, versus going to individual homes. With nursing
8 facilities there's the idea that there's potentially a
9 duplication of services, that there are aides in facilities
10 and then there are hospice aides, and so there could be
11 some economies that way.
12 Patients in these settings also tend to have
13 longer stays, and so there are, you know, sort of that
14 dynamic that's throughout the payment system also plays out
15 in that setting. But it seems to be more than just that.
16 And, you know, people always do talk about the idea that
17 there could be some ownership issues going on between
18 nursing facilities and hospices, and so there could be --
19 that could be generating some profitability, and that could
20 be something to look at certainly.
21 I think there are also providers that may not be
22 affiliated with the nursing home itself but that focus on

1 those patients or focus on assisted living facilities, and
2 it's kind of almost a different business model. And so
3 there's all of those things going on.
4 DR. DeBUSK: I have a question about the 2
5 percent cut, sort of the source of the 2 percent cut, and I
6 was noticing on Chart 13 of the presentation you were
7 looking at the providers who went above their cap, and even
8 after they returned the payments they still came out right
9 at about two points ahead of the people who didn't exceed
10 their cap. Is that correlated to the 2 percent cut in any
11 way? I mean, where did the 2 percent come from?
12 MS. NEUMAN: I don't think that the cap piece was
13 sort of driving that 2 percent number. I don't know.
14 Should I --
15 DR. CROSSON: This is hard to admit, but -- well,
16 I'm kind of out there right now.
17 [Laughter.]
18 DR. MATHEWS: I could pull you back in, if that -
19 -
20 DR. CROSSON: These update recommendations are an
21 exquisite composite of science and judgment, and sometimes
22 the judgment is easily traceable to the science, the

1 numbers, and sometimes it's not. And that's why we have a
2 Commission.
3 DR. DeBUSK: Thank you.
4 [Laughter.]
5 DR. DeBUSK: Well, again, at the risk of
6 encroaching on round two territory, when I saw the minus 2
7 in the draft recommendation and then I realized that if you
8 get caught going above your cap and have to give that
9 revenue back up, if you took that 2 percent, that's sort of
10 the differential there.
11 The other thing I was going to get at is they're
12 providing those services and then having to surrender that
13 revenue, a portion of that revenue. So would this -- and
14 this, again, is not rhetorical. It is a question. Does
15 this suggest, though, that we're still overpaying for the
16 middle of the stay?
17 Back to our original, MedPAC original
18 recommendations, it appears that we've addressed it some,
19 but does this mean we haven't fixed it if you can still
20 surrender all of your revenue above the cap and still come
21 out 2 points ahead of someone who didn't exceed their cap?
22 MS. NEUMAN: I think that all of the data that we

1 have to this point, the cap, as well as just what we're
2 seeing about margins by length of stay, suggests that the
3 payment system effects have only made a modest difference,
4 and that the underlying concerns that we've had about
5 profitability by length of stay remain.
6 DR. DeBUSK: So we should just steepen -- the
7 adjustment was directionally correct, then, in your
8 opinion. We just need to steepen the adjustment?
9 MS. NEUMAN: The Commission originally had a
10 steeper suggestion than what CMS implemented, and so that
11 is one way to go, to think about steepening it, and we
12 could think about rebalancing it more in general as well.
13 MS. MARJORIE GINSBURG: [Speaking off
14 microphone.]
15 MS. NEUMAN: Right now, days 1 to 60 is one rate,
16 and days 61-plus is another rate. The costs actually look
17 much more like this. It's not like this, and so you could
18 think about whether the structure should be a little bit
19 different. That's one possibility.
20 DR. CROSSON: Jim.
21 DR. MATHEWS: So just to try and add a little bit
22 more rationale behind the 2 percent reduction that is on

1 the table for this sector, in contrast to other sectors,
2 IRF and SNF -- or I'm sorry -- IRF and --
3 DR. CROSSON: LTCH.
4 DR. MATHEWS: No. Let's stick with IRF for a
5 moment, where we are recommending at minus 5 percent.
6 MS. BRICKER: Home health?
7 DR. MATHEWS: Pardon?
8 MS. BRICKER: Home health?
9 DR. MATHEWS: Home health.
10 Where in those sectors we've seen very pronounced
11 trends of very strong margins in many instances, year-over-
12 year increases and we have been able to point to specific
13 program integrity issues or potential program integrity
14 issues and specific payment system changes that we think
15 need to be brought into play, and that has resulted in a
16 more aggressive recommendation of minus 5 percent, here we
17 definitely see strong financial performance under Medicare.
18 And we don't see Medicare's payments as being an impediment
19 to access to care or any signal of payment adequacy
20 concerns.
21 But we're not 100 percent sure that the signals
22 we are getting warrant as deep a cut as we have recommended

1 for home health and for IRF. We've kind of gone not as far
2 here.
3 DR. CROSSON: Paul, I think I had.
4 DR. PAUL GINSBURG: Yeah. I just want to note
5 that a number of the write-ups on the topics we've been
6 covering sometimes point to private equity interest as an
7 indicator that this is extremely profitable, and I think
8 it's really more mixed.
9 And this came up at a -- I run a Wall Street
10 Comes to Washington meeting each year, and it came up this
11 year in the area, and that sometimes private equity
12 identifies often nonpublic companies that are doing very
13 well and could grow a lot faster with more capital. But
14 sometimes it's also used for particularly some of these
15 public companies that are struggling, which in a sense --
16 and there's a perception that they could be profitable, but
17 they're going to need better management. They're going to
18 need to do tough things. So they go private for a period
19 of years to do that, with the hope that then they can be
20 returned.
21 So we just need to be careful not to say private
22 equity means extremely profitable, but go a little deeper

1 into what's drawing the interest to private equity.

2 DR. CROSSON: Thank you. Good point.

3 Okay. So I think we'll now move on to the

4 discussion period. We have the recommendation, Kim. The

5 recommendation is for 2 percent reduction.

6 Again, let's hear comments about the

7 recommendation.

8 [No response.]

9 DR. CROSSON: Seeing none, I'm taking this as an

10 indication that the recommendation is supported. So we

11 will bring this forward in expedited fashion in January.

12 Thank you very much, Kim.

13 We'll move on to the next presentation.

14 [Pause.]

15 DR. CROSSON: Okay. The next presentation is on

16 payment updates for home health services. Evan is here,

17 and you've got the microphone.

18 MR. CHRISTMAN: Good morning.

19 Now we will review the indicators for home health

20 using the framework you've seen in other presentations.

21 As an overview, this presentation will cover the

22 basics of the benefit, the current issues the Commission

1 has identified, and the bulk of it will review the payment
2 adequacy framework and present the draft recommendation.
3 As a reminder, Medicare spent $17.7 billion on
4 home health services in 2017. There were over 11,800
5 agencies, and the program provided about 6.3 million
6 episodes to 3.4 million beneficiaries.
7 In terms of the payment system, the Commission
8 has noted two problems. The first issue is the high level
9 of payments. Medicare has overpaid for home health since
10 the PPS was established. The fact that home health can be
11 a high-value service does not justify the excessive
12 overpayments.
13 As discussed in the paper, Medicare margins have
14 averaged better than 16 percent in the 2001-to-2015 period.
15 These overpayments do not benefit the beneficiary or the
16 taxpayer.
17 The second issue is an incentive in the current
18 system. The current PPS uses the number of therapy visits
19 provided in an episode as a payment factor. Payments
20 increase as more therapy visits are provided in an episode.
21 This incentive and the fact that more profitable HHAs tend
22 to favor therapy episodes raised concerns that the

1 financial incentives of the payment system may be
2 influencing the type of care provided.
3 The Commission recommended the removal of therapy
4 as a payment factor in 2011.
5 Major revisions to the PPS will be implemented in
6 2020. The first is a policy that addresses our
7 recommendation to eliminate the therapy thresholds. The
8 second is the implementation of a 30-day unit of payment,
9 and concurrently, CMS also plans to revise the home health
10 PPS with a new case mix system and payment adjustors.
11 These will be the most significant changes to the PPS since
12 it was implemented.
13 These changes are intended to be budget-neutral
14 but will redistribute payments among providers. Estimates
15 of the redistribution have some uncertainty because
16 agencies have a history of changing coding and operational
17 practices when the PPS is altered, but based on current
18 patterns, CMS estimates that payments for nonprofit,
19 facility-based, and rural agencies will increase, and for-
20 profit, freestanding, and urban agencies will decrease.
21 As a reminder, here is our framework, and again,
22 it's the one you've seen in earlier presentations.

1 We begin with supply. As in previous years, the
2 supply of providers and the access to home health appears
3 to be very good. Eighty-four percent of beneficiaries live
4 in an area served by five or more home health agencies.
5 Ninety-seven percent live in an area served by at least one
6 home health agency.
7 In turning from access to supply, the number of
8 agencies was over 11,800 by the end of 2017. There was a
9 decline of about 3 percent, or slightly under 400 agencies
10 in 2017, relative to the prior year, but overall, the
11 supply of agencies has increased about 57 percent since
12 2004.
13 The recent decline is concentrated in a few
14 areas, such as Texas and Florida, that have been the
15 targets of efforts to reduce fraud, and these areas
16 experience rapid growth in prior years.
17 Next, we look at volume. Overall, the volume of
18 episodes and the number of beneficiaries declined in 2017
19 relative to the prior year. Cumulatively, however, the
20 volume of services has increased substantially, and the
21 number of episodes is about 54 percent higher in 2017
22 compared to 2002. The number of users is over 35 percent

1 higher, and total spending is up over 80 percent.
2 This substantial growth coincides with a period
3 of high payments under Medicare, and margins for home
4 health have ranged between 10 and 23 percent since the
5 advent of PPS in 2000.
6 The marginal profit in 2017 was 17.5 percent,
7 indicating that home health agencies had substantial
8 incentive to serve additional beneficiaries.
9 Our next indicator is quality. I've split the
10 quality measures into two groups. The first group of
11 measures on the left are based on provider-reported data
12 collected by home health staff at the start and end of home
13 health care.
14 The group of measures on the right are claims-
15 based measures that use Medicare claims to detect the
16 incidence of hospitalization or emergency care use for home
17 health patients.
18 As you can see, the first group shows that the
19 frequency of patient improvement in walking or transferring
20 has generally steadily increased from year to year.
21 In contrast, hospitalization and ER use rates
22 have had a mixed annual trend but have not changed

1 significantly in most years and certainly do not show the
2 same substantial improvements as the functional measures.
3 The contrast in these two groups of measures is
4 striking, and though many factors may explain them, it is
5 important to keep in mind that differences in the methods
6 of data collection may account for some of the divergent
7 trends.
8 Next, we look at capital. It is worth noting
9 that home health agencies are less capital incentive than
10 other health care providers, and relatively few are part of
11 publicly traded companies. But overall, financial analysts
12 have concluded that the publicly traded agencies have
13 adequate access to capital.
14 We have seen a recent uptick in mergers and
15 acquisitions, and it appears that some firms are increasing
16 their capacity in this sector. And the all-payer margins
17 equaled 4.5 percent in 2017.
18 Turning to Medicare margins for 2017, we can see
19 that the margins for this year were 15.2 percent. The
20 trend by type of provider is similar to prior years, with
21 for-profits having better margins than nonprofits and urban
22 agencies having higher margins than rural, but the

1 differences are relatively small. And, again, these
2 margins did not change substantially from the 2016 level.
3 The high margins in 2017 are notable because the
4 Patient Protection and Affordable Care Act mandated 4 years
5 of payment reductions in 2014 through 2017. However, the
6 PPACA offset these reductions with an annual market basket
7 update. The net effect was that payments were reduced by
8 less than 1 percent in each year, and the Commission has
9 long expressed that the PPACA reductions would not
10 significantly lower margins.
11 And as you can see, the margin results for 2014
12 through 2017 bear this out. Margins in all years of
13 rebasing have exceeded 10 percent and in the last three
14 years have been almost 3 percentage points higher than the
15 margins in 2013, the year before the PPACA reductions went
16 into effect.
17 The net effect is that despite the PPACA
18 policies, average payment per full episode in 2017 is 5
19 percent higher than the average payment in the year before
20 rebasing began.
21 This year, we also examined the performance of
22 relatively efficient home health agencies. Recall that we

1 define "relatively efficient providers" as those that are
2 in the lowest third of providers in cost or the best
3 performing third of providers for quality, without having
4 extremely low performance on any measure. About 7 percent
5 of agencies met this standard.
6 Compared to other agencies, efficient providers
7 have lower hospitalization rates. They typically have
8 higher patient volume. Their standardized cost per episode
9 were 15 percent lower than other home health agencies,
10 likely reflecting economies of scale from their larger
11 size.
12 On the payment size, average payment per episode
13 was 5 percent higher; the efficient providers' average
14 margins of almost 26 percent.
15 We estimate margins of 16 percent in 2019. This
16 is a result of several payment and cost changes. For
17 payment changes in 2018, we included the payment update of
18 1 percent, which was offset by a coding adjustment that CMS
19 implemented in this year.
20 For 2019, we included the payment update of 2.2
21 percent.
22 Cost growth has been historically low in home

1 health, and we assumed cost growth of 0.5 percent a year,
2 which is above the long-term average.
3 Before I summarize our indicators and turn to the
4 draft recommendation, I want to explain a payment reduction
5 for 2020 that is required by the Bipartisan Budget Act of
6 2018. Recall that three changes are happening as a
7 consequence of the Bipartisan Budget Act: a new unit of
8 payment, removal of therapy as a payment factor, and a new
9 case-mix system.
10 Statute requires that these changes in 2020 be
11 budget-neutral. CMS has projected the behavioral responses
12 by home health agencies to the new policies will increase
13 payments by 6.42 percent in 2020, which would equal about a
14 $1 billion increase in payments.
15 Consequently, CMS plans to implement a 6.42
16 percent reduction in 2020. Again, this reduction is
17 necessary to offset the spending spike in 2020 due to the
18 behavioral changes. It does not address payment adequacy.
19 Our analysis suggests that payments for 2019 will
20 be more than adequate, and the planned 2020 reduction,
21 since it is budget-neutral, should not substantially change
22 provider margins.

1 Turning back to our framework, here is a summary
2 of our indicators. Beneficiaries have good access to care
3 in most areas. The number of agencies has declined
4 slightly but remains high. For quality measures, we saw
5 trends consistent with earlier years. The rates of
6 hospitalization or ER use are unchanged, and the functional
7 measures showed improvement in 2017, with the caveat I
8 mentioned earlier.
9 Access to capital is adequate, and the financial
10 performance of the sector under Medicare is strong, and
11 these are the highest margins of any provider you have seen
12 in this update cycle.
13 This brings us to the draft recommendation for
14 2020. That Congress should reduce the calendar year 2020
15 Medicare base rate for home health agencies by 5 percent.
16 This recommendation reflects that payments in 2017 are more
17 than adequate, and that significant action is necessary to
18 reduce payment.
19 In past years, we have recommended a two-year
20 rebasing to follow immediately in the year after a 5
21 percent cut. While it is likely that significant
22 reductions after 2020 will be necessary, the payment

1 changes being implemented in 2020 would make it problematic
2 to pursue a rebasing in 2021.
3 Ideally, data for a rebasing should reflect the
4 mix and level of services HHAs provide under the new
5 payment policies for 2020, but this data will not be
6 available until mid-2021. As a result, our recommendation
7 today only addresses payments for 2020.
8 The impact of this change would be the lower
9 spending relative to current law. In terms of beneficiary
10 and provider impacts, it should be limited. It should not
11 affect access to care for beneficiaries or provider
12 willingness to serve beneficiaries.
13 This completes my presentation. I look forward
14 to your questions.
15 DR. CROSSON: Thank you, Evan.
16 Questions for Evan? Paul.
17 DR. PAUL GINSBURG: Evan, a really great
18 presentation.
19 Do you have any data on how commercial rates for
20 HHAs compare to Medicare?
21 MR. CHRISTMAN: So what we hear on average is
22 that the rates are lower. I think this majorly comes up

1 with Medicare Advantage, and what we understand is that in
2 some cases -- I think this has gotten better in recent
3 years, but in general, Medicare Advantage pays less per
4 visit and provides fewer -- and ends up with fewer visits
5 in an episode.

6 DR. CROSSON: Jon.

7 DR. CHRISTIANSON: I guess two questions. One is
8 do we have -- is the data that you present on the quality
9 measures, is that from fee-for-service or from Medicare
10 Advantage and for example?

11 MR. CHRISTMAN: Those numbers are fee-for-service
12 patients only. My examination of this has not suggested
13 that the MA looks that different.

14 DR. CHRISTIANSON: Okay. So I think we need to
15 be clear when we introduce the data on the quality measures
16 that we don't have data we're reporting on Medicare
17 Advantage --

18 MR. CHRISTMAN: Okay.

19 DR. CHRISTIANSON: -- which is a third of our
20 beneficiaries.

21 The other thing about the quality measures is I
22 think we've had this discussion before, and, Evan, you can

1 remind me. We've probably put this in other chapters and
2 not in the update.
3 I like your observation that the provide-reported
4 functional status measures -- you don't say it this way,
5 but make us a little nervous about the validity of them.
6 To me, it would help clarify that whole discussion if we
7 kind of started out by saying what we want is to know if
8 the functional status of beneficiaries improved due to
9 their home health care.
10 We have two ways of getting at it. One is a very
11 crude, very high-level claims analysis of ER admissions and
12 so forth, which really doesn't do the job, and the other is
13 the provider-reported functional status measures, which we
14 question whether that does the job. So the bottom line
15 here for me is that we really don't know a lot about
16 whether quality has improved because of the shortcomings
17 and the two different ways we go about doing it.
18 To me, that's the bottom line here. I don't know
19 whether you agree with that or whether we've probably gone
20 into this issue in greater detail and I'm forgetting about
21 it in past work.
22 MR. CHRISTMAN: I guess I would say two things.

1 Yes, I think we do have concerns about whether the
2 functional measures accurately reflect the experience of
3 patients, and I think we can sharpen that a little bit in
4 the discussion.
5 I think the other point is a piece of this is
6 also obviously being explored in the project that Carol and
7 Ledia are leading sort of looking at the use of the
8 functional data in general, and so I think a lot of what
9 you're talking about will also get teased out in that work.
10 DR. CHRISTIANSON: And I think it's worth saying
11 that. Again, to reiterate my point, I don't think -- the
12 way it's laid out now, we have these measures, and they're
13 going up or they're going down. My feeling about it is we
14 really don't know, not nearly to the degree we would like
15 to know, and I think that needs to come through in that
16 discussion.
17 DR. CROSSON: Jon.
18 DR. PERLIN: Thank you, Evan, for a really
19 thoughtful report.
20 One of the things that would be interesting just
21 to understand, almost less in terms of the specific
22 recommendation than in terms of thinking about post-acute

1 generally, is you noted an increase in the volume of
2 utilization of home health services. Are you able to tease
3 apart what percentage of that is attributable to patients
4 who are enrolled in bundles, the incentives to otherwise
5 get patients to the most efficient level of post-acute
6 service?
7 MR. CHRISTMAN: We haven't looked at that
8 specifically, but I can think of three experiences that
9 probably inform your question. One is a general theme and
10 things like CJR and BPCI is that for some patient
11 populations, it's definitely been true that they have sent
12 more patients to home health.
13 Obviously, those demonstrations are a fraction of
14 the volume, and then the groups within that, that I'm
15 talking about, are a fraction. So whether it's enough to
16 really show up in national-level statistics, I think would
17 be interesting.
18 The other experience is the ACO performance, an d
19 the ACO performance, I guess I think of -- I keep three
20 facts in mind when I think about them. In aggregate, the
21 work has shown a decline in home health use, but you have
22 to keep two things in mind. The work that has split home

1 health utilization into episodes immediately preceded by a
2 hospitalization have actually gone up just a tiny tick.
3 Those episodes not preceded by a hospitalization -- we kind
4 of call them "community-admit" -- have actually gone down
5 significantly.
6 So if you look at it in an aggregate, you will
7 see that home health utilization probably has gone down in
8 ACOs, but it's because of that community admit piece and
9 not the hospital piece.
10 And then the third fact to keep in mind is that
11 generally the ACO studies show the hospitalization going
12 down. We haven't pulled this all together, but it's quite
13 possible that there might have been a slight uptick in the
14 use of home health after hospitalization.
15 DR. CROSSON: Thank you.
16 David.
17 DR. GRABOWSKI: Thanks, Evan.
18 This was hard to unpack, given we're not just
19 thinking about a payment update, but CMS is also shifting
20 the method of payment for this sector with the patient-
21 driven groupings model.
22 You had mentioned CMS has estimated sort of a 5

1 percent behavioral decrease, and I wondered if you could
2 say more about that. How do they estimate that? Do you
3 sort of trust that?
4 I've done some of these estimates, and they're
5 based on a lot of assumptions. It's really challenging
6 work. So I'm curious what you think of that approach and
7 in general whether we think going forward that that change,
8 along with our payment update, where that's going to leave
9 us at the end of the day.
10 Thanks.
11 MR. CHRISTMAN: Sure. So, yep, 2020 is a big
12 year. That's a lot going on. And so there's -- I want to
13 put this in -- I want to take this in two buckets. One is
14 the changes will be redistributional within the industry,
15 and the general way to think about those changes is that
16 it's going to move money from home health agencies that are
17 doing more therapy today, which tend to be more profitable,
18 to agencies that are doing relatively less therapy, which
19 tend to be less profitable. So, in a sense, the agencies
20 with lower average margins today are going to see money
21 redistributed towards them, and the ones with average
22 margins today are going to see money redistributed away.

1 So that's one thing. That's the budget neutral
2 piece -- the case mix redistribution. Excuse me.
3 The other piece is how the aggregate coded case
4 mix of this population will change in 2020. CMS is
5 implementing a new system that uses 432 payment group sot
6 set payment, and CMS has estimated that agencies will
7 change their behavior in a way that will cause the reported
8 case mix to go up by 6.42 percent without the severity of
9 the patients changing. And breaking that 6.42 percent
10 apart, the biggest part of it is they expect that agencies
11 will be aggressive about, frankly, changing their clinical
12 coding so that fewer patients are in the lowest-paid
13 category. And, you know, that's about two-thirds of that
14 effect.
15 The other sort of 2 points come from expecting
16 agencies will be more aggressive about coding
17 comorbidities, because comorbidities will count in a way
18 that they don't today, so there will be more reported
19 comorbidities. And the threshold for moving from a small,
20 short-stay outlier payment to a full episode payment is
21 going to be lower. So there's a sense that agencies may
22 add one or two visits to pick up another $1,000, basically.

1 If you look at the 6.42 percent that CMS has set
2 for 2020, and what has happened in the past when CMS has
3 made changes, you know, I appreciate that, you know, as
4 Yogi Berra said, predictions are uncertain, especially
5 about the future, you know, when they implemented the
6 changes in 2008 to a new system, payments in that year went
7 up between 3 and 5 percent, and that is a much smaller set
8 of changes than what we had before.
9 I think that there is a sense that, you know, the
10 industry is pretty nimble. There are a lot of examples I
11 could provide. But, you know, to their credit, what the
12 law does is it requires CMS to implement all of these
13 things in a budget-neutral way, and CMS has laid down the
14 6.42 percent. But the law also requires them to look back,
15 and if they've figured out they've taken out too much,
16 they're required to put the money back in.
17 DR. CROSSON: Okay. Thank you. Seeing no more
18 questions we'll move on to the recommendation, which is for
19 a 5 percent reduction for home health services. Discussion
20 with respect to the recommendation?
21 Karen.
22 DR. DeSALVO: I missed round one so I'm going to

1 bridge. Is that okay? Because I just had a question --
2 I'm sorry, but I just had a question for you, Evan, about
3 when you're thinking about number of providers or agencies,
4 when there is consolidation in the market, how do you
5 reflect that? I see that you say that there's beneficiary
6 access, but I'm just wondering if that continues, how we're
7 going to know it's not just a declining industry. It's
8 just that there's M&A.

9 MR. CHRISTMAN: Right. Okay. So there's a lot
10 going on there. I think just to be clear, so that we're
11 clear, you know, when we report numbers those are the
12 number of licensed Medicare agencies. And in general, in
13 my experience when they buy a new agency, for a variety of
14 reasons -- licensing and whatnot -- they don't consolidate
15 a lot of provider numbers.

16 DR. DeSALVO: Mm-hmm.

17 MR. CHRISTMAN: So I haven't seen consolidate
18 itself really have a serious effect on the overall number
19 of reported agencies on the Medicare side. But I would
20 take your point as this, that part of the challenge with
21 measuring the home health supply is that agencies vary
22 widely in their size, and it's across within a state and

1 across states. And so that point is taken. You know, we
2 have agencies that provide hundreds of thousands of
3 episodes a year and agencies that provide 20. And, you
4 know, I think there's one agency in the state of New Jersey
5 that provides 30 percent of all the episodes in that state.
6 So it's a little difficult. I guess what I also
7 just track on is the other aggregates, the number of users
8 and the number of beneficiaries.
9 DR. DeSALVO: Okay. Thank you. I support the
10 recommendation. I did want to make a comment about the way
11 we think about this part of the sector, particularly
12 wearing my doctor hat, which is to say that home health is
13 kind of, for me, in some ways, the poster child of a siloed
14 fee-for-service marketplace. And what I hope to see is
15 that, over time, home-based care is more a part of the
16 continuum of care in models like ACOs, as an example, or
17 MA, simply because of the importance of connecting that
18 really critical post-discharge often part of care with my
19 patient who is acutely ill, very nearly.
20 And I think what most doctors would tell you in
21 the field is that we're not as encouraged, or we don't have
22 opportunity, for whatever reason, to tightly communicate

1 with home health. And so I think the incentive structure,
2 financially and from a quality standpoint, to really drive
3 the system and coordinate that transition of care, to
4 really think about helping the person stay at home is
5 something that I'd love to see us focus more on.
6 You had this one section in the chapter about the
7 value-based care attempt for home health, which I
8 appreciate in and of itself wasn't success. But I would
9 like for us to paint a picture in the chapter that we don't
10 think that this is an opportunity for value-based care. I
11 just had a sense from the chapter that maybe we think that
12 -- not that we think this but I would like to try to find a
13 way to shape the message that this is part of the care
14 continuum and that better care coordination, there may be
15 opportunities for efficiencies but also for better outcomes
16 in quality of care. That's kind of how I read some of the
17 quality numbers.
18 The other thing I just wanted to mention, for
19 future thinking, is the -- Jon, you're right. Right now
20 we're using claims and physician or clinician assessment,
21 but there's an opportunity to think about the individual's
22 assessment, whether that's through CAHPS or through other

1 measures like NPS or Healthy Days.

2 So I don't know where CMS is going with their

3 quality measurement but I'd love to see the incentives

4 aligned, both in terms of health outcomes and finances, so

5 that this was better connected to the rest of the care

6 system.

7 DR. CHRISTIANSON: Evan reminded me that Ledia

8 and -- who was the other person? I'm sorry.

9 MR. CHRISTMAN: [Speaking off microphone.]

10 DR. CHRISTIANSON: Yeah, were working on that.

11 DR. CROSSON: Sue and then Bruce.

12 MS. THOMPSON: Evan, thank you for this chapter,

13 and I, too, simply want to say that I was really conflicted

14 as I read this chapter, not with the data, not with the

15 methods, but with what home health represents and has

16 contributed to our work in ACOs and looking to the future

17 of that platform in terms of being able to move more care

18 out of our expensive hospitals and long-term care hospitals

19 into a home environment. I mean, I think if we looked

20 ahead five years, seven years, we are going to be marveling

21 at the kind of technology we're going to take into the

22 home, and that's going to require an organization, a

1 platform of providers that are very, very comfortable
2 working in home environments.
3 And so there's a tone in the chapter, which I
4 know relates to bad actors in this business. I mean, there
5 are program integrity issues. We have lots of evidence
6 where folks have taken advantage of, this is a part of the
7 industry where you can be nimble, and you can move quickly.
8 But I just really -- there is a part I just have to comment
9 on that has something to do with the tone that we send
10 about how important this element is to our continuum, and
11 where, in the future, we're going to look to be able to
12 provide care in a less-expensive environment.
13 So I just want to add that to my comments. I can
14 support the recommendation but with that caveat.
15 DR. CROSSON: And I think we can look at that
16 balance.
17 Bruce.
18 MR. PYENSON: I look back at the MedPAC
19 recommendations from last year and it was also a 4 or 5
20 percent reduction. I think the reality was that CMS
21 actually had an increase, I think. So if that's the case I
22 would suggest we think about more than the same reduction

1 that we suggested last year. And I'm not sure if that -- I
2 didn't look up if that should really be for two or three
3 years. I think we've been making a similar reduction.
4 DR. CROSSON: So, Bruce, you don't support the
5 recommendation?
6 MR. PYENSON: Well, I think the 5 percent is a
7 minimum reduction. I should have asked the question, is
8 the -- was there an increase last year.
9 MR. CHRISTMAN: Yes. Yeah. They've gotten an
10 increase of around 2 percent.
11 MR. PYENSON: Yeah. I think our assumption from
12 last year was 1 percent.
13 MR. CHRISTMAN: Yeah. I guess if I had to go --
14 when you say last year I don't want to -- yeah, so in 2018
15 it was -- they were basically -- excuse me. In 2018, they
16 were basically level because they had the 1 percent going
17 in and the case-mix adjustment coming out. So that was
18 basically flat. For next year they're going to get a 2.2
19 percent increase.
20 MR. PYENSON: Okay. So then I'm fine with the 5
21 percent. I just want to keep in mind the consistency of
22 our recommendation. I do support the recommendation.

1 DR. CROSSON: Okay. Thank you. Marge.
2 MS. MARJORIE GINSBURG: Just as a matter of full
3 disclosure I actually was a home care nurse at some point
4 earlier in my career. I do support the recommendation, but
5 I also support, I can't remember whose comment, about how
6 closely the work of home care is linking to other aspects
7 of the care they're getting from their physician and their
8 health care system.
9 And I don't know, Evan, whether you have any
10 information about how home care services are communicated.
11 I mean, I can remember the olden days about how we
12 communicated, which has no relevance to today, but I would
13 imagine that home care nurses have their tiny little iPads
14 or laptops and they actually record right into the
15 patient's medical record. Is that right?
16 MR. CHRISTMAN: Sure. I think I would say two
17 things. You know, in part because of the patient
18 assessment requirements in home health, home health
19 agencies frequently use some sort of point-of-care system
20 for their own medical records, and some, I think, do offer
21 that data in a portal for physicians to access.
22 But my understanding of how a lot of the

1 communication happens, Marjorie, is that it will probably
2 not be that different in that, you know, it's calling
3 physicians, faxing, talking, trying to get to the office.
4 My impression is that -- as other Commissioners have
5 mentioned -- this still remains a flash point in the
6 benefit. You know, there are some physicians who know the
7 setting very well and work closely with their agencies, but
8 my understanding is that those are more the exception.
9 And, you know, sometimes I hear the words "said it and
10 forget it."
11 So I wish I could say that it had changed more.
12 MS. MARJORIE GINSBURG: And just to reinforce, at
13 least my expectation and hope, is that, in fact, the work
14 of the home care staff really becomes integrated and part
15 of the entire comprehensive care that patients are getting
16 and not seen as just isolated ancillary services that have
17 no relevance to the care they receive. And I don't know
18 what it takes to make that happen more convincingly.
19 DR. CROSSON: Okay. Thank you. Seeing no
20 further comments it's my judgment that there's broad
21 support for the recommendation. Therefore, we will bring
22 it forward in January as an expedited voting process.

1 Thank you, Evan. Nice job. We will move on to
2 the final presentation for the December meeting.
3 [Pause.]
4 DR. CROSSON: So the final presentation today is
5 our annual update on the Medicare Advantage program. There
6 are no recommendations here but I anticipate a vigorous
7 discussion. Scott, Carlos, and Andy are here, and it looks
8 like, Andy, you're going to be beginning? Oh, Scott.
9 Sorry. Go ahead.
10 DR. HARRISON: Good morning. I am going to
11 present our analysis of the Medicare Advantage enrollment,
12 plan availability and bids for 2019. Then Andy will give
13 you an update on risk coding intensity, and, finally,
14 Carlos will talk about MA quality.
15 Let me briefly summarize the MA payment system.
16 Plans submit bids each year for the amount they think it
17 will cost them to provide Parts A and B benefits. There is
18 a separate bid for Part D drugs, but the MA plans just get
19 paid for D as if they were stand-alone Part D plans.
20 Each plan's bid is compared to a bidding target
21 or "benchmark." CMS sets county benchmarks based on the
22 fee-for-service spending in each county. These benchmarks

1 range from 115 percent of fee-for-service in the lowest-
2 spending counties to 95 percent of fee-for-service in the
3 highest-spending counties. A plan's benchmark is the risk-
4 adjusted average of the county benchmarks of its enrollees.
5 Quality bonuses can increase plan benchmarks by up to 10
6 percent. Carlos will discuss these plan quality bonuses
7 shortly.
8 If a plan bids below its benchmark, as plans
9 almost always do, Medicare pays the bid plus a rebate which
10 is calculated as a percentage of the difference between the
11 bid and the benchmark. The rebate percentage ranges from
12 50 percent to 70 percent, depending on the plan quality
13 ratings. The rebate must be used to provide extra benefits.
14 If a plan bids above its benchmark, Medicare pays the
15 benchmark and beneficiaries make up the difference with a
16 premium.
17 Enrollment in MA plans continues to grow rapidly.
18 In 2018, MA enrollment grew 8 percent to 20-and-a-half
19 million enrollees. That growth is about the same as the
20 average annual growth over the last 12 years. Plans
21 project double-digit enrollment growth for 2019, presumably
22 based on both an increase in the number of plans bidding

1 and the extra benefits being offered. By plan type,
2 enrollment in HMOs grew 7 percent while local PPOs grew by
3 16 percent. Regional PPOs, however declined slightly.
4 Thirty-three percent of Medicare beneficiaries are now
5 enrolled in Medicare Advantage plans.
6 Medicare beneficiaries have a large number of
7 plans from which to choose and MA plans are available to
8 almost all beneficiaries.
9 For 2019, 99 percent of Medicare beneficiaries
10 have at least one plan available, 97 percent have an HMO
11 and/or a local PPO available, 90 percent have a zero-
12 premium option available that includes the Part D drug
13 benefit, and that is up from 84 percent in the previous
14 year.
15 As I mentioned, there is a large increase in the
16 number of plans bidding. The average number of plans
17 available in each county increased to 13, from 10 in 2018.
18 Weighting by the number of beneficiaries in each
19 county tells us the number of plan choices available to the
20 average beneficiary, and that increased to 23 plans, up
21 from 20.
22 Finally, the average rebate that plans have

1 available for extra benefits in 2019 has increased to $107
2 per member per month, a record high. Note that these
3 record levels have developed over a period when PPACA
4 reduced the benchmarks. Plans were able to respond to
5 fiscal pressure by increasing the efficiency of their bids.
6 For 2019, we estimate benchmarks, bids, and
7 payments, including quality bonuses, will average 107, 89,
8 and 100 percent of fee-for-service, respectively. These
9 numbers have been stable over the past three years as the
10 PPACA benchmark reductions were completed in 2017. So we
11 are now in a period where on average nationally, per capita
12 spending to plans, are roughly equivalent to spending on
13 fee-for-service Medicare beneficiaries, and 2 to 3 percent
14 of those MA payments are attributable to quality bonuses.
15 The plan benchmarks, however, include an average
16 of 4 percent for quality bonuses and an average of a total
17 of 107 percent of fee-for-service, on average.
18 Looking at the bids column we see plans,
19 especially HMOs, are usually able to bid below fee-for-
20 service costs, averaging 89 percent of fee-for-service
21 overall and 88 percent for HMOs. The other plan types bid
22 higher and local PPOs are bidding 96 percent of fee-for-

1 service, although that is down from 99 percent last year.
2 Bear in mind that all the numbers on this slide
3 assume that risk differences are properly accounted, but
4 next Andy will say that not all risk is properly accounted
5 for. If we incorporated the uncorrected coding intensity
6 differences, we would say that 2019 payments would average
7 101 to 102 percent of fee-for-service.
8 I have one last slide before I hand it over to
9 Andy. This chart shows how much plans bid relative to fee-
10 for-service for service areas with different ranges of fee-
11 for-service spending. As expected, plans bid high
12 relative to fee-for-service in areas with low fee-for-
13 service spending and bid low relative to fee-for-service
14 where fee-for-service spending is high.
15 If you look at the left-most column which shows
16 the bids for plans with service areas concentrated in
17 counties in the lowest spending quartile where the
18 benchmarks are set at 115 percent of fee-for-service, you
19 will see that the median bid is 99 percent of fee-for-
20 service. This means that most plans in these counties,
21 which were presumed to be the most challenging for MA plans
22 to compete in, are bidding below local fee-for-service

1 spending.

2 That has not always been the case. As benchmarks

3 have declined over the past few years, the median bid for

4 these areas has decreased from 111 percent of fee-for-

5 service in 2013. However, the increased efficiency of plan

6 bids in these areas have not translated to Medicare

7 savings. For 2019, Medicare is still paying an average of

8 111 percent of fee-for-service in these areas, because the

9 benchmarks average 118 percent of fee-for-service when you

10 include the quality bonuses the quality bonuses.

11 Now Andy.

12 DR. JOHNSON: Medicare payments to MA plans are

13 unique to each enrollee and are the product of two factors.

14 The first is a base rate that Scott described earlier. The

15 second is a beneficiary's risk score, which is a

16 standardized measure of expected spending. A risk score

17 adjusts the base rate by increasing payment for

18 beneficiaries who are more sick and therefore expected to

19 have greater health care expenditures, and vice versa.

20 The risk model includes demographic information

21 and certain medical conditions, identified by diagnosis

22 codes and grouped into HCCs. Risk scores are the sum of

1 the relative spending amounts for each component in the
2 model. The more HCCs indicated for a particular enrollee,
3 the larger the risk score and the larger the Medicare
4 payment will be for that enrollee.
5 The risk model is estimated using fee-for-service
6 data, and therefore relative spending amounts reflect the
7 spending and diagnostic coding practices in fee-for-service
8 Medicare. There is little incentive to document all
9 diagnoses in fee-for-service Medicare, as most HCCs are
10 documented on claims paid based on procedure codes rather
11 than diagnosis codes.
12 In MA, however, there is a significant financial
13 incentive to document all diagnoses as payment is tied
14 directly to the number of HCCs identified. The difference
15 in fee-for-service and MA coding intensity causes
16 beneficiaries of equivalent health status to have higher
17 risk scores and to generate greater Medicare spending when
18 enrolled in MA.
19 Our analysis of 2017 data found that MA risk
20 scores were 7 percent higher than fee-for-service
21 beneficiaries with comparable health status. Each year,
22 CMS applies an adjustment that reduces all MA risk scores

1 to account for the impact of coding differences. The
2 adjustment was 5.66 percent in 2017. The remaining
3 difference of 1 to 2 percent generates payments to MA plans
4 in excess of what fee-for-service Medicare would have spent
5 to care for the same beneficiaries. Through 2015, our
6 analysis found that the overall impact of coding
7 differences was increasing each year, but this difference
8 has decreased in the past two years.
9 We believe three factors contribute to the
10 reduction. First, CMS implemented new versions of the risk
11 score model that are less susceptible to coding
12 differences. Second, fee-for-service risk scores grew
13 faster during the past two years than prior years, nearly
14 matching annual MA growth rates. The fee-for-service
15 growth rate may have been influenced by the transition from
16 ICD-9 to ICD-10 diagnosis codes, as well as other factors.
17 Finally, MA risk scores were reduced slightly by the use of
18 encounter data in risk adjustment.
19 Although we have seen a reduction in the overall
20 impact of coding intensity, the coding adjustment policy
21 continues to generate significant inequity across MA
22 contracts. The coding adjustment is shown by the yellow

1 line. Each black columns shows one MA contract's coding
2 intensity relative to fee-for-service.
3 This graph shows significant variation in coding
4 intensity across MA contracts. Considering that the coding
5 adjustment reduces all MA risk scores by the same amount,
6 contracts on the left of the dashed line are penalized by
7 the coding adjustment, and contracts on the right are
8 overpaid despite the coding adjustment.
9 In 2016, the Commission recommended a three-part
10 approach that would make the coding adjustment more
11 equitable across MA contracts and would account for the
12 full effect of coding differences.
13 I will now turn it over to Carlos.
14 MR. ZARABOZO: As Scott mentioned, MA has a
15 quality bonus program that provides bonus payments to
16 highly-rated plans. Plans are rated using a 5-star system
17 and contracts with an overall average rating of 4 stars or
18 higher receive bonuses. The bonus takes the form of a 5
19 percent increase in MA benchmarks, and in some geographic
20 areas a 10 percent increase. Using the most recent star
21 ratings, 75 percent of MA enrollees are in contracts with a
22 2019 star rating of 4 stars or higher, with expected

1 expenditures of about $6 billion for bonus payments in
2 2019.
3 One aspect of the quality bonus program is that
4 plan sponsors can use contract consolidations to move non-
5 bonus contracts to bonus status. The plan sponsor can
6 merge a contract that has a rating below 4 stars with a
7 contract at or above 4 stars and choose to have the higher
8 rating apply to the newly formed combined contract. This
9 consolidation process is occurring in the current cycle,
10 with 550,000 enrollees being moved to bonus status under
11 merged contracts. Over the last 5 years, nearly 5 million
12 enrollees have been moved to bonus status through
13 consolidations.
14 Beginning next year, the policy applied in
15 contract consolidations will change so that rather than
16 allowing one contract's star rating apply to the merged
17 contract, the star rating will be determined based on the
18 weighted average quality results for the contracts being
19 merged. However, under the new rules, a plan sponsor would
20 still have the opportunity to obtain unwarranted bonuses by
21 designing mergers where the averaging method results in an
22 overall rating that is at 4 stars or higher.

1 The contract consolidations that have occurred
2 over the last 5 years have affected our ability to judge
3 quality in MA and changes in the level of quality over the
4 years. As we discussed at the November meeting, because of
5 consolidations, MA contracts can cover wide, disparate
6 geographic areas. As a result, since star ratings are
7 determined at the contract level, star ratings are not a
8 good indicator for evaluating quality. Even if we examined
9 individual measures in MA, many quality measures are based
10 on small samples drawn at the contract level, regardless of
11 the size and geographic reach of the contract. So results
12 examined at the measure level also may not be a valid
13 representation of quality in MA.
14 To summarize the status of the MA program, the
15 program is doing well, as evidenced by the growth in
16 enrollment, increased plan offerings and extra benefits
17 that are at a historically high level. As Andy explained,
18 certain policies have helped reduce the impact of coding
19 differences between MA and fee-for-service.
20 For the immediate future, we plan to continue
21 looking at issues with the MA quality bonus program,
22 looking at ways to account for continued coding differences

1 between MA and fee-for-service and how to address those
2 differences in a complete and equitable way, and ensuring
3 the completeness and accuracy of encounter data.
4 Going forward, the Commission may wish to look at
5 MA payment policy from a broader perspective. When the
6 PPACA payment reforms were instituted that reduced MA
7 program payments, there was some concern about whether MA
8 would continue to grow and attract Medicare beneficiaries.
9 The fiscal pressure did not have the effect that some had
10 predicted. Instead, bids have come down in relation to
11 fee-for-service. This is true, as Scott mentioned, even in
12 areas where sponsors might have found it challenging to
13 operate successful plans, such as in areas where MA
14 benchmarks are at 115 percent of fee-for-service.
15 On average across the nation, MA payments are
16 nearly at parity with fee-for-service expenditure levels,
17 consistent with the Commission's support of equity between
18 the two programs. A reasonable question to ask, though, is
19 whether 100 percent of fee-for-service is the right
20 yardstick for evaluating the efficiency of the MA program,
21 given that we would expect plans to be more efficient than
22 fee-for-service.

1 In setting payment policy in fee-for-service, the
2 Commission tries to have a level of fiscal pressure applied
3 to providers to promote the efficient provision of care
4 while maintaining good access. Fee-for-service payment
5 policies of that nature have an effect on MA payments
6 because MA benchmarks are based on FFS expenditure levels.
7 In the future, the principle of parity can encompass the
8 concept of achieving an equal level of cost and quality
9 pressure between MA and FFS.
10 That concludes our presentation. Thank you.
11 DR. CROSSON: Thank you. Very good update. We
12 now open for clarifying questions.
13 Jonathan and then Marge.
14 DR. JAFFERY: Thanks for a great update. I guess
15 I have two questions. I guess these are for Andy, and the
16 first one may not be easy to answer. Can you explain at
17 all how the coding adjustment factor is determined? And
18 the second part is, I think you mentioned that
19 Commissioners in the past made, I think, three
20 recommendations regarding addressing issues with coding
21 adjustments. Can you remind us what those are?
22 DR. JOHNSON: So the coding factor is set in

1 statute to increase each year. I think it started in 2014,
2 and it will level out starting in 2018 at about 5.9
3 percent. The Secretary has authority to go above that
4 amount. It's a minimum adjustment amount but to date has
5 not applied a higher factor.

6 And the second question was about our three-part
7 recommendation. The first part was to remove health risk
8 assessments as a source of diagnosis for risk adjustment,
9 so that only diagnoses that were documented on assessment
10 but not had any care provided outside of that assessment
11 would be removed. And we think that is associated a little
12 bit with the graph that shows that there is wide disparity
13 in coding intensity across contracts.

14 The second part of the recommendation was to use
15 two years of diagnostic data, both in MA and fee-for-
16 service, and that would decrease some of the disparity
17 between MA and fee-for-service coding rates. And the last
18 part was to, after implementing those two, identify the
19 remaining impact of coding intensity and apply either an
20 across-the-board adjustment or afterwards we discussed
21 separating that out into groups of low, medium, and high
22 adjustments to address the rest of the coding impact.

1 DR. JAFFERY: Thanks.

2 DR. CROSSON: Marge, and then Jon.

3 MS. MARJORIE GINSBURG: This is a real basic
4 question, I guess. So the goal of maintaining equity
5 between the two ways Medicare beneficiaries get their
6 services, original Medicare and Medicare Advantage, why? I
7 think it's been shown that folks in Medicaid Advantage
8 plans use services more efficiently, I think have better
9 health outcomes. It should be a less expensive way, and
10 probably better way, to provide care for seniors.

11 So what is the philosophy behind maintaining
12 equity in how much money the government spends on these two
13 services? Thank you.

14 DR. CROSSON: Go ahead.

15 DR. MATHEWS: So this notion of parity between MA
16 and fee-for-service goes back quite a few years and has
17 been one of the standing principles of the Commission that
18 the Commission should be indifferent with respect to, you
19 know, financial incentives regarding a beneficiary's choice
20 of MA versus fee-for-service. And so for the better part
21 of at least a decade now that has been the Commission's
22 principle, that as long as it is neutral to the program the

1 beneficiary should be able to select the delivery model
2 that is of most, you know, interest and utility to the
3 beneficiary.
4 But as the presentation articulated, now that we
5 have, you know, reached parity, putting aside, you know,
6 any potential residual coding differences, the question for
7 the Commission's discussion is, you know, is that
8 sufficient, or do we want to look at ways to impose
9 additional financial pressure directly on MA the way we do
10 through the fee-for-service sectors. And so that's the
11 question that's under discussion.
12 MS. MARJORIE GINSBURG: Because I, I mean, in my
13 mind, you know, a major function of the Commission is to
14 keep an eye on how much the taxpayer is paying Medicare,
15 and so if we're not particularly attentive to how dollars
16 are being spent where they don't have to be spent, that's
17 of high interest to me. Thank you.
18 DR. CROSSON: Did I see Pat? Oh, I'm sorry. Jon
19 was first, then Pat. Go ahead, Pat.
20 MS. WANG: So the sort of observation that
21 payments to MA are now about equivalent to fee-for-service
22 is sort of like the top-line story, and underneath that, of

1 course, is because there are different benchmarks by
2 county. It's a blend, that 100 percent equivalency is a
3 blend of plans in lower benchmark counties bidding far
4 below fee-for-service, by definition, because the benchmark
5 is 95, and those that are bidding, you know, up to 115
6 percent of fee-for-service.
7 As I recall, one of the rationales behind kind of
8 doing the tiers of benchmarks in that fashion was partly to
9 try to attract MA to counties that had low fee-for-service
10 spending and maybe they were rural areas, what have you.
11 I'm thinking about Sue's comment yesterday, I guess -- it
12 seems like a week ago -- yesterday, that, you know, in her
13 area it's still difficult to get MA plans in, even though
14 maybe she's in a 115 percent benchmark county.
15 I just wonder whether, with the passage of time,
16 you have a feel for whether that strategy to put the
17 benchmarks 15 percent or 7 percent above fee-for-service
18 has worked in attracting MA into the areas, or whether
19 there might be other strategies needed to bring MA in, like
20 provider network, which Sue raised.
21 DR. MATHEWS: And Scott and Carlos, before you
22 answer, can you scroll back to Slide 7?

1 DR. HARRISON: Thanks. That's where I was going
2 to go.
3 So you still see that there are differences
4 between the quartiles, but it has moved. Now I believe
5 about 25 percent of rural beneficiaries are in Medicare
6 Advantage, and that's quite an increase from what it had
7 started at.
8 Most rural beneficiaries have access to plans,
9 even multiple plans, and so, yes, certainly plans have
10 shown up. They're still not everywhere. There's none in
11 Alaska, and there's a few other counties, pockets of places
12 where there aren't any. But for the most part, the plans
13 have now established themselves.
14 Now the question would be -- yeah. What's next?
15 DR. CROSSON: Jon.
16 DR. CHRISTIANSON: First, a quick question on
17 Slide 6. The $107 figure, I know you said this in the
18 presentation, but I missed it. What's the time period for
19 that? Is that a per-month figure or per-year figure?
20 DR. HARRISON: Oh, you mean -- I'm sorry. You
21 mean the rebates?
22 DR. CHRISTIANSON: The rebates available for --

1 DR. HARRISON: That's per member per month. I'm
2 sorry.
3 DR. CHRISTIANSON: Per member per month.
4 DR. HARRISON: Yeah.
5 DR. CHRISTIANSON: So there's $107 per member per
6 month, plans have to spend on extra benefits for Medicare
7 beneficiaries --
8 DR. HARRISON: Right.
9 DR. CHRISTIANSON: -- over and above fee-for-
10 service. Okay.
11 The general comment, I guess is on the quality
12 discussion. On a status report for the Medicare Advantage
13 Program, for me on quality, the headline news would be how
14 does the quality in Medicare Advantage plans compare to the
15 fee-for-service system.
16 MR. ZARABOZO: And the answer would be we don't
17 know.
18 DR. CHRISTIANSON: Well, that's not here, though,
19 right? I mean, I think that's an important headline story
20 to me, and I think you start with that and say, "Okay. We
21 don't know how the quality compares for 33 percent of our
22 beneficiaries in the Medicare Advantage plans versus those

1 that have elected to stay in fee-for-service." So that's
2 an important first choice the beneficiaries make: Do I do
3 a plan, or do I stay in fee-for-service?
4 Your focus on quality is if you choose to go to
5 Medicare Advantage, can you compare the plans? So I think
6 your conclusion there is that beneficiaries can't even do
7 that reliably, given the information they have that's
8 publicly reported in the Star ratings.
9 Are there other measures that allow us to compare
10 these two that could be in this report, that allow us to
11 compare plans?
12 MR. ZARABOZO: Well, the CAHPS measures, for
13 example, on the Health Plan Finder, you can compare CAHPS
14 results in fee-for-service with MA results.
15 DR. CHRISTIANSON: Yeah. So I think you focus in
16 the status report on what the beneficiaries have available,
17 which is appropriate and reflects your work that's been
18 done, which is great. Is there something else we could
19 report on what data are available that we could compare
20 plans on in this status report?
21 MR. ZARABOZO: Again, other than the CAHPS, I
22 would say not really, that we don't have a good basis for a

1 comparison.

2 DR. CHRISTIANSON: Okay.

3 MR. ZARABOZO: Now, as you know, we have a

4 recommendation that says we would like to be able to

5 compare fee-for-service and MA and have measures that are

6 comparable between the two.

7 DR. CHRISTIANSON: Yeah. So I think a complete

8 discussion of the status of quality needs to have those

9 things in it. We are at a stage where 33 percent of

10 beneficiaries have chosen Medicare Advantage plans, and we

11 don't know whether quality is better or worse for those

12 beneficiaries in aggregate. Plus, we don't have

13 information that allows them to make choices between plans,

14 if I understand your --

15 MR. ZARABOZO: Yes.

16 DR. CHRISTIANSON: That, to me, is the bottom

17 line of the quality discussion is in terms of status of the

18 MA program.

19 DR. CROSSON: On this point, Jon?

20 DR. PERLIN: Thanks.

21 I think Jon's point is really well taken, and it

22 just drives me to the challenge and fundamentally in the

1 data. Without the adequacy of the diagnostic information
2 and fee, you not only have a financial issue in terms of
3 the benchmark setting, but you also have inadequate basis
4 for a comparison of the fundamental health status of the
5 beneficiaries to be able to then evaluate the quality
6 outcomes.
7 DR. CROSSON: Okay. Further questions?
8 Clarifying questions?
9 [No response.]
10 DR. CROSSON: Seeing none, we'll start the
11 discussion about the report. We've heard some comments to
12 that effect already.
13 Pat, I think you are going to lead off.
14 MS. WANG: I'll just kick it off.
15 I thought it was really a great chapter, so I
16 commend you guys for all the work that you've done on this.
17 Just a couple of things. Just starting with risk
18 adjustment, reiterating the recommendations of the
19 Commission in past, I think this is a really small
20 technical thing, but just on the recommendation of
21 excluding HRAs, HCCs obtained on HRAs, it's important if
22 that proposal is to be developed to make sure that CMS is

1 distinguishing like a face-to-face encounter from an HRA.
2 In April, there was something published that was
3 an attempt to define a chart review that excluded, that
4 didn't include nurse practitioners administering an HRA,
5 which should have been included. So I just point that out
6 as further exploration of going deeper, so that there are
7 not further inequities that are created because of the way
8 that they are defining, that they know how to capture what
9 they want to capture.
10 Andy, you know what I'm talking about.
11 As far as quality is concerned, I really share
12 Jon's concern over quality. I think it's unfortunate that
13 the whole phenomenon of contract consolidations, which have
14 just completely obscured anybody's ability to see what's
15 really going on with quality in the program -- it's also I
16 think an unfortunate device that many multi-region plans
17 have used to game the bonuses and get bonuses that we've
18 discussed before.
19 And there are inequities for plans that don't
20 have the ability or have chosen not to do that. So I just
21 state that for the record, and I think it leads to the
22 dissatisfaction overall with the data that exists.

1 On consolidations, the report does not that the
2 measures taken by Congress address it, to a certain extent,
3 by using the weighted average, but that it's still possible
4 to manipulate the system with the right combination of
5 plans.
6 I didn't see it in here. It may have been in
7 here, and I may have missed it. But I think that there was
8 another phenomenon for new plans, which get a 3 percent
9 increase in payments. I don't think it's called "star,"
10 but there have been observations that some plans are
11 setting up new plans getting the 3 percent bump and
12 consolidating lower or no-bonus status contracts into
13 those. So I would suggest if it's not in here to mention
14 that as another thing that needs to be addressed.
15 The issue around quality -- and there are a lot
16 of recommendations about smaller geographic areas, et
17 cetera, et cetera, which are all good. I think the thing
18 that also needs to be said is if you get to that point of
19 being able to measure at a local level, that the measures
20 should be consistent with the measures in fee-for-service.
21 We had this conversation yesterday about the HVIP
22 and the overlap of one very key measure, which is avoidable

1 readmissions, just making sure that it's capable, they're
2 capable of doing an apples-to-apples comparison.
3 In particular, I think that the recommendations
4 of MedPAC around peer grouping are critically important to
5 somehow pull into the MA program because even if all this
6 stuff gets straightened out, Jon, and you get to see what's
7 happening at a local level, there's a totally different set
8 of quality metrics that have different SES or no SES
9 adjustments. It's still going to be really hard to do a
10 cross-walk between fee-for-service and MA.
11 So I think I would encourage the Commission to
12 continue to try to bring the quality measures used in those
13 systems together to the greatest extent possible.
14 Totally agree on some of the other observations
15 around treatment of EGWP, disenrollment, I-SNP, readmission
16 measures, and excluding those as kind of outliers. I still
17 suggest that for I-SNP, the care of older adults and the
18 SNP HRA measures are also a little bit different when you
19 have a captive audience in I-SNP situation, and that those
20 should be looked at as potentially skewing the results.
21 I appreciate the observations around CAHPS. We
22 sort of talked about that.

1 I would just point out -- I think it was on page
2 43, Table 8. This is just an observation. The headline is
3 there was little change in results for survey-based
4 measures in MA over the last year, and then there is
5 measures collected through the Health Outcomes Survey,
6 measures collected through CAHPS. It is just one year of
7 observation year over year. That plus the tightness of the
8 clustering of these scores, I'm not sure that there's a
9 headline here to be observed.
10 I just wonder whether you have more longitudinal
11 information that might make a comparison of over-time
12 changes.
13 MR. ZARABOZO: The next page is the four-year
14 look of those.
15 MS. WANG: Oh, okay. Okay. I missed that.
16 Thank you. Good.
17 As far as the benchmarks are concerned, it's a
18 great conversation to have. I think it really is important
19 to emphasize on this Chart 7, again, that the 100 percent
20 fee-for-service equivalency is a combination of plans in 95
21 percent benchmark counties bidding at 79 percent of fee-
22 for-service and those in 115 percent counties bidding at 99

1 percent fee-for-service, and in some cases, over the blend
2 of those is what creates the 100 percent.
3 So in deciding how to march forward to bring the
4 systems closer together, I think that's an element of how
5 do you adjust -- are there still four tiers of benchmarks.
6 What's the approach? I just want to make sure that that
7 piece is in there. Not everybody is bidding on the same
8 benchmark.
9 Okay. That constitutes my comments, but I think
10 it was a really great chapter. So thank you.
11 DR. CROSSON: Okay. Thank you, Pat.
12 Other comments to improve the report?
13 Brian.
14 DR. DeBuSK: I just wanted to take a moment in
15 the discussion around -- first of all, thank you on a
16 really well-written report -- to comment on it's promising
17 that the difference in the risk scoring between MA and fee-
18 for-service appears to be shrinking now.
19 I mean, I think when I first joined the
20 Commission, we were sitting at about 10.1, I think was the
21 difference, and now we're down to 7.
22 I do hope that we can work into the report -- and

1 even as a Commission -- develop a philosophy on encouraging
2 the proper coding of patients in the fee-for-service world
3 because I think on the program integrity and the RADV
4 audits and things, to make sure that over-coding doesn't
5 occur in the MA world, obviously.
6 But I still contend that we will not be able to
7 treat patients -- we won't be able to make the correct cost
8 adjustments between the programs, and to the point that Jon
9 made earlier, we're talking about wanting to compare
10 quality between MA and fee-for-service. Well, if the
11 patients are coded fundamentally differently -- in one
12 system, they're coded just enough, and the other one,
13 they're, if anything, over-coded -- I don't see how you can
14 make -- and maybe I just don't know quality well enough.
15 But I don't see how you can make that many adjustments and
16 correct for data that just isn't there.
17 And we talk about coordinating care, and we talk
18 about providers in fee-for-service becoming more
19 accountable. If these patients aren't properly coded, I
20 don't even understand how we're going to develop plans of
21 care. I mean, to me, it seems like you'd be trying to
22 build a building with only half a set of plans.

1 So, again, I think any policies that would
2 encourage parity in the coding, I think would be good for
3 the program and good for the beneficiaries.
4 DR. CROSSON: Bruce.
5 DR. PYENSON: I'd like to pick up on Pat's point
6 with respect to Slide 7 and raise the question whether this
7 structure makes sense to have the subsidies for the lowest-
8 cost areas. It's an issue we've grappled with in other
9 topics in the last day and a half and whether from a policy
10 standpoint this is the direction we want to go in.
11 It strikes me that there are alternatives in many
12 of the lowest-cost areas through the ACOs for managing
13 care, and as we hope that ACOs and Medicare Advantage will
14 increasingly dominate the health care system, I think we
15 can reflect on those alternatives and the roles they play
16 in different areas.
17 One aspect of that I'd like to consider is the
18 role of ACOs and Medicare Advantage with respect to the
19 socioeconomic determinants of health, and that perhaps is
20 seen strongly in I-SNPs and D-SNPs, where the socioeconomic
21 determinants of health are perhaps very important. But in
22 theory, it would seem that the ACOs with their physical

1 location in communities should be able to access the
2 resources in the communities to the advantage of the
3 beneficiaries.
4 Bringing in those kind of determinants into the
5 program of whether it's ACOs or Medicare Advantage, I think
6 is important.
7 We've begun to see some of that with rebates
8 being used in ways that can address non-Medicare benefits,
9 which I think is very useful. It's less clear to me that
10 that's gotten the attention it deserves to bring value to
11 the program and to beneficiaries.
12 DR. CROSSON: Bruce, thank you.
13 And I'll just talk to Jim. We will ask the staff
14 to look at in the next year an analysis of the MA payment
15 system.
16 Okay. I didn't see who was first, but Jonathan
17 and then Kathy.
18 DR. JAFFERY: Thanks.
19 This is a comment that builds on both what Bruce
20 just said and Brian before, mostly Brian.
21 I agree with you. It's really important to get
22 some parity in the two types of systems for us to

1 understand risk.

2 What I think we are really getting at, though,

3 what we really want is to make sure that we can compare our

4 assessment of risk in patients, both for payment equity and

5 outcomes and whatnot and not coding, per se.

6 So I wonder if over time there is a risk

7 assessment model that does more than what we've seen in MA

8 and now we're seeing in fee-for-service, particularly in

9 some of the ACO models that have risk adjustment factors

10 baked in to get at risk assessment, and where that aligns

11 with what Bruce was saying I think is perhaps bringing in

12 social determinants as well or other types of things where

13 we can get data from external sources and aren't just

14 asking providers, both because it's using more

15 administrative time and cost and a bit of a burden for

16 providers, it's time consuming. And then we get some

17 perverse outcomes, I think sometimes, so something to think

18 about.

19 DR. CROSSON: Thank you.

20 Kathy.

21 MS. BUTO: So I was just thinking. I was looking

22 at Slide 14, the fourth bullet down, disconnect between

1 fee-for-service and MA, and I think some of the comments
2 made so far point to some of those disconnects.
3 The statement that if fee-for-service strategies
4 are successful, MA benchmarks go down, I don't see that as
5 a problem. Maybe you weren't identifying it as a problem,
6 but it sort of caused me to think about something else,
7 which I think we could spend more time on, which is that MA
8 plans are able to leverage fee-for-service on DRG payments,
9 for instance, to hospitals.
10 There are areas where MA plans are kind of at the
11 mercy of fee-for-service policies, like coverage, midyear
12 coverage decisions that may have big implications.
13 I think we should spend a little more time, not
14 in this report, thinking about those places where MA plans
15 are able to leverage fee-for-service and where they are not
16 and why this issue of parity is maybe difficult to fully
17 address. But we should be aware of those areas where there
18 are opportunities that maybe we haven't spent enough time
19 thinking about, because I'm reflecting back to the work two
20 or three years ago now where we looked at premium support,
21 and we found in some areas, fee-for-service was the most
22 efficient. In other areas, MA or even potentially ACO fee-

1 for-service was more efficient.

2 And it strikes me that where fee-for-service is

3 able to really leverage national policymaking in setting

4 rates -- and I guess by implication, having to leverage the

5 budget implications of making a policy decision in fee-for-

6 service -- MA plans are much more at the mercy of their

7 local conditions and so don't have that same leverage.

8 So I just think we need to get our minds a little

9 bit more around those issues and not think that we can

10 achieve full nirvana and equity in the way these two play

11 out together in an area.

12 MR. ZARABOZO: Just on the point of midyear

13 coverage changes, midyear coverage changes that are

14 significant are paid by the fee-for-service program, not

15 the MA plans.

16 MS. BUTO: Okay. So they did make that change.

17 Okay.

18 MR. ZARABOZO: Yeah. It's been longstanding.

19 MS. BUTO: It's just all the other ones that are

20 quote/unquote "not significant."

21 DR. CROSSON: Jon.

22 DR. PERLIN: Terrific report. It's interesting.

1 Our conversation has two threads. I mean, one obviously is
2 the comparison of the MA versus fee. The other is sort of
3 taking the broader context of how do we fulfill our
4 fiduciary responsibilities to support the Medicare program.
5 And to go back to really thinking about the
6 conversation yesterday about everything ranging from social
7 determinants to improved outcomes to coordination of care,
8 and it just strikes me that, you know, maybe one of the
9 things that we should consider, as a committee, not in the
10 context of this specific conversation but more broadly, is
11 that we're suffering from sort of administrative
12 limitations here in terms of comparison of data for the
13 purpose of understanding the utility of the resources
14 expended and simultaneously the quality of the outcomes for
15 the beneficiaries.
16 Now if you sort of step back from that it takes
17 me back to my VA days, where, you know, there and DoD, a
18 functional data assessment, regardless of whether the
19 patient was managed by direct service provision or through
20 a contractual relationship or otherwise, it provided a
21 basis for understanding what the inherent risk for
22 individuals were, which allowed some attention to social

1 determinants, but also stepping back to the risks of
2 population.
3 And, you know, as we go forward, would this be a
4 point where patient-completed functional status assessment
5 would have utility that would transcend some of the
6 limitations that we're talking about in terms of these
7 programmatic comparisons and simultaneously help providers
8 address those social determinants and planners address
9 population health opportunities. Thanks.
10 DR. CROSSON: So I agree, and I think Jon made
11 similar points earlier that, you know, perhaps as we go
12 into the next round and the next year, and we take a look
13 at MA, this particular point, which is, you know,
14 comparisons of what we're getting for our dollar, if you
15 will, may be the paramount issue.
16 Jon.
17 DR. CHRISTIANSON: I think one of the things that
18 your chapter did, obviously, as we hear the comments, is
19 stimulate some sort of higher-level thinking about where
20 we're going and how we get there. And so we see the
21 Medicare program moving more and more towards some kind of
22 population-based payment with a value component to it, and

1 you're kind of reporting to us on the status of the
2 component of the program that has had, at least the
3 population-based payment part of it, for 33 years now. And
4 Carlos and I were there at the beginning. A lot of these
5 discussions sound pretty familiar to me, and you didn't
6 even bring up encounter data in your presentation.
7 [Laughter.]
8 DR. CHRISTIANSON: So, I mean, I think it re-
9 emphasizes to our group what a daunting challenge it's
10 going to be to Medicare, given here's where we are after 33
11 years, as they move in this direction -- clearly things are
12 moving in this direction -- how really hard it's going to
13 be to get this right, and what a challenge it's going to be
14 for us as a Commission to help Medicare get this right.
15 DR. CROSSON: Yes, David.
16 DR. GRABOWSKI: Yeah, I just wanted to build on
17 Jon's comments there. I'm struck by the fact that we've
18 spent roughly a day and a half on all these different
19 sectors, and gone over them with a fine-tooth comb, and
20 looked at margins and all these other metrics, and then
21 it's not just a quality issue for Medicare Advantage. All
22 those other metrics we've thought about -- adequacy of

1 payment, access to capital -- all of these same issues are
2 present here. And I'm just struck by how different we
3 think about this sector, which accounts for a third of
4 beneficiaries relative to all these different fee-for-
5 service beneficiaries in all the different sectors that
6 they touch.
7 And so I share the other Commissioners' concerns
8 around quality but I think this could even be a broader
9 discussion about how we think about Medicare Advantage and
10 how we think about a lot of the metrics here, and going
11 back to some of the comparisons we want to make across,
12 obviously, Medicare Advantage and traditional Medicaid but
13 also thinking about splitting traditional Medicare into
14 these different alternative payment models we've been
15 advocating for alongside those who are in traditional fee-
16 for-service relative to Medicare Advantage.
17 So I think we have a lot of work to do. This was
18 a great chapter but I think it's a start towards beginning
19 to think about some of these comparisons more generally.
20 DR. CROSSON: Good point. And just to be clear,
21 particularly for the new Commissioners, the reason we don't
22 do a Medicare Advantage update analysis and recommendation

1 is that the Medicare Advantage payment system is set in
2 law, and as was mentioned, it spins off the fee-for-service
3 payment benchmarks. So it's not part of our -- it would
4 make no sense for us to do that sort of analysis, in the
5 context of the update work that we do in December and
6 January. But we have, you know, almost on an annual basis,
7 taken on one part of MA or the other traditionally, to try
8 to analyze, from a policy perspective, how the system
9 should work and whether it should be changed, and we're
10 going to continue to do that.
11 Yeah, Pat.
12 MS. WANG: Just on something that Jon said, we
13 really will not be able to understand what goes on in MA
14 without full encounter data. That's what's missing. And
15 so I think that we should take every opportunity to
16 continue the conversation. You guys last time presented a
17 lot of information on, you know, the state of encounter
18 data submissions, and I think that there are issues on both
19 sides. But a strong signal really has to be sent to
20 everybody, including, you know, CMS, which has tried and
21 struggled. But I think, you know, many plans are having
22 issues. I think CMS is having issues.

1 And so, you know, just coming up with like we're
2 going to do this, we have to do this, would perhaps, I
3 think, you know, we should continue to say that. I don't
4 think that it's all on one side or the other. I think it's
5 just a lack of -- I think we're a little stuck in the
6 progression towards full encounter data submission, and
7 even if it just focuses on, you know, development of risk
8 scores and encouraging CMS to keep that blend going, to
9 keep folks focused on at least those components of
10 encounter data that needs to be submitted and then I know
11 that the more challenging ones are, you know, physician
12 offices, home health, things like that. That can be phase
13 two.
14 The other thing is -- and I don't have a proposal
15 for this -- I think it is important for the Commission to
16 be thinking about what to do with benchmarks. Obviously
17 the program has grown and companies have adjusted to the
18 benchmarks that exist, which is really interesting, which I
19 think demonstrates that there is -- there's no magic to
20 setting the benchmarks where they are. There's no science.
21 There's no, you know, sort of needed policy rationale.
22 There were some in the beginning but clearly the managed

1 care industry can continue to adjust, flex, adapt to change
2 in the benchmarks. And they're kind of old and the program
3 has grown a lot, so I think it's good time to have an open
4 mind about what should the future look like? MA is here to
5 stay, which I think is a great thing. I think it's a great
6 thing.
7 But these things shouldn't be, you know, like
8 locked in stone forever, probably. Maybe they should but
9 they should be validated that they should be locked in
10 forever.
11 DR. CROSSON: Well, at least that question can be
12 analyzed.
13 MS. WANG: Yeah.
14 DR. CROSSON: Okay. Seeing no further discussion
15 I'd just like to make one comment before we have the public
16 comment period. I'd like to thank the staff for the
17 excellent work that has led to these discussions. It's
18 always that way, but I think this year, particularly, it's
19 been terrific.
20 Beyond that, I really would like to thank the
21 Commission. You know, over the years I've warned
22 Commission members about the December meeting, because

1 sometimes it can be quite repetitive and difficult to
2 maintain concentration at times. This has been a very
3 different experience for me. I mean, I think the energy
4 here, the quality of thought, the dedication that I saw
5 yesterday as well as today to make sure we get it right,
6 you know, kept up, for me, the intellectual energy
7 necessary, because I was feeding off of what is just an
8 excellent group of people, and I thank you for that.
9 So we are open now for public discussion. If we
10 have any members, any of our guests who would like to make
11 a comment, please step to the microphone.
12 [No response.]
13 DR. CROSSON: Seeing nobody heading that way we
14 are adjourned until the meeting in 2019. How about that?
15 [Whereupon, at 11:55 a.m. the meeting was
16 adjourned.]
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