MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 7, 2017
9:17 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
DAVID GRABOWSKI, PhD
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AGENDA PAGE

P R O C E E D I N G S

[9:17 a.m.]

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

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

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

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

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

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

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

private insurance payments.

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

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

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

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

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

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

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

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

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

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

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

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

penalties in any value-based purchasing program in Medicare.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Each clinician will get a composite MIPS score

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

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

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

into potentially massive differences in payment adjustments.

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

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

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

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

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

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

Clinicians would need to join voluntary groups of

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

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

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

at in the context of those programs.

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

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

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

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

which we plan to discuss this spring.

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

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

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

DR. CROSSON: Thank you, Kate.

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

Clarifying questions? Alice.

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

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

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

DR. COOMBS: About 35 cents, roughly?

MR. WINTER: 35 cents?

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

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

DR. COOMBS: The conversion factor.

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

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

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

DR. COOMBS: Okay.

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

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

DR. COOMBS: Just by comparison, if you find

yourself in an advanced APM that meet the threshold --

MS. BLONIARZ: Yeah.

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

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

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

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

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

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

MS. BLONIARZ: That's right.

DR. COOMBS: Okay.

DR. CROSSON: Brian, on this point?

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

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

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

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

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

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

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

MR. WINTER: Yeah.

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

MR. WINTER: We can look into that.

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

DR. REDBERG: That would be a good start.

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

it down?

DR. REDBERG: Office-based procedures --

MR. WINTER: Okay.

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

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

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

MR. WINTER: Yeah.

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

MR. WINTER: Yes.

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

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

DR. CROSSON: Okay. Other clarifying questions?

Jack.

DR. HOADLEY: Thank you again for this chapter,

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

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

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

DR. HOADLEY: Yes.

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

DR. HOADLEY: Right.

MR. WINTER: -- that is physicians.

DR. HOADLEY: Right.

MR. WINTER: Primary care physicians.

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

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

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

Kate, do you want to add something?

MS. BLONIARZ: Yeah.

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

DR. HOADLEY: Designation.

MS. BLONIARZ: -- is APRN.

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

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

think about what's available.

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

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

DR. HOADLEY: Right.

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

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

DR. HOADLEY: Okay.

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

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

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

DR. CROSSON: Questions?

Pat.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Questions?

Bruce.

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

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

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

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

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

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

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

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

MR. PYENSON: Thank you.

DR. CROSSON: Okay. Clarifying questions?

Warner.

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

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

MS. BLONIARZ: Of reporting costs?

MR. THOMAS: Yeah.

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

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

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

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

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

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

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

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

MS. BLONIARZ: I would say that's a concern now even with MIPS.

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

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

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

DR. CROSSON: Kathy.

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

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

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

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

DR. CROSSON: David.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. GINSBURG: I think this is a --

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

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

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

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

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

DR. CROSSON: Jon.

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

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

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

into hospital settings.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay.

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

DR. CROSSON: Yes, go ahead, Kathy.

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

DR. HOADLEY: Site-neutral payments.

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

DR. HOADLEY: Right.

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

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

DR. CROSSON: Pat, on this point?

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

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

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

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

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

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

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

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

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

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

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

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

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

Paul, Kathy, and then Rita.

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Warner.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Perfectly valid. Yeah.

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

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

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

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

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

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

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

DR. CROSSON: Fair enough. Alice.

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

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

And then there's another algorithm on her

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay. Bruce.

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

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

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

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

density of the influence is a very powerful thing.

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

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

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

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

DR. CROSSON: Thank you. Pat.

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

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

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

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

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

Paul?

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

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

DR. CROSSON: Okay. Kathy.

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

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

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

makes a lot of sense.

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

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

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

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

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

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

[Pause.]

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

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

until we get that adjusted.

Who's going to begin? Zach?

MR. GAUMER: Yes.

DR. CROSSON: Okay.

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

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

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

margins for 2018.

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

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

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

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

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

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

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

Access to capital is good for most hospitals. In

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

to control their costs.

And with that I turn it back to Jay.

DR. CROSSON: Thank you, Stephanie.

We'll now do clarifying questions.

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CHRISTIANSON: Go ahead.

MS. WANG: This is actually on the same topic

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

MS. CAMERON: We are not.

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

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

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

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

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

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

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

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

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

MS. WANG: Okay.

DR. GRABOWSKI: -- confusion lies.

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

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

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

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

of ICD-10?

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

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

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

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

DR. COOMBS: Broadened it.

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

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

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

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

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

DR. CROSSON: Brian, on this point.

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

Can we tease apart how much of that really could

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

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

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

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

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

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

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

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

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

DR. HOADLEY: Right.

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

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Questions? Warner.

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

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

but OBs is in that 62 percent.

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

MR. GAUMER: How do we run?

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

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

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

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

MR. THOMAS: Okay.

MS. CAMERON: -- over time.

MR. THOMAS: And on the efficient hospitals now,

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

DR. STENSLAND: No.

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

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

DR. CROSSON: Bruce.

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

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

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

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

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

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

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

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

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

DR. CROSSON: Amy.

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

Medicare side, if I follow the material.

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

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

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

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

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

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

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

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

-- continue to just erode over time?

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

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

DR. CROSSON: David.

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

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

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

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

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

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

DR. CROSSON: On this point?

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

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

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

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

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

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

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

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

DR. NERENZ: Sometimes.

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

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

DR. CROSSON: Fair enough.

DR. GINSBURG: If I could just jump --

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

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

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

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

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

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

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

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

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

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

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

DR. STENSLAND: Yeah.

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

basically looking at trends and forecasting and just extrapolating.

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

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

DR. CHRISTIANSON: Right.

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

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

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

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

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

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

DR. DeBUSK: It's the death spirals.

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

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

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

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

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

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

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

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

MS. CAMERON: That's correct.

MS. WANG: Okay. Thank you.

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

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

DR. CROSSON: Paul.

DR. GINSBURG: Pass.

DR. CROSSON: Jack.

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

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

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

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

DR. CROSSON: Okay. Warner.

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

MS. CAMERON: It is.

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

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

MR. THOMAS: Yeah, yeah.

MS. CAMERON: Yes. We have that information.

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

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

MS. CAMERON: We can get that to you.

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

Jack. Jack and Pat.

DR. HOADLEY: Warner, I think, also.

DR. CROSSON: Jack and Pat and Warner.

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

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

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

DR. CROSSON: Pat.

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

little bit of a concern.

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

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

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

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

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

DR. CROSSON: Warner and then Alice.

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

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

I think the second phenomena that we have here is

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

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

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

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

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

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

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

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

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

What percentage do we have of hospitals that are

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

DR. STENSLAND: Fifteen, something like that.

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

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

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

Yeah. Okay. So --

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

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

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

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

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

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

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

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

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

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

Where I would differ a little bit is we tend not

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

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

DR. CROSSON: Okay. Bruce, David.

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

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

DR. CROSSON: Thank you. David?

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

DR. CROSSON: Thank you. Jon.

DR. CHRISTIANSON: Yes, I was going to say

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

So I don't see that differential declining, and

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

DR. CROSSON: Okay. Alice.

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

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

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

DR. COOMBS: Right.

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

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

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

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

DR. CROSSON: Thank you. Further comments?

[No response.]

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

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

[Pause.]

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

MR. GAUMER: Yeah. No rest.

DR. CROSSON: You're up again.

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

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

degree of physician ownership.

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

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

So in our assessment of payment adequacy, we use

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

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

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

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

to higher intensity services, such as implanting spinal neurostimulators.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

services.

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

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

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

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

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

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

Clarifying questions. Brian.

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

and the conversion factor difference of 45.58 versus 78.64.

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

DR. ZABINSKI: Yeah, it is.

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

DR. ZABINSKI: A little less than that.

DR. DeBUSK: A little less than 60 cents.

DR. ZABINSKI: Yeah.

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

DR. ZABINSKI: Correct.

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

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

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

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

DR. ZABINSKI: Oh sure.

DR. DeBUSK: This is a justification.

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

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

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

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

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

DR. DeBUSK: Thank you.

DR. CROSSON: Okay. Jon next.

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

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

DR. CROSSON: Paul.

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

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

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

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

DR. GINSBURG: The implication is that when we

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

DR. CROSSON: Pat.

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

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

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

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

DR. CROSSON: Okay. Jack.

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

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

perspective?

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

DR. HOADLEY: Okay.

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

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

DR. ZABINSKI: Yeah.

DR. CROSSON: On that point?

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

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

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

[Laughter.]

DR. CROSSON: Rita?

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

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

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

DR. REDBERG: There's more.

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

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

DR. CROSSON: Okay. Questions? Kathy.

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

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

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

MR. GAUMER: CMS has finalized that already.

MS. BUTO: All right. I got it.

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

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

MR. GAUMER: That's correct.

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

The second question I have --

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

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

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

MS. BUTO: We did have this discussion?

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

MS. BUTO: And we decided --

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

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

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

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

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

DR. MATHEWS: The cost reporting requirement?

DR. CROSSON: Yeah.

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

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

DR. MATHEWS: Correct.

MS. BUTO: I thought we had done that.

DR. MATHEWS: Correct.

MS. BUTO: Okay.

DR. CROSSON: Yeah, I --

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you.

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

[Laughter.]

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

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

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

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

MS. BUTO: Lower of those two, okay.

DR. ZABINSKI: Yeah.

MS. BUTO: So they still do that calculation?

DR. ZABINSKI: They still do that.

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

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

DR. ZABINSKI: No, there's not.

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

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

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

MS. BUTO: Okay. Thank you.

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

PARTICIPANT: No.

DR. CROSSON: What? What?

[Laughter.]

DR. CROSSON: Alice, okay.

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

[Laughter.]

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

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

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

currently by something that's really obsolete.

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

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

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

DR. CROSSON: Good.

[Laughter.]

DR. CROSSON: All right. Jack?

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

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

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

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

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

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

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

[No response.]

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

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

AFTERNOON SESSION

[1:31 p.m.]

DR. CROSSON: Okay. Let's see if we can convene here. We've got five -- or four -- four or five presentations this afternoon. Wait a minute. I've got five. One, two, three, four -- I've got five things here.

[Pause.]

DR. CROSSON: So I'm ready. Are you?

So now we're going to turn to Carol again, and we're going to have two presentations. We're going to return to the issue we discussed last November and try to get that nailed down, and then we're going to take up the more traditional question of updates for skilled nursing facilities.

Carol, you have the floor.

DR. CARTER: Great. Okay. So, as Jay mentioned, I'll be going through two presentations back to back, and then we'll have your discussion.

At the November meeting, we discussed a way to increase the equity of payments within each post-acute care setting before implementing a unified payment system by using a blend of the setting-specific and PAC PPS relative

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

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

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

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

Based partly on their mix of patients and therapy

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

percent.

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

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

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

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

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

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

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

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

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

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

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

The metrics we use here are standardized cost per

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And finally, as recommended by PPACA, we report

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

And with that, I look forward to your discussion.

Should I put up the first recommendation?

DR. CROSSON: Let's --

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

DR. CROSSON: Let me -- yeah.

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

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

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

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

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

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

So did I get it?

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

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

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

Did I confuse you?

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

DR. CROSSON: The first presentation is interim.

DR. COOMBS: Right.

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

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

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

MS. WANG: Okay.

DR. CROSSON: That assumes perhaps 2021.

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

DR. CROSSON: That's correct.

MS. WANG: Okay.

DR. CROSSON: Jack?

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

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

DR. HOADLEY: That's what I thought.

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

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

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

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

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

DR. CARTER: Right, right.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: David.

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

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

I like this a lot.

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

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

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

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

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

DR. CROSSON: Jon.

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

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

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

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

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

DR. CARTER: They have to have low cost.

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

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

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

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

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

DR. CARTER: Right.

DR. CROSSON: Okay. Yes, Bruce?

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

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

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

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

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

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

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

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

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

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

MR. PYENSON: Okay. Thank you.

DR. CROSSON: Brian.

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

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

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

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

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

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

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

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

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

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

DR. CARTER: Okay.

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

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

DR. DeBUSK: Okay, so --

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

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

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

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

DR. CARTER: Right.

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

DR. CARTER: Okay. Good.

DR. DeBUSK: Thanks.

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

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

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

DR. CROSSON: Yes, Alice?

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

DR. CROSSON: Jack.

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

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

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

DR. CROSSON: I agree. David.

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

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

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

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

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

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

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

DR. CARTER: Just using the relative weights?

MS. BUTO: Yeah.

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

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

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

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

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

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

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But note: high-margin IRFs are giving their stroke patients without paralysis a function score that is

virtually the same as the score low-margin IRFs are giving their stroke patients with paralysis.

All else equal, the payment for these two stroke cases, with a motor score of 29, would be the same, even though, on average, stroke patients with paralysis have an average length of stay that is more than two days longer.

This raises questions about inter-rater reliability in the assessment process, and that's a problem for any payment system. Medicare's payments should be aligned with patient costs, with higher payments made for patients with greater resource needs. For that to happen, providers need to be reasonably consistent in how they rate patients' relative resource needs. If they are not, some providers will receive payments that are too high relative to the costs they incur, while other providers will receive payments that are too low.

Our findings led Commissioners to make two recommendations in March 2016, which we reiterated in March 2017. First, MedPAC recommended that CMS ensure payment accuracy through focused medical record review, and we encouraged the Secretary to reassess inter-rater reliability across IRFs.

Second, MedPAC recommended that CMS reduce potential misalignments between IRF payments and costs by redistributing payments through the high-cost outlier pool. Expanding the outlier pool would increase outlier payments for the most costly cases, and I will come back to that recommendation in a bit.

So I'll turn now to our review of payment adequacy for IRFs. We have used our established framework that you've seen already many times today, so we'll start by considering access to care.

We first look at the supply of IRFs. In 2016, there were just under 1,200 IRFs nationwide, with more than 36,000 beds. As you can see in the facilities column on the chart, only 23 percent were freestanding facilities. But these facilities tend to be bigger, so they accounted for half of Medicare discharges from IRFs in 2016. The number of freestanding IRFs has been growing, and the pace of that growth picked up between 2013 and 2016.

Overall, 31 percent of IRFs were for-profit entities. These accounted for half of all cases in 2016. The number of for-profit IRFs grew, on average, 4.7 percent per year between 2013 and 2016.

This slide shows the number of IRF cases on a fee for service basis. You can see that use of IRF services has been relatively stable over the last decade. The number of cases per fee for service beneficiary increased 1.4 percent in 2016.

We also looked at the quality of care furnished in IRFs, using risk-adjusted measures developed for MedPAC. Overall, we found that quality has improved since we first developed the measures in 2011. The risk-adjusted rate of potentially avoidable readmissions during the IRF stay was 2.5 percent in 2016, and was 4.4 percent during the 30 days after discharge. These rehospitalization rates are low compared with those of other PAC settings, and that's not surprising. Remember that IRF patients are selected because they can tolerate and benefit from intensive therapy, which means they tend to be less frail than, say, SNF patients. And IRFs themselves are certified as hospitals.

On average, IRFs' patients gain more than 24 points in motor function during the IRF stay, and 4 points in measured cognition. But remember that function scores are self-reported. Given our concerns about coding, changes

in function must be interpreted with caution.

Turning now to access to capital, as I noted earlier, more than three-quarters of IRFs are hospital-based units, which access needed capital through their parent institutions. As you heard this morning, hospitals maintained good access to capital.

As for freestanding IRFs, we don't have much information about independents or small chains, which represent about half of all freestanding facilities. The other half of providers in the freestanding IRF category is owned by one large chain. Market analysts indicate that this chain has good access to capital. The company has continued its pursuit of vertical integration, by entering into joint ventures with acute care hospitals to build new IRFs and by strengthening ties between its IRFs and home health agencies.

This is a strategy we are seeing in several large post-acute care companies. The companies believe that providing a continuum of post-acute services will allow them to respond to reimbursement pressures and make them desirable participants in coordinated care delivery models and bundled payment arrangements.

In 2016, the Medicare margin for IRFs was 13 percent, down from 13.8 percent in 2015.

Financial performance continued to vary widely across IRFs. The aggregate margin for freestanding IRFs was 25.5 percent. Hospital-based IRFs had an aggregate margin of 1.2 percent.

So, why do we see such a disparity between hospital-based and freestanding IRFs? We think there are a number of factors that are listed here.

First, hospital-based IRFs are more likely to be nonprofit, so they may be less focused on reducing costs to maximize returns to investors. They also have fewer economies of scale. They tend to be much smaller than freestanding IRFs, and they have fewer total cases. Their occupancy rates are also somewhat lower.

Hospital-based IRFs also tend to have a different mix of cases. It's not clear why this is the case. As I mentioned earlier, some case types may be more profitable than others, resulting in higher margins for facilities that admit larger shares of those cases.

And finally, hospital-based IRFs may assess their patients differently. During conversations with people in

the industry, we've heard some suggest that hospital-based IRFs devote less time to training assessment staff and verifying accuracy of assessments, resulting in less reliable measures of patients' motor and cognitive function. Others in the industry have suggested that freestanding for-profit IRFs are aggressively assessing their patients so as to maximize payment. As I noted earlier, the integrity of the payment system is contingent on the inter-rater reliability of the assessment tool. If hospital-based IRFs consistently assess their patients as less disabled, for whatever reason, their payments and margins will be systematically lower.

Despite the comparatively low margins, Medicare payments to hospital-based IRFs exceeded marginal costs by a substantial amount, 19.3 percent. This compares to a marginal profit of 40.9 percent in freestanding IRFs.

We expect that cost growth is likely to exceed payment growth in 2017 and 2018, and so we've projected that the aggregate margin will fall to 11.9 percent in 2018. Payment growth will be limited because PPACA and MACRA set payment updates for fiscal years 2017 and 2018 at below market basket levels. And though cost growth in this

industry was very low from 2009 to 2015, cost growth was higher in 2016. We have anticipated this trend will continue.

So to summarize, we observe capacity that appears to be adequate to meet demand. Our risk-adjusted outcome measures have improved over time. Access to capital appears adequate. We estimate that the margin was 13 percent in 2016, while marginal profit was 19.3 percent for hospital-based IRFs and 40.9 percent for freestanding IRFs. We project a margin of 11.9 percent in 2018.

That brings us to the update for 2019. You will recall that the Commission recommended that the update to IRF payments be eliminated for fiscal years 2009 through 2017. Then, as the aggregate margin neared historic highs, the Commission recommended that the Congress reduce the IRF payment rate for 2018 by 5 percent. But in the absence of legislative action, CMS has been required by statute to increase payments. Though cost growth picked up in 2016 and margins declined somewhat, we project that aggregate payments will remain well above the costs of caring for beneficiaries. Indications, then, are much as they were last year.

So we've started from the Chairman's draft recommendation from last year. It reads:

The Congress should reduce the fiscal year 2019 Medicare payment rate for inpatient rehabilitation facilities by 5 percent. We do not expect this recommendation to have an adverse effect on Medicare beneficiaries' access to care or out-of-pocket spending. Even with a 5 percent reduction in the payment rate, we project that the aggregate margin for IRFs will remain above 5 percent. This recommendation may increase the financial pressure on some low-margin providers, but this effect would be eased by this year's draft recommendation that CMS establish IRF payments using a blend of the unified PAC PPS and current IRF PPS relative weights.

The Chairman's draft recommendation assumes that the 5 percent payment cut would be coupled with previous recommendations to the Secretary to expand the outlier pool and improve payment accuracy and program integrity by reviewing IRF assessment and verifying the tool's inter-rater reliability. As I noted earlier, our recommendation from 2016 that the high-cost outlier pool be expanded would further reduce potential misalignments between IRF payments

and costs by redistributing payments within the IRF PPS. Expanding the outlier pool would increase outlier payments for the most costly cases. But this is only a stopgap measure until CMS can do more complete analyses of case-level profitability and assessment reliability. The expanded outlier pool would be funded by an offset to the national base payment amount.

Reducing the payment rate for IRFs by 5 percent, using the blended payment weights that Carol discussed earlier, and expanding the outlier pool from 3 to 5 percent would decrease total payments to IRFs by 5 percent. Because of the blended weights and the expanded outlier pool, the impact would be smaller for IRFs that care for larger shares of stroke cases and medically complex cases.

That concludes my presentation. I'll put the draft recommendation back up and I'm happy to take questions.

DR. CROSSON: Thank you, Dana. I have -- I'm going to start with one question and that is, because we've been all over the place on this particular policy over the years. One option here, perhaps, in addition to the update recommendation would be to reprint, as opposed to text or

text box the previous recommendations that you just referred to. So do you have a thought on -- well, does anybody have a thought on the relative impact of doing so, or is it generally viewed as not needed?

MS. KELLEY: I think, typically, we've put them in text boxes, but I don't know what Jim thinks about --

DR. CROSSON: I mean, sometimes we've -- haven't we -- sometimes we've repeated recommendations.

DR. MATHEWS: Sometimes there has been a consensus among the Commission that's strong enough that the current members of a given cohort want to collectively and affirmatively re-emphasize a prior Commission recommendation. In other instances, there's simply momentum, you know, along the lines of don't forget we have a standing recommendation that does X, Y, or Z, and I believe it's the latter approach that we've used to the prior IRF recommendations.

DR. CROSSON: Okay. Well, it's open for discussion anyway.

Clarifying questions, other than that. Jack.

DR. HOADLEY: On the -- specifically on the point of those two previous recommendations, they're both

recommendation to the Secretary, but it sounds like the Secretary has taken no action in either of these cases. Is there any -- has there been any indication of consideration, or has it been brought up at all in notice and comment?

MS. KELLEY: The Secretary has said, in proposed and final rules, that they don't think expanding the outlier pool from 3 to 5 percent is necessary, so they have given that some consideration.

DR. HOADLEY: Specific disagreement.

MS. KELLEY: Yes. There has not been a reaction from them that I am aware of regarding our concerns about the reliability of the assessment tool.

DR. HOADLEY: Or notion that specifically to auditing or any kind of --

MS. KELLEY: Right.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Questions? Bruce.

MR. PYENSON: Carol's presentation, on one of the first pages, the statement "lack of evidence-based guidelines to base decisions about PAC," and I should have asked her, but I assume that applies to IRF as well -- in

particular. And do you know if the lack of evidence-based guidelines is because nobody has tried, or they've tried and it just doesn't work?

MS. KELLEY: There's been a lot of research in this area, and I'll ask Carol to back me up, if necessary, but my recollection is that the research is really hindered by selection issues.

Remember that IRF patients need to be able to tolerate an incentive level of therapy, which means they can often be more frail than patients in SNFs, and that tends to cast some questions on any findings that come out of comparisons between SNF and IRF patients.

The American Heart Association and the American Stroke Association did release stroke guidelines a few years ago in which they recommended IRF care for stroke patients, but even in their recommendation, they acknowledged that the literature is simply not definitive in this area.

DR. CROSSON: David.

DR. NERENZ: Thanks, Dana.

Sorry if I missed it, but I don't recall seeing anything in this chapter about all-payer margins or payer

mix. Is it there and I missed it, or do we not have that?

MS. KELLEY: We do have it. Sixty percent of IRF discharges on average are Medicare, and I'm sorry. I can't recall the all-payer off the top of my head, but I'll bring that for you next time.

DR. NERENZ: Okay. Also, just to extend the point, payer mix, I'm just curious if it varies by for-profit, not-for-profit, hospital-based, freestanding. Do we have that kind of information as well?

MS. KELLEY: Freestanding tend to have a higher Medicare share, but the difference is not stark, and I can bring that for you next time as well.

DR. NERENZ: Okay. Because these are required to meet the conditions of participation of hospitals, is there any formal obligation, say, to take uninsured patients or to take Medicaid patients? How does that work?

MS. KELLEY: No. And the Medicaid share right now is, on average, about 19 percent. It has come up a little bit, which is probably due to the expansion of Medicaid, but no, they do not have the same requirements.

DR. CROSSON: Yes, Pat.

MS. WANG: The information that you provided on

Slides 13 and 14 about the different financial performance of for-profit versus not-for-profit, hospital-based versus freestanding, is so dramatic that I'm wondering if you have -- it sounds like different provider types.

On Slide 14, the cost increases in not-for-profit versus freestanding, it is dramatic. I mean, to the extent that those are hospital-based, is it a cost allocation issue? But just overall, we often see a different spread like that, but in this case, it almost seems like these are two different provider types. If you can comment?

MS. KELLEY: I don't think we know the answer exactly, but there are a couple of things going on here that can inform our thinking about it.

The first is that when we've looked at cost allocation issues, we don't see a huge difference in overhead cost. The costs are higher in hospital-based IRFs across the board, and they're quite a bit higher.

Which brings me to my second point, which is that from about 2009 to 2015, cost growth in freestanding facilities was incredibly low, even negative in some years. So they have held the line on their costs to an extent that is pretty remarkable, I think, whereas hospital cost growth

in IRFS, anyway, has been above market basket for sort of that earlier period and then a little bit below as we get out closer to the current day, but still much what you would expect.

MS. WANG: I'm just trying to recall offhand from the chart that Carol just showed if the PAC PPS were implement, is there a more dramatic shift of payment in the IRF world from one provider type to the other? I just don't remember.

MS. KELLEY: It's not dramatic. It would move dollars towards nonprofit hospital-based facilities, but it's not a dramatic switch due to the blended rate.

DR. CROSSON: Okay. Seeing no more questions, we'll now move to the recommendation on page 18 and entertain a discussion with respect to the recommendation.

Jack.

DR. HOADLEY: I guess I would make one comment to the question of the reprinting of these recommendations. I mean, it does seem like we've done different things and that there's value sometimes in doing more of a formal reprint to emphasize. I mean, this seems like this might be one of those cases where it feels like there's a pretty

-- I mean, the numbers on that one chart that show the stroke scores are just so dramatic, and it feels like -- especially, I'm thinking of the first of the two, but if we do -- I guess we should do both -- to do that kind of auditing. And given that the Secretary has not responded, maybe that's worth reemphasizing that way.

But otherwise I'm certainly supportive of the new recommendation as well.

DR. CROSSON: I think I agree with that.

Dana pointed out earlier in the presentation in dollar terms how what appear to be relatively small coding differences move -- well, I mean, I think you said $4,000, and the average admission was $19,700.

MS. KELLEY: Yes.

DR. CROSSON: So, I mean, I don't know for sure, but it would seem to me that if that's the case, that that could go in part to explain the differences that you just described.

It seems rather subject to manipulation -- I'm not right?

MS. KELLEY: No, no.

DR. CROSSON: Oh, okay. Good.

So, anyway, I was sort of seconding Jack, but go ahead, Brian.

DR. DeBUSK: I was just thinking, to that end, would we want to make a recommendation as part of Chart 18 that says we'd like to narrow or that we'd like to be more specific in some of these coding practices? I mean, is there an opportunity to tighten that up?

When you rattled off those numbers, it made perfect sense. I mean, that was 20 percent.

DR. CROSSON: Right.

DR. DeBUSK: And we're looking at the chart, and it's a delta of about 20, 25 percent. That may be the issue.

DR. CROSSON: It's suspicious, although not proven.

Alice, on this?

DR. COOMBS: Yeah.

So this was a specific thing that drive us to this corridor, I think, is watching that slide a few ways back to say that there's some inconsistency with how we place the severity of illness in certain categories, and this led to all strokes are not the same. And that just

because you have a DRG that says stroke, some strokes have little -- have major disabilities.

And so from that, we said let's look at resource utilization because that has a lot more to do, rather than the diagnosis of stroke, because some people may have minimal residual and don't require three hours of rehabilitative interventions.

So this is the very thing that we did to look at neutrality in terms of resource utilization, so that if you had inputs that were necessary, that were equivalent across a continuum, and that's when we came up with some of the issues regarding the complexities and CCI, specifically because of this, and that chart just brings home the message of different bars and different benchmarks for different entities in the industry because clearly someone with paralysis has a different functional status than someone without paralysis.

So from that, we deliberate that whole corridor before we started, and to say that IRFs -- there's a tremendous overlap between IRFs and SNFs and LTCHs just because of this very issue of resource utilization based on DRGs. And we just can't say just because it's a stroke

that it should go to an IRF versus an LTCH. It really is the syndrome and the utilization of the resources. I support the Chairman's recommendation.

DR. CROSSON: Thank you.

But specifically to the addition of the previous recommendations?

DR. COOMBS: Yes.

DR. CROSSON: Yeah. Okay. All right.

Kathy.

MS. BUTO: I don't remember who said it. Maybe it was Jack mentioned going back to the previous MedPAC recommendations, and I actually think I'm worried about -- it may not be fraud and abuse, but it at least looks like up-coding in the context of some of these cases. That we did recommend focused medical review, and I'm wondering whether we ought to actually suggest that and the Secretary should consider some sort of coding adjustment a la what is done in other settings. It certainly points in that direction, so not just focus medical review and we're going to be watching over you, but really this may lead to an adjustment that we make on a regular basis, something along those lines.

DR. CROSSON: Jim.

DR. MATHEWS: If we could, it's something I'd like to reserve the right to think about a little bit more.

While on the one hand, there do seem to be these pronounced differences in coding among high-margin compared to low-margin IRFs, I am not sure from a clinical perspective we fully understand the nuance of what's going on here, which is part of the reason we made the recommendation last year -- two years ago? -- two years ago that there should be some medical review.

The patterns we see are very pronounced and very indicative, but from a clinical perspective, I don't know that we have 100 percent of the picture in the same way we did, say, for example, when we looked at hospital up-coding, or now that we're looking at MA coding, where we have a much greater understanding of what's going on, here there seems to be something going on. We don't quite know what it is.

DR. CROSSON: So, Jim --

MS. BUTO: Oh, I definitely think you want to reserve final judgment on what to do, but it's striking that coding in the hospital is in one direction --

DR. MATHEWS: Yes.

MS. BUTO: -- not so severe, and then once they get to the IRF, it goes the other -- I mean, this disparity is what I think struck me.

DR. MATHEWS: Yeah. I don't disagree with that at all, but I'd like to, on behalf of the staff, understand it a little bit better before we make a recommendation to the Secretary that says, "You need to make this kind of coding adjustment, and here is why."

DR. CROSSON: So it's the coding adjustment you'd like to hold in abeyance?

DR. MATHEWS: Correct.

DR. CROSSON: Okay.

Jon.

DR. CHRISTIANSON: Yeah, I agree with that. When I looked on Slide 6, these are like so many of the measures, where provider self-reported measures, there seems to be a clear incentive to sort of maximize revenue.

And you look at 6, and I'm wondering why there should be that pattern. Why wouldn't everybody have exploited that there? Right? I mean, the fact that you have this 29.2, 29 thing, it doesn't make any sense to me

if everybody is out there working to maximize payment. So I do think there's more that we need to understand about this before we talk about it across the board kind of attack on this.

MS. BUTO: Suggesting that we go there, I'm was just saying --

DR. CHRISTIANSON: No, I think I understand.

MS. BUTO: -- we ought to say we might go there.

DR. CHRISTIANSON: I'm with you on that. I'm just trying to reinforce what Jim said because I think there's some things here that I would like to better understand about why we're not seeing a certain pattern consistently across different providers.

DR. CROSSON: Yes, Brian. Bruce.

I get out the first two letters, and then I'm lost.

[Laughter.]

MR. PYENSON: Bro.

I have a process question. It seems to me in this arena, the lack of evidence-based guidelines is a real hindrance to the kind of understanding that we're talking about of coding and a lot of other things.

Is there a way we can suggest that to CMS or HHS that tackling this issue is important; it's not a reason to delay any of the recommendations. But this is one area where development of evidence-based guidelines would probably be very, very helpful.

DR. CROSSON: It sounds reasonable to me. I think that could be added to the text. Sure.

Jack.

DR. HOADLEY: To follow on this last discussion, I mean, it seems like we could probably -- or you could consider some text language that could say, depending on what we learn from these reviews, consider the need for some kind of coding adjustments. I don't know whether some of the overall PAC coding issues would begin to mitigate some of this, but we could put some language in that talks about some potential consequences down the road, depending on what we learn from the medical reviews. And then that would sort of help get to Kathy's point.

DR. MATHEWS: And speaking for myself, I think there are two separable issues here. There's what's going on with respect to functional status coding within the IRF setting as a silo, and we'd like to better understand that.

And then to address Bruce's comment or inquiry about the development of evidence-based guidelines as to when a patient needs post-acute care and if that determination is made, what the appropriate setting is, and that is a huge, huge undertaking. You're looking at millions of patients, tens of thousands of providers across four different PAC settings, not even contemplating PAC services provided in ambulatory settings, physical therapy, that kind of thing. And so that is one approach. You could head down that path and say you should develop for stroke patients, this decision tree; for hip and knee replacement patients, here is a decision tree for where they end up to get their rehabilitative care services.

But I would make two points before we start heading down that path. One, as we try and move more providers into risk-bearing arrangements, A-APMs, accountable care organizations, those kinds of decisions will need to be made at the level of the local provider or local organized delivery system, and in that sense, they may be able to use their own local market intel to be able to determine here is a highly effective provider, irrespective of whether they're a SNF or an IRF or a home

health agency and send patients there. That's one point.

The second is some of this may be mitigated by the continued development and implementation of a unified PAC PPS, where the label on the pile of bricks or on the side of the minivan in the case of home health becomes less important, and again, the payments are based on the clinical needs of the patient, as determined by patterns of care extracted in the aggregate across all settings rather than trying to say this kind of patient needs to go to this kind of inpatient rehabilitation facility, so two alternate approaches here short of the kind of resources that would need to be brought to bear to a true robust set of evidence-based guidelines.

DR. GRABOWSKI: If I could just pick up on that. Jim's answer was great.

I think -- and Dana, you said this earlier -- I don't think we have the evidence yet. It's really due to the selection issue, the kind of individual patient that's been discharged in an IRF is very different than the patient that's been discharged to SNF, and so it's been very hard, at least historically, to kind of make that comparison and decide if you have a moderate stroke, are

you better served being at an IRF versus a SNF.

We should do that research, and I think --

MR. PYENSON: I'm not sure it's all that hard, and I'm going to --

DR. COOMBS: It is.

DR. GRABOWSKI: It is.

[Laughter.]

MR. PYENSON: There are some parts of the country where an IRF is not nearly as available as others, but I suspect -- I didn't want to give my guess at what's going to happen. But I suspect the statistical uncertainty and the fox of results mean that it is not possible to do that, to create decision trees. It really depends on the quality of the service, and I think that would be a very important finding because then you could skip all these other arguments and move to the unified basis. So that's, I think, a direction that's consistent with the unified PAC.

DR. CROSSON: I think we're getting a little far afield here.

My sense is that -- and I agree that trying to develop clinical guidelines that suggest that someone with a particular condition should go to a particular kind of

entity in the face of what we're doing doesn't make any sense.

However, I do think -- and this may not be our role or even Medicare's role. From a clinical perspective, trying to support decision-making that says a patient with this particular type of condition should receive this particular set of services from whoever is able to do that, assuming that that's not already adequate in the environment -- and it may or may not be because the implication of our unified PAC PPS is that we're asking people to think differently. And so it's entirely conceivable that there's a body of work there that could be done.

I'm not sure it's in our province necessarily to do that, but I understand the point you're making.

Okay. I think this. I think despite the fact that we've had conversations about various points that might be altered in the text, I think I have a consensus saying that we should reprint the previous recommendations. Is there any objections there?

No objections. Bobblehead consensus. So I'm going to suggest that in January, we come back with three-

part recommendations, and without objection we take it through the expedited voting process in January, okay?

Thank you very much, Dana.

Oh, and by the way, to the extent that Dana and others make changes in the text, remember you're going to get the opportunity to have one final review of that information. It will come out in the January mailing.

Okay. Got a little sign language going on

[Pause.]

DR. CROSSON: Okay. Stephanie is all set and is going to take us through a discussion of updates for LTCHs.

MS. CAMERON: Good afternoon. Today we are here to discuss how payments to LTCHs should be updated for fiscal year 2019. We will discuss changes in policy that are current law. Then using the established framework, we will evaluate the adequacy of Medicare payments to LTCHs.

First, I will summarize some background information that was included in your mailing materials. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute-care hospitals and have an average length of stay for certain Medicare cases of greater than 25 days. Care provided in

LTCHs is expensive. The average Medicare payment in 2016 was over $41,000 across all cases and close to $47,000 across cases that qualify to receive the full LTCH PPS payment rate that I will discuss momentarily. Medicare pays LTCHs on a per discharge basis with an upwards adjustment for cases with extraordinarily high costs. LTCHs also have a downward payment adjustment for cases with extremely short lengths of stay.

Beginning in fiscal year 2016, an LTCH discharge either needed to have three or more days in the referring hospital's ICU or receive an LTCH principal diagnosis that includes prolonged mechanical ventilation to qualify for the full LTCH standard payment rate. Discharges that don't meet these criteria receive a site-neutral payment equal to the lesser of an IPPS comparable rate or 100 percent of the costs. As you'll recall, the criteria to qualify for full LTCH standard payment rate are consistent with the direction of the Commission's 2014 and 2015 recommendation for chronically critically ill beneficiaries.

Although the dual payment policy began in fiscal year 2016, the multi-year phase-in and range of hospital cost report periods will blend into claims and cost report

data over the next several years. We don't expect to see the full effect of implementation until our December 2020 and 2021 analyses.

I will now turn to the question of how payments to LTCHs should be updated for fiscal year 2019. To determine the update recommendation, we review payment adequacy using our established framework consistent with what you've seen in other sectors throughout the day today.

First, supply. We have no direct indicators of beneficiaries' access to needed LTCH services, so we focus on changes in occupancy, capacity, and use. As you know, historically, this product has not been well defined, and the absence of LTCHs in many areas of the country and the variation in availability across markets makes it particularly difficult to assess the adequacy of supply.

Here we show the cumulative growth of LTCHs and beds since 2006. From 2012 through 2015, the number of facilities and beds calculated based on the cost report data is inaccurate because of a larger than average number of LTCHs that changed their cost reporting periods, as indicated by the dashed lines. We anticipate that this cost report issue has been resolved and that the number of

beds and LTCHs in 2016 reflect a more accurate depiction of supply. As you can see, the number of facilities and beds has decreased since 2012. The number of beds has declined more quickly because, on average, larger facilities have closed while smaller facilities have opened.

In 2016, LTCH occupancy rates averaged around 66 percent, suggesting that LTCHs have excess capacity in the markets they serve.

Using claims data which does not have the same data issues I discussed on the previous slide, this chart shows what's happening with LTCH cases per 10,000 fee-for-service beneficiaries. Controlling for the number of beneficiaries, the number of LTCH cases declined after 2011 when volume peaked at 38.3 cases per 10,000 beneficiaries. Volume declined more rapidly from 2015 to 2016 compared to previous years where the 4.2 percent decrease in volume resulted in a 12-year low of 32.7 LTCH cases per 10,000 fee-for-service beneficiaries. Given the reduction in the number of LTCHs and LTCH beds and the implementation of the patient-specific criteria, this decline in service use is not unexpected, nor does it represent an undue reduction in access to medically necessary LTCH-level care and instead

reflects intended industry change.

Now, quality. LTCHs began submitting quality data on a limited number of measures to CMS in fiscal year 2013. CMS has expanded the number of measures required for reporting since and began publicly reporting two of these measures last December. But because of the Commission's interest in understanding changes in the quality of care provided to Medicare beneficiaries over time, we continue to rely on claims data to assess gross changes in quality of care in LTCHs. Between 2012 and 2016, mortality and readmission rates were stable or declining for most of the common diagnoses. The aggregate mortality rate reminds us of how sick some patients in LTCHs are. On average, about one-quarter of LTCH patients die in the facilities or within 30 days of discharge, with a wide variation across the top conditions including close to 50 percent for patients with septicemia and prolonged mechanical ventilation use. During this same time, the unadjusted aggregate 30-day readmission rate was 9 percent.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of

Medicare payments since Medicare accounts for about half of LTCH total revenues. However, this year, and in recent history, the availability of capital says more about the uncertainty regarding the regulations governing LTCHs, the effect of the moratorium which recently ended, and uncertainty regarding the industry's ability to comply with the new patient-level criteria than it does about payment rates.

Since the phase-in of the patient-level criteria began in October of 2015, LTCHs have been working toward adapting their admission patterns, costs, and case mix to mitigate the effect of the payment reduction for cases that don't meet the new criteria. Major chains have been diversifying their portfolios and have been strategic in their purchase, sales, and closure of LTCH facilities in more competitive LTCH markets. The Commission expects continued industry consolidation, limited need for capital, and limited growth opportunities until after the LTCH patient criteria becomes fully implemented and LTCHs adjust accordingly. There is also a degree of long-term uncertainty associated with the industry-wide shift toward using providers with lower costs of care through

accountable care organizations and the acute-care hospital VBP program which may have long-run implications for LTCH use and capital investment.

Turning now to LTCHs' per case payments and costs, LTCHs historically have been very responsive to changes in payment, adjusting their cost per case when payments per case change. From 2008 through 2016, both the average annual cost and average annual payment growth equaled about 1.6 percent. Between 2015 and 2016, growth in the Medicare payment per case was stagnant; accordingly, the average cost per case increased by about 1 percent, which represents the lowest increase in per case cost since 2011.

Increase in cost growth relative to payment growth between 2015 and 2016 resulted in a 2016 aggregate Medicare margin of 4.1 percent and a 6.3 percent margin for qualifying cases.

As you can see, there is a wide variation in the Medicare margins, similar to what we see in other settings, with the bottom quarter of LTCHs having an average margin of minus 17.5 percent and the top quarter having an average margin of positive 17.7 percent across all Medicare fee-

for-service cases. Consistent with other sectors, the for-profit facilities, which account for 87 percent of cases, have a higher average margin compared to nonprofit facilities. Across all cases, for-profit LTCHs had an aggregate average margin of 5.7 percent while nonprofit facilities have a margin of negative 4.7 percent.

LTCH marginal profit across all cases was close to 20 percent in 2016, similar to the past two years. We contend that LTCHs have a financial incentive to increase their occupancy rates with Medicare beneficiaries.

Looking more closely at the characteristics of established LTCHs with the highest and lowest margins, this slide compares LTCHs in the top quartile for 2016 margins with those in the bottom quartile. As you can see in the top line, high-margin LTCHs tend to be larger and to have higher occupancy rates, so they likely benefit from more economies of scale. Low-margin LTCHs had standardized costs per discharge that were 30 percent higher than high-margin LTCHs.

High-margin LTCHs have fewer high-cost outlier cases and fewer short stay cases. High-margin LTCHs are more likely to be for-profit based on their demonstrated

ability to restrain costs in this sector and across the other provider types we've seen today.

We project that the 2016 LTCH margin for cases that qualify to receive the full LTCH standard payment rate of 6.3 percent will decline in 2018. We expect cost growth to be higher than current law payment growth since updates to payments in 2017 and 2018 were reduced by PPACA-mandated adjustments equaling over one percentage point per year. Using historical levels of cost growth, we project that LTCHs' Medicare margin for qualifying cases paid under the LTCH PPS will be 4.7 percent in fiscal year 2018.

In sum, occupancy rates across the industry have remained stable. Although growth in the volume of LTCH services per fee-for-service beneficiary declined, this decline is in large part from the implementation of the patient-level criteria as intended by law. We have little information about the quality of care in LTCHs, but unadjusted mortality and readmission rates appear to be stable or improving. The effect of fully implementing patient-specific criteria will limit growth in the near term. Our projected margin for qualifying cases paid under the LTCH PPS in 2018 will be 4.7 percent, assuming the

current underlying cost structure for these cases.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments; therefore, we make our recommendation to the Secretary. And with that, the Chairman's draft recommendation reads: The Secretary should eliminate the fiscal year 2019 Medicare payment update for long-term-care hospitals.

Eliminating this update for 2019 will decrease federal spending relative to current law.

We anticipate that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in cost with no update to payment rates for qualifying cases in LTCHs in fiscal year 2019.

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

DR. CROSSON: Thank you, Stephanie. We have clarifying questions. David.

DR. NERENZ: Essentially, the same questions with Dana. Do we have all-payer margins or payer mix data here the way we might for the IRFs?

MS. CAMERON: Sure. So there is a little bit of a difference with some of the data for LTCHs generally, and

that is, what I can tell you is that the all-payer margin is about 3 percent. It is slightly higher for nonprofit LTCHs than it is for for-profit LTCHs. But, on average, it's about 3 percent.

DR. NERENZ: If I can just stop you, so that's actually a flip of --

MS. CAMERON: That is a flip.

DR. NERENZ: What does that mean?

MS. CAMERON: That essentially means that there are revenues coming into for-profit margins that are not similar as coming into -- excuse me. There are revenues coming into nonprofit margins that are different from those coming into for-profit margins. I don't know if that's from higher commercial rates. I don't know if that's from other sources of revenue like donations and charitable contributions.

DR. NERENZ: Okay. Well, if we could know more -- I mean, that really changes my thought about a recommendation, and it would be important for me to know that or, I assume, for us in general. Don't just do it for me, but if others would care about that, I think that's a very important thing that you just said.

MS. CAMERON: Okay.

DR. CROSSON: Other clarifying questions? Jack.

DR. HOADLEY: I'll do another similar question to what somebody else asked for Dana. The differences in margins across the different categories, urban, rural, for-profit, not-for-profit, how much does the consolidated PAC PPS sort of narrow those differences?

MS. CAMERON: It does narrow them a bit, so the PAC PPS would lower the for-profit a little bit. It would bring up the nonprofit. It would have -- it appears at this point it would actually decrease the margins in the rural areas and increase them in the urban areas. But what I will say -- and I don't know if you're considering that in context of the negative rural margin -- that, you know, there are very rural LTCHs. They make up 5 percent or less of Medicare payments to LTCHs. And when you get down to a number of facilities, you know, fewer than 20, one or two facilities in particular can really sway that margin.

So, you know, I think while we do look at these on the basis of kind of these categories, I would urge caution because there are two LTCHs in particular that have very low margins that appear to be driving that negative

margin.

DR. HOADLEY: Does some of that -- I mean, your split on for-profit and not-for-profit is 87 percent of cases versus 12. Is there a similar issue there --

MS. CAMERON: There are --

DR. HOADLEY: -- or is that assumed to be less?

MS. CAMERON: I think that's less of an issue --

DR. HOADLEY: Okay.

MS. CAMERON: -- because there are - as a percentage, there are, I believe, about 20 and 25 percent of LTCHs themselves are nonprofit; whereas, you know, going from 5 percent to kind of the 20 percent, that is a difference.

DR. HOADLEY: Okay. Thank you.

DR. CROSSON: Alice.

DR. COOMBS: I think we did this on one of the other PACs. Did we do a case mix difference between the nonprofits versus the for-profits.

MS. CAMERON: We do, yes. And the case mix is slightly higher. The case mix index is slightly higher in the for-profit facilities.

DR. COOMBS: Okay, but it's not dramatic like the

other one we saw earlier?

MS. CAMERON: No.

DR. CROSSON: Yes, David?

DR. GRABOWSKI: I've always been interested with LTCHs just that there's only 400 of them in the country, and they're very geographically focused, and there are lots of markets in the U.S. without LTCHs.

This really picks up on Bruce's comment from earlier, but have you -- so you say in the chapter that in those markets where there are no LTCHs, individuals typically end up staying longer in an acute-care hospital or maybe going to a skilled nursing facility. Have you tracked those individuals and looked at anything around their costs or around their outcomes and even anecdotally, as part of a prior MedPAC report or analysis? I've always been curious by that issue, and it's really worth thinking about. Obviously, to Jim's comment earlier, as we move toward site neutrality, some of this gets leveled out, and hopefully in risk-bearing models like the APMs this gets addressed. But I'm wondering if you've thought about this at all. Thanks.

MS. CAMERON: We have thought about it. There

are a few things that make it extremely difficult to make comparisons on discharges from acute-care hospitals that go to different settings and discharges that go to LTCHs. And one of the issues is there's such a small number of proportion of beneficiaries that go to LTCHs generally.

When you look at Medicare beneficiaries in acute-care hospitals, I'm rounding but you're looking at about 10 million. Here we're looking at about 125,000. And then when you think about on a DRG basis the discharges from an acute-care hospital, the pathway to an LTCH based on kind of a DRG basis, we could certainly pick some of our favorite DRGs, you know, or DRG groupings like vent, for example, where there are kind of a larger portion of beneficiaries that go to LTCHs in that category. But I do think it's very difficult to kind of tease out whether you're a similar beneficiary in an acute-care hospital and how that pathway works.

DR. CROSSON: Pat, and then John.

MS. WANG: On that point, I think that the unified PAC PPS is absolutely the right direction, but to me, the sort of thing to keep in mind is that the post-acute care delivery system looks really different in

different areas. I mean, it's not like a hospital is a hospital is a hospital. And, you know, my observation, my experience is that the post-acute care system grows up to meet needs but maybe in different ways. So maybe the areas that don't have LTCHs have more IRFs, or nursing homes that will take ventilator-dependent patients, whereas the places that are more dependent on LTCHs there is no place else. If you need to place somebody long term who is vent-dependent, there is no other alternative.

And so the transition to the PAC PPS, I think, is important to keep in mind because I don't think that facilities just can flip overnight and suddenly a nursing home decides, oh, why, I guess I better put up a vent unit now because that's like a really big deal.

So it's just -- it's a thing to remember, I think, about moving in the direction of payment rationalization, is that the delivery system in this area is so different. And Bruce, you know your comment or your question before was a great one, but I think it's even harder to do when you have such diversity of types of providers who perform these services.

MR. PYENSON: It might be impossible to do.

MS. WANG: Yeah, it might be impossible.

DR. CROSSON: Jack.

DR. HOADLEY: Yeah. I'd very much reinforce what you're saying. I mean, I was part of a project about 10 years ago that where we interviewed -- did interviews in communities that had LTCHs and those that didn't, for MedPAC, and we heard exactly some of those things, in particular, a nursing home that would develop a ventilator capacity because there was no LTCH and there was a need for that in that community. And, you know, there might have been such a nursing home in another community that had an LTCH, but if there was a particular need to develop it then that's what developed, or if there wasn't, then the hospitals responded by, you know, keeping people until they were ready to go to the facilities that were available.

So, yeah, I think it -- you know, that is -- that's only qualitative evidence but it's certainly evidence that points in that direction.

DR. CROSSON: Jon.

DR. CHRISTIANSON: I actually had a request of David. When you were talking about the additional information that you wanted to have, I wanted you to keep

talking and sort of walk through. That information is going to be very important in how you viewed the recommendation, and, you know, work that out for me a little bit.

DR. NERENZ: Well, yeah, and I don't know, since we're scheduled to six how much longer you want me to talk. I was trying to keep it concise.

DR. CHRISTIANSON: Well, if it was just me, as long as you want.

DR. NERENZ: No, it's pretty brief. You know, through a number of these threads -- and we see it here, we see it elsewhere, we see this distinction, say, between for-profit and not-for-profit, and in a couple of cases then we see how that plays out in terms of all-payer margin, and some things balance but maybe they get exaggerated. And in this case I was just astonished, frankly, to say that if you look at the all-payer margins you see this total reversal.

And when it comes down to the recommendation is that the recommendation does not, and it cannot distinguish between for-profit and not-for-profit, and it can't distinguish between freestanding. So I have to look at one

number and say, how is that one number going to affect these different segments? And perhaps just based on where I come from, I always get nervous about what it's going to do to the people who already have negative margins, because unless we just, you know, want to punish them for being badly managed, or we want to, I don't know, do something with some desired behavioral effect, I worry about that. But then if you tell me that their all-payer margin is actually pretty good, then I worry less.

So it's no more complicated than that, but I think the dynamic looks different here than what we've seen in some of the other payment areas.

DR. CHRISTIANSON: So worry about it in the sense that you would -- take that one step further. You would be more amenable to a recommendation that did X?

DR. NERENZ: No. In this case I'm inclined to support the recommendation, but I can do that and lose less sleep because if -- the people I would worry about would be the ones currently holding the negative margins, because I just tend to believe they are not, in fact, that badly managed. I think there's something else going on. I'm never quite sure what that is. I tend to think it's

because they may have some stronger mission components. They may be doing some things that add cost, that, you know, we have a hard time picking up. I just don't that. You know, we typically don't see that data.

So every time we look at these updates I find myself being fairly comfortable with them as applied to the subsets that have high margins. Okay. But then when we look at those who have very small or negative margins and say we're going to take people who already are struggling in this payment stream, we're going to make them struggle more -- well, I mean, it depends on the recommendation.

So, no, I'm going to end up supporting this, but I find it relevant to that decision to know the all-payer margins.

DR. CHRISTIANSON: Yes. So this is something that you are concerned about sort of generically as we go from recommendation to recommendation.

DR. NERENZ: All day long, and tomorrow.

DR. CHRISTIANSON: Yeah. Okay. That's what I wanted to understand too.

DR. CROSSON: Okay. Warner.

MR. THOMAS: If I can just add on to that

comment. I think one of the things that would be helpful is that it appears that we analyze and/or look at information differently based upon the different service that we're analyzing. So I think just this comment about David. I mean, if we have the all-payer information, if we have rural versus for-profit, I mean, I think we ought to look at it all consistently across all of the services, and share all of that data.

I mean, we look at the all-payer data, say, in hospitals, but we haven't looked at it in other services. So I think it would just be helpful to have it consistent across all of the services that we analyze.

DR. CROSSON: Okay.

MS. CAMERON: And just to be clear --

DR. CROSSON: Yeah.

MS. CAMERON: -- both all-payer margins for for-profit and nonprofit were positive. I wanted to make sure. You know, the average was 3.1. I can't exactly remember the numbers -- one -- but it was hovering 4 and 2. It wasn't a negative and a positive, just to be clear. And when you said "flipped" it made me a little nervous.

DR. NERENZ: No, and I understand. I got that

completely. I just used "flipped" in a different sense. There was a group of places that went from negative -- which was the only number we saw -- to positive -- which is the number we didn't see.

DR. CROSSON: Okay. I think we've come to the end of the comment period. I have to admit I'm a little bit uncertain here as to whether we go to expedited voting on this issue or whether David and Warner, you want to see more data in January before we do that or not.

DR. NERENZ: No. I got -- the simple answer is no. I said I'm willing, and was willing, to support the recommendation. But I just think this issue of seeing the all-payer margins is important to round out the whole picture. That would not change my vote. Therefore, I think we could go expedited.

DR. CROSSON: Okay. So, Stephanie, is that something that you can access and put into the paper for January?

MS. CAMERON: Yes.

DR. CROSSON: Okay. All right. Okay.

MR. THOMAS: I would agree with David. I'm the same. I mean, it's not going to change how I view the

recommendation, but I would like to see the data consistent across each -- and not just as it relates to LTCH but all of the disciplines we've been looking at.

DR. CROSSON: Okay. Good. So then seeing no objection, we will move this forward in January on expedited voting process. And that's the end of the issue. Thank you, Stephanie.

[Pause.]

DR. CROSSON: Okay. Evan, we're off and running. This is the last presentation of the day on home health services, recommended update. You're up.

MR. CHRISTMAN: Very well. Good afternoon. Now we will review the framework as it relates to home health.

As an overview, this presentation will cover the basics of the benefit, the current issues the Commission has identified, and the bulk of it will review the payment adequacy framework.

As a reminder, Medicare spend $18.1 billion on home health services in 2016, and there were over 12,200 agencies. The program provided about 6.5 million episodes to 3.4 million beneficiaries and accounted for about 5 percent of fee-for-service spending.

Before we continue, I just wanted to remind you of some of the issues with the home health benefit. Home health is an effective service when appropriately targeted and can be an important service for serving frail, community-dwelling Medicare beneficiaries. However, eligibility for the benefit is poorly defined and does not encourage efficient use.

As I will note in a minute, there has been rapid growth in episode volume, which raises particular concerns in the current fee-for-service environment.

The benefit also has an unfortunate history of program integrity problems. The Secretary and the Attorney General have made a number of efforts to address fraud in the benefit, but many patterns of unusual utilization suggestive of fraud remain.

We have also noted significant geographic variation in this service, which program integrity and the broad benefit definitions likely contribute to.

In terms of the payment system, the Commission has noted two problems. First are issues with the incentives in the current system. The PPS uses the number

of therapy visits provided in an episode as a payment factor. Payments increase as more therapy visits are provided, sometimes increasing by hundreds of dollars for a single additional visit.

The share of episodes qualifying for these payments has increased every year in the PPS. This trend and the fact that more profitable HHAs tend to favor therapy episodes raise concerns that the financial incentives of the payment system were influencing care. MedPAC recommended the elimination of therapy as a payment factor from the PPS in 2011.

CMS recently proposed removing these thresholds as one component of a larger payment reform, but it has withdrawn this proposal, and it is not clear when or if they will address this vulnerability.

The second issue is the high level of payments. Medicare has overpaid for home health since the PPS was established. The fact that home health could be a high-value services does not justify these high payments.

As discussed in the paper, Medicare margins have averaged better than 16 percent in the 2001 to 2015 period. These overpayments do not benefit the beneficiary or the

taxpayer.

We begin with supply. As in previous years, the supply providers and the access to home health appears to be very good. Eighty-six percent live in an area served by five or more home health agencies. Ninety-nine percent of beneficiaries live in an area served by one home health agency.

Turning to the number of agencies, we have reached over 12,200 by the end of 2016. Though there was a net decline of about 140 agencies relative to the prior year, the overall supply of agencies has increased by about 60 percent since 2004.

The recent decline is concentrated in a few areas, such as Texas, Florida, and Michigan, that have been the target of efforts to reduce fraud. These areas experienced higher growth in utilization and supply in prior years.

Next, we look at volume. Overall, the volume of episodes and the number of beneficiaries did not change significantly in 2016 relative to the prior year. Cumulatively, however, the volume of services has increased substantially. The number of episodes is about 60 percent

higher compared to 2002 and 2016. The number of users is almost 40 percent higher, and total spending is up over 80 percent. This substantial growth coincides with a period of high payments under Medicare, and margins for home health have ranged between 10 and 23 percent since the advent of PPS in 2000.

Our next indicator is quality. I have split the quality measures into two groups. The first group of measures are based on self-reported data collected by HHA staff at the start and end of home health care.

The second group of measures are claims-based measures that use Medicare claims to detect the incidence of hospital or emergency care use during a home health episode.

The first group shows that the frequency of patient improvement in walking or transferring was steady until 2016, when both measures experienced a significant 10 percentage point or more jump.

In contrast, hospitalizations and ER use have not changed significantly in most years and do not show the same substantial improvement in 2016 as the functional measures. The contrast in these two groups of measures is

striking, and though many factors may explain them, it is important to keep in mind that methodological differences in the collection of these measures may potentially account for at least some of the divergent trends.

In addition, the trends may reflect Medicare's implementation of a VBP demonstration in nine states in 2018. Under the demonstration, how well agencies performed in 2016 relative to 2015 on 20 measures, including the four listed here, will determine whether they receive a bonus or penalty next year.

Though the jump in functional measures observed here was nationwide and not just in the nine states, there is some evidence that the jump was higher in states where VBP will apply.

Next, we look at capital. It is worth noting that home health agencies are less capital-intensive than other health care providers. Also, few are part of publicly traded companies.

Financial analysts have concluded that the publicly traded agencies have adequate access to capital, and we have seen a recent uptick in mergers and acquisitions. And it appears that firms are increasing

their capacity in this sector.

Turning to margins for 2016, we can see that margins for this year were 15.5 percent, not much of a change relative to 2015. The trend by type of provider is also similar to prior years, with for-profits having higher margins than nonprofits and urbans having higher margins than rurals, but the differences are mostly relatively small.

The marginal profit for home health agencies was 17.4 percent in 2016. I would also note that these data rely upon the home health cost report, which have been found to overstate costs in past audits.

The Patient Protection and Affordable Care Act mandated four years of payment reductions in 2014 through 2017, commonly referred to as "rebasing." However, the PPACA offset these reductions with an annual market basket update. The net effect was that payments were reduced by less than 1 percent a year, and the Commission has expressed concerns that this rebasing will not sufficiently reduce payments.

The margin results for 2014 through '16 bear this out. Margins in all years of rebasing have exceeded 10

percent, and in the last two years, they have been almost 3 percentage points higher than the margins in effect in 2013, the year before rebasing began.

The double-digit margins we report for these two years -- for these years contrast with an earlier estimate of the policy's impact produced by the home health industry.

In 2013, an industry analysis projected that margins for 2014 would be 5 percent and margins for 2015 would be 1 percent, for example. This obviously contrasts with the actual results for these years, which are well above these estimates.

This year, we also examined the performance of relatively efficient home health agencies. Recall that we defined relatively efficient providers as those that are in the lowest third of providers in cost are the best performing third of providers for quality, without having extremely low performance on either measures. About 9 percent of agencies met this standard.

Relatively efficient providers had an average cost per episode that was about 6 percent lower than other agencies and median Medicare margins that were about 8

percent higher. Relatively efficient providers were typically larger in size with the median efficient provider about 60 percent larger than the median for other agencies.

Relatively efficient providers also had lower hospitalization rates. They provided about the same mix of nursing, therapy, and AIDS services to their patients, and they also delivered similar numbers of outlier and low-use episodes.

Efficient providers tended to serve a more urban mix of patients compared to other providers.

We estimate margins of 14.4 percent in 2018. This is a result of several payment and cost changes. For payment changes, we included the payment updates for 2017 and 2018, and we also included the coding reductions of slightly less than 1 percent in 2017 and 2018 CMS has implemented.

On the cost side, cost growth has been historically low in home health, and we assumed a cost growth of one-half percent a year, which is above the long-term average.

Turning back to our framework, here is a summary of our indicators. Beneficiaries have very good access to

care in most areas. The number of agencies is high, reaching 12,200 in 2016. The volume and utilization was flat overall. The functional measures showed improvement in 2016, with the caveats discussed earlier, and the rates of hospitalization and ER use were mostly unchanged. Access to capital is adequate. The margins for 2016 are 15.5 percent, and the estimated margins for 2017 are 14.4 percent.

I would note that these are average margins, and our review of the quality and financial performance for relatively efficient providers suggest that better performing agencies can achieve good outcomes with profit margins that are significantly higher than other agencies.

This brings us to the draft recommendation for 2018. This recommendation has two parts. First, bringing the level of payment down; and second, it ends the use of therapy as a payment factor, which would be budget-neutral but redistributive.

Also, recall during Carol's session that we are considering our recommendation for Medicare to blend the home health PPS-specific payment weights with a set of cross-sector payment weights. This would also be budget-

neural and redistributive.

The recommendation reads, "The Congress should reduce Medicare payments to home health agencies by 5 percent in 2019 and implement a two-year rebasing of the payment system beginning in 2020. The Congress should direct the Secretary to revise the PPS, to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

The impact of this change would be to lower spending relative to current law. The impact to beneficiaries should be limited, and it should not affect provider willingness to serve beneficiaries.

Like the proposed recommendation to blend the PAC PPS in setting specific weights, eliminating therapy as a payment factor would be budget-neutral in aggregate but redistributive among providers. Nonprofit agencies would see their aggregate payments increase due to the elimination of the therapy thresholds, while for-profit agencies would see a decrease.

This completes my presentation, and I look forward to your questions.

DR. CROSSON: Thank you, Evan.

We are open for clarifying questions.

Yes. Warner, Dana, and then David.

MR. THOMAS: So I have, I think, a kind of similar question I had before. For MA payments and commercial payments for home health, how do they usually compare to traditional Medicare?

MR. CHRISTMAN: Okay. Maybe just to fast forward here, the overall margins for home health are in the mid-single digits. I can't pull it out of my head exactly, but they are lower than the Medicare margins.

And Medicaid is a big player in this, but you asked specifically about MA, and that's a really good question. In the MA realm, the plans and the providers negotiate a rate, and my understanding is there's sort of two sets of practices going on. One is that often plans will negotiate. They won't pay on a 60-day episode. They'll pay on a visit basis, and it has been a longstanding concern of the industry that the rates that they can get from the MA plans on a per-visit basis average out to less than what they get from fee-for-service. So that's been one issue.

And I would just add that there has been -- I

don't think it's overtaken, become the most common practice, but there have been some plans that, as I understand it, are flipping over to an episodic payment. I don't know that they pay the Medicare rate, but they're going to a bundle. But on average, the payments are lower.

MR. THOMAS: So what we've been looking at are margins just specifically on Medicare, correct?

MR. CHRISTMAN: Medicare fee-for-service.

MR. THOMAS: Okay. And not the -- okay.

And then is this all home health agencies? Because I know there's different designations. There's freestanding. There's hospital-based.

MR. CHRISTMAN: Right. So this is the freestanding, and this is about 85 percent of agencies.

For the 15 percent of facility-based agencies, the average margin is about negative 15 percent. It's a little worse than what it's been in recent years. When we have looked at the differences between facility-based and freestanding agencies, we haven't really found a big difference in the patients they serve. The most striking difference we have found is in their cost per visit. The cost per visit for the facility-based agencies, which are

mostly hospitals, is astronomically higher than what we see on the freestanding side.

MR. THOMAS: So the payment recommendation here would apply to all, though?

MR. CHRISTMAN: Right.

MR. THOMAS: Freestanding as well as hospital-based?

MR. CHRISTMAN: Right. And so an important wrinkle to keep in mind with this is that pulling -- there's two parts, and there's the rebasing that cuts the overall rate, and then there's pulling out the therapy thresholds. And the redistributive part of pulling out the therapy thresholds is important because it has the effect of moving money from providers that do lots of therapy to providers who do less of therapy and more of nursing, and that is typically hospital-based agencies. They typically -- I'm not going to say it makes up the 15 percent margin they've got right now, negative margin, but it moves money towards them.

MR. THOMAS: Going to David's point on the last discussion, is there anything else that you can identify in those differences in the agencies as far as payer mix or

things like that, that would drive the hospital-based versus freestanding or just the differential in the profitability of entities?

MR. CHRISTMAN: When we have looked at the factors that explain the differences and profitability among agencies, we haven't found a big difference in patients. I kind of have become a broken record on this, but it is striking. The biggest difference in the cost per visit.

MR. THOMAS: Okay.

MR. CHRISTMAN: Not even the payments. The payment difference isn't that great. It's definitely better for agencies that do more therapy, but the cost difference is really a much greater variance than that.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: Dana.

DR. SAFRAN: Thank you. Thanks for this clear work.

My question kind of could have related to any of the post-acute topics that have been discussed, so I'm just asking it now since I just arrived. But is there any part of the analysis that you do that tells us the extent to

which any of these are substituting for other services?

So as we're looking at the increased utilization, which if I remember right was kind of happening across the board in all of these, we don't know whether there are substitution effects happening or at least not from what I've read, and I just wonder if that's part of the analysis or enters into our thinking.

MR. CHRISTMAN: I would say in aggregate across the four sectors, I don't think we've done an analysis that really has looked at shifts and volume among the sectors. I think sometimes issues have arisen where it becomes quite clear. When CMS got more rigid about enforcing the 60 percent rule, there were a lot of patients who moved out of IRFs, and it appears at that point, we saw them move into home health, some of them. But you get into an interesting game where a lot of IRF patients, it's a very small number of home health patients. So it's not a big piece of -- I can't say it's a significant piece of the trend.

But obviously, when we don't have clear guidelines about where people belong and it's a struggle to measure severity across sectors, people have done dives at the work that you're talking about. But it's always a

challenge.

DR. CROSSON: David.

DR. NERENZ: Warner asked the question I was going to ask about freestanding hospital-based.

Let me just extend that, though, and this may go beyond what you can do for January. When you say the costs are higher, cost per visits higher in the hospital-based, I certainly would want to know why that is and not, you know, a plan where I was before. And I've said this for years, actually, around this table. I always find it really hard to believe that the managers of hospital-based facilities are uniformly incompetent, lazy, careless. I just don't believe that. So I want to know why, but we may not be able to know why.

MR. CHRISTMAN: Well, I appreciate you ending on that.

[Laughter.]

MR. CHRISTMAN: I don't think we've ever -- we've never really gotten to, I think, an ironclad answer on that, but the two things I would note, specifically for home health, is that sometimes you get into the issues that this is a SNF On a hospital floor, and somehow it's getting

the hospital level of cost.

Obviously, in home health, you don't have that. It's the beneficiary's home, and when we've had this conversation, I think the pieces that have come back to you are overhead, administrative overhead and such from the system or the hospital the agency is a part, maybe that's a piece of it.

But I think you also sometimes get into an interesting dynamic that hospital-based agencies may have a different approach to a lot of things because they're part of a hospital, and I think the canonical example, as I remember talking to a manager at one that said that she had to offer higher wages because if she didn't, it was easier for other departments of the hospital to come and take her nurses.

And so it's a different dynamic because they are a part of a larger organization than a freestanding agency.

DR. NERENZ: Even an example like that is helpful. I think there are probably many other wrinkles to the story, but that's the kind of thing I was looking for.

DR. CROSSON: Paul and then Jack.

DR. GINSBURG: I would be very interested, I

think for the future, not for this round, in learning more about how MA plans approach home health, how they manage it, because from your paper, it's clear that fraud has been a significant issue in the home health benefits showing that there's a long way to go as far as finding a way of managing it well. This could be -- I presume this is one of the big advantages. I think post-acute care in general is one of the advantages that Medicare Advantage has over fee-for-service Medicare.

Some of the techniques being used could be very instructive to modifying the fee-for-service program.

DR. CROSSON: Jack.

DR. HOADLEY: So you talked a little bit at the beginning about CMS having this new proposal and then withdrawing it. Do we have any more insight on -- and I know you said in the paper they just needed to review more comments, but do we have any more insight on concerns that were raised or what they're -- you know, is something where it feels like they would go forward in another year?

MR. CHRISTMAN: I guess I would honestly confess that, you know, my Magic 8 Ball says, "Future is highly uncertain." You know, the two main complaints were, as

it's discussed in the paper, CMS implemented this in a way that was going to take money out of the system, and I think that produced a very strong reaction. And the second piece is there's always, you know, redistributive aspects of these proposals that, you know, the industry generally has a hard time dealing with. And I would say, you know, those were sort of the two main industry complaints. I think they were -- they also had a complaint that they felt like they didn't have enough information to evaluate the whole system, but I would say in my experience CMS put out as much information on a new payment system change as they always do.

So, you know, CMS just -- they didn't even respond to the comments on the payment system and the rule in any detail. They just kind of said we're going to look at these comments and make some decisions. But they didn't really give you a road map forward.

DR. HOADLEY: And are there any lessons from that back-and-forth for what we're talking about?

MR. CHRISTMAN: I guess, you know, for me, I think in the back-and-forth I'm not sure there's too much for me to react to. I guess what I would take away is just

that, you know, it was great to see CMS recognizing the issue that therapy thresholds have posed, and they have tried a series of administrative changes to tighten supervision and change the pricing to make it a little harder to game. But I think that pulling therapy out of its entirety is a recognition that those efforts have not succeeded as well as one would hope. So I really don't see -- I don't really know where they're going to go from here.

DR. CROSSON: Questions? Warner.

MR. THOMAS: Have we modeled the recommendation of the 5 percent reduction into the industry? Because I think, you know, Medicare's a pretty significant component of home health revenues. So have we modeled a 5 percent impact on kind of total margin? Do we have an estimate of that?

MR. CHRISTMAN: I mean, I would say currently it's not wrong to think of it as taking 5 points off their margin.

MR. THOMAS: Total margin.

MR. CHRISTMAN: Off their Medicare margin. Now, we could think about how to grind that down to the total margin, but I guess, you know, the -- I guess I'm trying to

understand what the significance is of the total margin that you're aiming for.

MR. THOMAS: Well, I mean, because you're saying that the total -- the all-payer margin you're saying was mid-single digits.

MR. CHRISTMAN: Right.

MR. THOMAS: So, you know, 5, 6 percent? So if you take 5 percent, it pretty much will take it to a breakeven. So I guess I'm just trying to figure out is that what we're talking about here.

MR. CHRISTMAN: Well, yeah, I mean, if it just took out 5 points, then if total margins were at 5 percent, they'd be closer to zero. But I guess the point I want to make that makes home health incredibly hard is that the cost side has in the past proven to be quite flexible, and then when they receive a payment change, they adjust their cost structures. So, you know, statically, I can say taking 5 points out of their payments reduces their margins by 5 points. In reality, you know, as you see in the table in there at the beginning, you know, you can see that they took visits down by something like 25 percent in two years when they went from a per visit payment system to the 60-

day PPS. And then there's a long history that I could ruin everyone's afternoon with of how they have changed the exact number of therapy visits they provide as the specific payment amounts for each thresholds were altered. This is a very nimble industry.

So if there's something specific you want us to think about, we can drive towards that. But I guess, you know, it is always a little bit uncertain when you're projecting these margins. Every time I've done this, just about every time, I've always been too low in what I expected their margins to be in the future.

MR. THOMAS: It's really just a question to try to understand what the -- because we don't have the -- you know, we don't have the all-payer margin in here, so I think to understand that and what the impact may be. So thanks.

DR. CROSSON: Okay. I think we're done with the questions. Let's move on to the recommendation on Slide 16, and we'll open for discussion on the recommendation. Yes, David?

DR. GRABOWSKI: I'll start by saying I'm supportive of the Chairman's draft recommendation. I just

-- and I don't know if it's a call-out to a previous recommendation, but I wanted to make the point that not all home health care, as Evan did in the chapter, is post-acute care. And home health not preceded by a hospitalization has often been thought by the Commission to be lower value, and I believe you've written in the past or at least recommended that potentially we could adopt cost sharing around that home health care use not preceded by a hospitalization. I don't know if there's a way to call back to that or to include that here, but I think that's really important.

This is one of the few parts of the Medicare fee-for-service system that doesn't have cost sharing. That's a place, to build on Paul's point earlier, where you could really leverage some of the tools that are used in Medicare Advantage and apply them here. And I think that would be a nice step forward. As a new member, I don't know how that gets fit into your draft recommendation, whether that's a call-out to a previous recommendation or part of this.

DR. CROSSON: Well, as we discussed a little bit earlier, we've done it in different ways. Sometimes we'll take it and just insert it into the text as "by the way."

Sometimes we'll put it in a text box for emphasis. And then sometimes, as we just did, or recommended we should do, we reprise the recommendation as part of the current recommendation.

Evan, when did we make that recommendation?

MR. CHRISTMAN: It was either 2010 or 2011. And we could add some discussion to the chapter where we talk about our recommendations and just kind of say, you know, mention this is something we've done in the past, I think would be one move. We could also put in a text box or something to reiterate that we've made the recommendation.

DR. CROSSON: Jon.

DR. CHRISTIANSON: In the literature, for home health care that's not preceded by a hospitalization, is there indication that home health are for some patients reduces the probability of a subsequent hospitalization?

DR. GRABOWSKI: So I haven't seen that research. It would be interesting. I was basing that largely on kind of Evan's work and others that I think there's a perception that it's lower value relative to kind of the home health that follows a hospitalization.

DR. CHRISTIANSON: I agree with that. I just

wanted to --

DR. GRABOWSKI: It would be interesting to look at the literature. And I don't know, Evan, if you want to speak to the work you've done.

MR. CHRISTMAN: I think it was sort of a couple of things. One is that if you -- again, the table in the paper, what we call the "community admit episodes" have more than doubled in this period, and this is the period of rapid supply expansion where the number of agencies went up by 60 percent, and the high margins, and the sense that, yes, this was a little bit more of a discretionary part of the benefit. When we talk to people about why these folks are in the system, we hear a variety of reasons, some of them, you know, very valid sounding but at the same time, lots of variations. So that was one piece.

I think a second piece was that applying cost sharing to the post-acute episodes raised a variety of issues because right now for a lot of beneficiaries, there is effectively no cost sharing for going into the institutional settings. And if you created it for post-acute without addressing that, you could have a situation where a patient could pay a $50 or $150 co-pay for going to

home health or zero for going to an IRF. And it's sort of implicated that if you wanted to do that for home health, you had to address the other sectors, and I think at that point the Commission was not looking at that.

Those were sort of the two corners, I think, that led us to the community admits.

DR. HOADLEY: What was the recommendation that was being referred to from 2010 or whatever?

MR. CHRISTMAN: There is a recommendation that says Medicare should apply cost sharing to home health episodes not preceded by a hospitalization or prior institutional PAC stay. And it's about two-thirds -- you know, in our universe you can think of them as community admits, and it's about two-thirds of episodes today.

DR. CROSSON: You know, I'm trying to come up with a good explanation for why I think differently about this one. My sense is that the recommendation was significantly long ago. To me, it feels a little bit complex, and I'm a little bit concerned about bringing it forward as a recommendation in January without a more robust consideration with this new Commission that has not looked at this issue before -- or this current Commission.

But I would be -- I think I would be okay, because it's historically true, to bring it forward, for example, as a text box in the rewrite in January. But I want to test that idea. What do people feel about that? Jack?

DR. HOADLEY: I mean, I agree, I don't think we should -- I mean, unlike something like we did a couple minutes ago on the previous thing about the additional auditing or whatever, that was sort of an incremental step within a payment system. This, which starts to implicate beneficiary cost sharing, is a much bigger -- you know, a different style of issue, and so I agree we should not try to go back and reprint that. Obviously, like you said, we can reference it as a historical event.

I might even -- if it was just up to me, I probably would not reference that because, as you say, we have not gone back, I certainly haven't gone back and tried to think about, you know, how I would think about that particular issue.

DR. CROSSON: Kathy?

MS. BUTO: I'd want to know more about the patients. For instance, if somebody's qualifying for home health care, essentially homebound, hasn't been in a

hospital, is it for something like treatment of pressure ulcers where you've got an episode -- I mean, how frail is the individual? And do you really want to be just sort of willy-nilly talking about applying a co-pay to that, co-insurance to that? And things have changed since whenever it was, seven years ago, when we first made the recommendation. So I'd want to know more about the patient characteristics before even considering a text box. I don't think I'd do it right now until we had more information about the patients.

DR. CROSSON: Okay. Alice.

DR. COOMBS: I was out, but I got the gist of it. Thank you. So we actually visited this I think three -- Rita, three, four years ago? And one of the concerns was that if you -- this is a very needed service, and you don't want to have a default decisionmaking where someone says, well, you know, this is going to stress out the non-LIS who are maybe on the margins in terms of being able to get services. Not that you can qualify for one -- so that if you don't qualify for one, you would want this kind of service to be available because it could escalate, where if you didn't have this kind of intervention, that you might

have more costly services that would be required in lieu of that. And providers will make that decision in an office where they say, well, the co-pay's going to be difficult for them, for home health. Is there some other kind of decision that we can do to help the patient out? And so it's not just the patient making the decision, but it's also the provider projecting onto the patient with the multiple comorbid conditions. So we actually revisited this, I think it was four years ago.

DR. REDBERG: Right, it penalizes the patient. I mean, like Alice said, home health service is very needed when it's needed, and we're trying to get at the fraud or the overuse, and that's not -- the co-payment is just going to penalize the beneficiary, but I don't think it's -- they're not the ones that generally are initiating the fraud and overuse kind of visits. So, you know, it's the problem we have that when the service is needed, it's great, but then there's a lot of evidence that there are services that aren't needed. But this isn't going to be the solution --

DR. CROSSON: Yeah --

DR. REDBERG: -- capitation, the prospective

payment system. Not this.

DR. CROSSON: I'm sorry. Thank you for bringing this up. I think we will revisit this issue again. But I think based on this discussion, we probably will not include it in this chapter at this time.

Okay. Warner, you have got your hand up?

MR. THOMAS: Are we on Round 2 or Round 1 [off microphone]?

DR. CROSSON: There you go. We're in Round 2. We're on the recommendation.

MR. THOMAS: Yes, so just real briefly because I -- my concern here is that -- and I realize there's a lot of challenge around the home health industry overall. I know there's fraud and abuse issues and what-not. My concern with the recommendation is, just as we were saying, if you look at the total all-payer margin, we're talking about an industry that's in the mid-single digits, and we're talking about a 5 percent reduction. And, you know, then we're talking -- and that's for traditional Medicare, and then MA and commercial is usually below traditional Medicare. So I think that puts tremendous pressure on, you know, a service that, frankly, is critical to the industry.

Now, I hear your point about it's flexible, they've been adjusting the cost structure. I just would caution us to think more about looking at the total picture of the industry and the total margin, not just Medicare. And that's why I think, going to David's point earlier, I think we need to do that everywhere and not just where commercial, you know, lifts the margin but also where commercial or MA decreases the margin. I think we need to look at it on both sides, not just one.

DR. GINSBURG: If I could follow up on that, I think that when we -- I don't know what percentage is Medicare fee-for-service of this industry, but if Medicare cuts its rates and its margins much higher, it doesn't mean everyone else is going to cut their rates. So we're not talking about wiping out the mid-single-digit total margin by cutting the Medicare rates. And, you know, I think the flexibility of the industry, the profitability of the industry is very important, and it shows that there is some ability to pay less.

MR. THOMAS: Just an addition -- well --

DR. CROSSON: Go ahead [off microphone].

MR. THOMAS: Just a comment on that. And I agree

that it does not mean that that's necessarily the case, although MA traditionally follows Medicare, traditionally, and, I mean -- well, in markets I've been in that, I've seen that.

DR. GINSBURG: I mean, on MA, MA cannot pay more than traditional.

MR. THOMAS: Right.

DR. GINSBURG: But when Medicare overpays, they do pay less.

MR. THOMAS: Yeah. But I think also when Medicare reduces, many times they reduce fees. So I would just -- I'm not saying that it shouldn't be considered. I just think it's not just -- you know, a 5 percent reduction, significant, and this is a critically important service. And what I worry about is that we continue to, you know, adjust our cost structure, and I worry at some point we get to a point where it's a service issue with patients. And, frankly, one of the challenges you have in home health, it's very difficult to measure service and measure quality when it's being done in the home. And I just get concerned about that for beneficiaries. And it doesn't include 15 percent of the home health agencies

which are hospital-based.

DR. CHRISTIANSON: So I share all of the concerns you have. I guess one thing to bring up is that we've had this generic discussion over the years around, well, for instance, if the private sector isn't paying real well for home health care and we're worried about it we should therefore pay more from Medicare, and that's a real slippery slope we don't want to go down. And I'm not suggesting you're saying that, Warren. I'm just saying it gets us to the edge of that, I think.

We do need to look at the whole picture, but if the whole picture suggests we wish the private sector were paying more or we need to pay more from Medicare because the private sector isn't paying more, then there's a little bit of a self-fulfilling prophecy potential there that we need to be careful to avoid, I think.

MR. THOMAS: And I totally agree with that, and I think it is a slippery slope, and I'm not necessarily advocating that. However, we just had a discussion earlier today where we said, well, Medicare's not paying hospitals enough, but it's okay because commercial pays more. So I just think, you know, we need to kind of look at the whole

picture in all components of the payment system. That's all.

DR. CHRISTIANSON: I didn't say that [off microphone].

MR. THOMAS: No, I'm not saying that you said that, but that's essentially the conclusion we came to this morning, is that we see Medicare margins for efficient inpatient hospitals at negative 1 and negative 9-point-something for all. And yet we said, well, the all-payer margin's 5 to 6 or 7 percent, so it's okay. It's just to me I think we've got to look at this consistently. That's all.

DR. CROSSON: Okay. Warner, respectfully, I don't think that's what we said. I think what we said was that hospitals' attention to cost structure and, therefore, its ability to be profitable in Medicare was in many cases a function of the high rates of payment that were going on in the commercial environment. But I don't believe what we said was, therefore, we should pay less. I think what we were saying was that if we were to pay more, we were simply chasing a phenomenon that was going on in the commercial world, which is -- you know, you can say that's the same

thing, but it's actually, you know, philosophically a little bit different.

I think, you know, as I've listened to the discussion today, particularly this afternoon, it kind of recalls for me a number of discussions that we've had over the years on the Commission, particularly in the earlier time when I was on there. And it gets to the basic question that I think Jon was getting to, which is how should we think about -- I mean, we're a Medicare Commission, right? And our role here really is to determine what Medicare should be paying based upon our own analysis of all the quality and everything else that people have brought forward.

We have in recent years brought forward the notion of all-pay margins or commercial margins because people were interested in them, and I think we heard that today. We'd like to know, you know, what's going on. But I don't think we've ever as a Commission come to the conclusion that the relationship between Medicare margins and commercial margins, whichever way it goes, whether, you know, commercial is higher, Medicare is lower, Medicare is higher, commercial is lower, as we find in this case,

should be a determining factor in making our own judgment.

Now, people can have a different point of view about that, but in the past -- and I think, you know, just over the time I've been on the Commission, even though it was interrupted for a few years, there's been kind of an increase in the focus on, you know, non-Medicare margins.

I think that what we need to do here, not today but when we have the time together as a Commission, is to sit down -- and we've done this twice in the last 15 years or so that I've been in a relationship to MedPAC. We need to go over that again so that we understand, you know, what we believe. You know, should we be -- to what degree, other than just information, to what degree should we be taking into consideration the payment levels outside of Medicare when we determine what we think Medicare should be paying? It's very complicated, and it's an area where people can disagree. And we've heard today, you know, a little bit about disagreements in both directions. And I do think there was a period of time earlier on the Commission where we were kind of saying let's not even look at those margins, and I don't agree with that. I think we need all the information -- as some of you asked for, we

need all the information in front of us. But I do think that we need to have a serious discussion, when we have the time to do that, about, you know, what we think now about the level or the degree to which non-Medicare payers should have an influence over what Medicare pays. Is that fair enough?

MR. THOMAS: Yeah, I think that's fair, and I guess part of my point is I think it would be helpful to look at, as I was saying earlier, information consistently across all the disciplines. So if we're going to look at non-payer -- or excuse me, all--payer profitability, let's look at it across all disciplines and have it very transparent.

You know, I think the other thing is that -- and, you know, I know we haven't talked about this a lot today, but it also goes to ancillary services or components of a system such as device and drug companies and margins there. And I know that's kind of going down another path, but they are considerations or should be considerations of the program, in my opinion, given we do all this payment adequacy, we're spending a whole day on this, which I think is very important, and yet we don't do the same sort of

diligence, I think, on margins and other components of the industry, which is significantly higher than anything that we've looked at today. So I would just encourage us to have transparency across all of those areas, and --

DR. CROSSON: So I agree with you about the transparency and providing the information. As I said a couple minutes ago, I do worry, though, that we become overly focused on what is going on outside of our province in Medicare. So we need to have a discussion about that.

In terms of drugs and devices, as you know, for the first time that I'm aware of, we have begun to go down the path of trying to understand the device industry and both on the Medicare Part D and Part B side, we do have recommendations that we have brought forward, which I think would have, if they are implemented by Congress, a pretty significant impact on the cost of drugs. So I don't think that we've been ignoring that. It's just that because Medicare does not pay directly for these things, in this particular part of our Commission work, in December and January, we deal with those things where Medicare pays directly and the issue of updates are not updates.

Okay. David and Kathy and then Pat.

DR. NERENZ: On this slide of discussion, which I think is very interesting, and certainly most of us don't have that track record with history of the Commission the way you do, about how we've looked at these things.

I guess what I'd say is I find myself somewhat in the middle. I don't want us to be drawn in one direction or another, strictly because of what other payers are doing, and I don't think we should. But every time we look at one of these, what I'm really trying to do is think of what's going to happen to beneficiaries if we do this or that, whatever it is we're considering? And the intermediate step is, what are the providers going to do?

Now we're speculating, in many cases -- we don't have a track record, we don't always know, but we have to guess, because eventually we're going to put our hands up, or not, and say, yes, I like this, or no, I don't. And that's the frame I put on it. But the thing is, when I'm trying to think what will providers do and then what will happen to beneficiaries, I have to take into account the larger environment. If, you know, the whole payer mix is X, you know, the direction, I think, may go here, with some effect on beneficiaries. If it's a different all-payer

environment, now the direction may go there with a different effect.

And I'm still worried about Medicare beneficiaries. That's who I'm thinking about. It's still Medicare, but I just can't step away from what's the rest of the ecology that's going on.

DR. CROSSON: Yeah, I think that's fair enough, and we try to do two things. Number one, you know, we try to assess access and quality and those things, and they're -- you know, they're imperfect. You know, they're kind of the best we can do, and it varies by payment area, depending on what data is available.

And the other thing, and I think Evan did that today, is to try to look at kind of what's happened in the past when there have been similar or kind of similar change to payment in a particular part of the industry. You know, has there been a catastrophe, or, in fact, has the industry appeared to be able to adjust pretty well without changing quality and access? And I think he gave an example. It doesn't mean it's always going to be that way, but he did give an example of an earlier change in payment here, and showed, in fact, in the materials that although there were

serious concerns in the industry for what would happen to their profitability, in fact, the industry adjusted pretty easily and that did not take place.

So that's -- you know, that's historical information. We don't always have that information because sometimes we're considering changes which have never happened before.

DR. CROSSON: Okay. So Kathy and then Pat.

MS. BUTO: I just wanted to add that I think something that's changed since you first look at this, Jay, is the issue of coming up with the Medicare profit margin analysis, where we're looking now at more variable costs and profit margins versus --

DR. CROSSON: Marginal margins.

MS. BUTO: Marginal --

DR. CROSSON: Whatever we called it, yeah.

MS. BUTO: -- yeah. So what strikes me about that is the issue that I think Pat raised earlier about, well, who attends to fixed costs? What is -- what, if any, responsibility do we have for that, if our bottom line is access for beneficiaries?

So when we have that larger discussion, I think

that's kind of what's changed, is we've gotten more surgical, if you will, in the way we've looked at it for our purposes, to make sure that Medicare is really just attending to Medicare. But in the meantime, have we walked away from some other things that we should be looking at?

DR. CROSSON: I think that's absolutely true, and it came up this morning when we were talking about hospital updates, and the fact that, you know, we may very well need to have a discussion at some point about how we approach hospital margins, because, in fact -- and I think this applies to other areas of payment as well -- we talk about the marginal Medicare margin, if you want, as having -- and I think we do that as if -- within and across payment levels, the Medicare burden, if that's the right term, but the Medicare weight is the same.

And depending upon -- and let's talk about hospitals for the moment -- depending on what percentage of discharges are Medicare, that marginal margin, if it's small in relationship to the number of patients admitted, has one effect, and if we have a hospital that is extremely dependent on Medicare revenue, somebody has to bear the burden of the capital costs, and it's a different

situation.

So I do think that this is -- that these are -- these issues need to be considered together. I do think we need to do it at a time when we have time together to give due consideration, so that, you know, eventually, and certainly before the next time we do this again, we've kind of -- we may not come to unanimity but we've at least discussed all the issues and come to some sort of sense of where we think we should be doing it, and how much weight we should put on these various factors -- the non-Medicare margin, the marginal margin, et cetera.

Because I think -- you know, commissions, over time, will have these discussions. They'll come to a meeting of minds, and then the composition of the commission changes. The issues are still there, and then they come back up again, and people are saying, "Well, why are we doing this? Why do we do it that way?"

And as you say, the environment also changes. So it's perfectly reasonable to go back and say, "Well, wait a minute. Why are we doing this again, and how much of this should we be considering and the like, and we will do this."

Pat.

MS. WANG: So this is a good conversation and I think -- and I look forward to the further exploration of the topic. But, you know, in thinking about the comments that have been made today, which have been very thought-provoking, I think, you know, my general inclination is that it's important to have all the information about margins, all-payer Medicare within that, but that at least I am unlikely to conclude that there is a one-size-fits-all approach to this, because providers are different. You know, the payer mixes in hospitals are different, and what commercial payers pay for there is going to be very big, I think, compared to what they pay for in the home health area.

Home health is a virtual service. I mean, there's really no fix. There's no capital. There's no drug costs, you know. And that's why I support the recommendation because I do think that the prior expressions of alarm on all of the changes, and what it would do to the industry really haven't come to pass because the sector has proved itself to be flexible with consolidating, changing the way the service is delivered.

It's really -- it's a labor force. And so I support the recommendation and I think it's further reason to support to movement to the PAC PPS.

The second thing I just want to note about Medicare Advantage, because people have been mentioning it, and I may have misheard, but I think somebody said that whatever the Medicare fee for service rate is, MA plans can't go above that. That's not true. MA plans can go above it, they can go below it. And so the good news/bad news -- the good news is there's more flexibility. The bad news is that you're subject to the market, like anybody else. So organizations or providers that have more market clout, you're going to be paying more like a commercial payer, and, you know, maybe taking that out of organizations that don't have the market clout. So I think it's important to know that.

I think the interest in knowing more about what MA plans do to arrange services, you know, manage services is really important, but I don't think that we should expect miracles there. If we did, then MA costs would not be equivalent to fee for service, now, right? I mean, the content of what MA plans are paying for and how they're

paying for it may increase cost, stimulate more efficiency in the delivery system, but when it comes to home health, for example, if a physician wants home health for their patient, there are few MA plans, that I'm aware of, who would say, "No, we have a different medical judgment there. There's no home health approved."

And as far as fraud, waste, and abuse is concerned -- yeah, everybody is chasing it. There's a lot of attention.

Somebody asked -- Dana, I think, asked the question about substitution and the difficulty of getting at that. The one area that I would suggest maybe could be a little bit on the petri dish to look for that is in the fully integrated products, because, in that case you've got -- you know, you've got all benefits for people who are, you know, also getting cared for a home, because -- or in a nursing home, I guess -- with a Medicaid benefit, but you might be able to see a little bit more closely there, you know, to Kathy's point. You know, a plan might well say, because somebody is at home, "I'm sending a VNS nurse in to see what's going on, because there may be an issue." And it's just one visit, but it might avoid having to get a doc

on call. It might avoid a visit to the emergency room.

But if there were an interest in exploring that, that might be an area to look for that.

DR. CROSSON: Okay. Dana, and then Rita.

DR. SAFRAN: Yeah. So, thanks, Pat, for those comments and for circling back to that issue, because, you know, this is my first time through this set of issues but I do find myself longing for some kind of analysis that would give me a holistic picture of post-acute care and the kinds of tradeoffs being made. And so, you know, if the idea of looking at MA to somehow understand how those dynamics play out there, that's one.

I find myself thinking about the organizations that have taken on Medicare risk, and the fact that they are sort of the purchasers for the price changes that we're talking about, and wondering, can we model out what different choices they might be making, based on this?

And then the last thing I would say is, I was really struck, and actually kind of excited about the fact that for several of these parts of the post-acute care spectrum there are functional outcome measures that are in place and being looked at, you know, in a longitudinal way

where we know change, and it just seems exciting to consider expanding that across the full set so that we could start to make some of those substitutions very specifically, and in an empirically based way, because we know certain settings are going to lead to better improvements in functional status for a patient who looks like this.

DR. CROSSON: Thank you. Rita.

DR. REDBERG: This has been a really good discussion of home health. I wanted to suggest we can talk about maybe fraud and abuse in a broader way. When I was coming to this meeting a colleague shared with me earlier this week, you know, his mother recently had knee replacement and home health came to evaluate her. She was doing well, but they evaluated her as being non-ambulatory and needing three-times-a-day therapy. And she protested and said she was fine, and they said, "No, no, no. This is what we do. Medicare covers it." And she called the Medicare carrier and tried calling the fraud line and they were not interested in hearing about it. They said, "No, we just cover."

And as I told years ago, you know, my mother had

the same experience with podiatrists and being billed for something that didn't happen, and tried calling the Medicare carrier and, you know, because of the system we have where the carrier is just paying out Medicare money, there's not a lot of incentive to sort of pay attention. I just -- I think it's a systemic problem, and obviously there's a lot of home health that's really needed, but some isn't. And beneficiaries who are really in the best position to know have no way -- no one to listen to. And I wonder if there is, you know, a way that we can sort of make a fraud line that actually listens to the beneficiary when they say, you know, I'm being billed or getting services I don't want and I don't need, and Medicare is paying.

DR. CROSSON: That's a good point. I do know that a previous CMS administrator was very keyed in to the home health issue because, in fact -- I'm trying to remember when, but I was, I think, in Los Angeles at a meeting when this individual personally went out with the FBI and had some individuals arrested on the spot for home health, Medicare fraud. So I do think that, at least at periods of time, CMS has been focused in on this, but I'm

sorry for what happened to your mother. But I would not have expected anything less from your mother.

DR. REDBERG: She gets so upset. Look at these bills. $4,000, and Medicare paid it.

DR. CROSSON: Paul.

DR. GINSBURG: I don't want to spend time on this, but since I was the one that said that Medicare Advantage plans don't pay more than Medicare, I just want to say that there are strong regulatory reasons for that. There's a literature which has reported that empirically and qualitatively.

And, so, but I think that there's no restriction on paying less when you can get it for less. So that's where I think the opportunity is to learn. If you're paying more for hospital services, let's talk after the meeting.

DR. CROSSON: Okay. So Paul and Pat are going to take it outside.

[Laughter.]

DR. CROSSON: Oh, my God. Where are we? Actually, we're working on this recommendation.

So I need to sort of test whether or not we have

unanimous support for the recommendation, or if not, do we have a proposal for a different recommendation?

DR. HOADLEY: I mean, and the other question we've been raising is whether there's enough people that are willing -- that are considering taking a different position, that want some more information prior to January, as opposed to the --

DR. CROSSON: Yeah.

DR. HOADLEY: -- the expedited voting.

DR. CROSSON: Exactly. So I -- thank you. I'm a little bit confused as to whether the issue is more information or whether the issue is that people would like -- Warner, for one, would like to have a different recommendation with not reducing the payment by 5 percent. So I'm -- Warner, where do you think you are?

MR. THOMAS: I think, at a minimum, I would like to see in the chapter more specificity around total margin and more clarity around the 15 percent of agencies that are not included in the analysis that we're reviewing, at a minimum.

DR. CROSSON: Jon?

DR. CHRISTIANSON: This is just a question.

Early on in the discussion, was there some concern about combining the rebasing with the 5 percent, or did I imagine that? We're all okay with that combination of those two things in one? Okay.

DR. CROSSON: Okay. I'm really not trying to put you on the spot. I'm trying to -- so we do need to sort of know whether we have unanimity on this recommendation and we take it to expedited voting in January, or we come back and discuss it again. What do people feel? Bruce.

MR. PYENSON: I support the recommendation as written.

DR. CROSSON: Okay. Is there anybody who doesn't support the recommendation? Gotcha.

DR. NERENZ: No, I will support this, but I just thought, you know, for clarity of understanding, since I raised a few questions. I understand clearly what I'd like to have, I can't get, meaning I'd like to have a recommendation that said we'll take 5 percent away from these but not 5 percent away from those. But we can't do that, so I understand hat.

DR. CROSSON: Yeah. Well, again, we can't do it right now, you know, because we don't have an analysis. We

would like to bring recommendations up twice for voting. You know the routine. Do you want to --

DR. MATHEWS: Yeah, if I could just make one point directly in response to David. With respect to the blended payment weight recommendation, for the last two presentations, LTCH and IRF, we did say that the blending of the payment weights does move money in the desired directions and offers cover for across-the-board, you know, update recommendations. Here -- Evan, correct me if I'm wrong -- here and in the SNF sector, that movement is actually of a higher order of magnitude, in terms of moving dollars, you know, away from patients who are getting large amounts of questionably necessary therapy and towards patients who need greater levels of nursing care, complex medical conditions, that kind of thing.

And the way those patients sort themselves out, that money travels from for-profit, freestanding types of entities to hospital-based, you know, nonprofit. But again, it's a function of the mix of patients that each type of provider tends to treat. So in home health and SNF, those impacts of a broad, uniform update recommendation, or reduction in this case, are more

mitigated by the blended payment weight recommendation than in IRF and LTCH.

DR. NERENZ: Thank you, and that did not escape my attention, and that's why I spoke in support of that, when we were on that.

DR. CROSSON: Okay. Kathy.

MS. BUTO: I support the recommendation. I just want to be clear in my mind, now I'm wondering. We would support doing both, right -- moving to the blended payment and --

DR. CROSSON: Yes.

MS. BUTO: -- and taking the reduction.

DR. CROSSON: Yes.

DR. MATHEWS: Yeah, yeah.

MS. BUTO: Okay. I just want to be really clear about that because I actually think what could happen is that if Congress needs some savings they'll go for the reduction first and then worry about blended payment. But I want to make sure we're for both.

DR. CROSSON: Jack.

DR. HOADLEY: I think on that point, what we haven't done, maybe because of how these two independent

streams have evolved, is to say more explicitly in each of the four chapters something about that notion that Jim was just talking about. And I think that would be -- that would help on a number of these points, to say, you know, reference the recommendation that's in the, you know, Chapter 7, and say now we're in Chapter 10 and, remember, if we do what -- if you do what's in 7 and you put it together with what we're doing in 10, you get this further impact.

DR. MATHEWS: Yes, and again, because of our historical protocol in the way we deal with draft recommendations, with the December meeting mail-out we don't include the draft recs because we don't trust any of you. But in the corresponding rationales for each of the PAC sector-specific recommendations, material you haven't seen yet but you have to take it as a matter of faith that it's going to be there, that blended payment weight rec is referenced in exactly this way.

DR. HOADLEY: And have the sort of numbers that were in the table that Carol presented, that would sort of say, and here's the impact in this sector, and obviously, beyond that, you talk about how the two sort of intersect

is maybe not numerically done but you can at least talk more qualitatively.

DR. MATHEWS: But directionally, yes.

DR. HOADLEY: Yeah.

DR. CROSSON: I just want to be very clear. Jim was joking.

DR. MATHEWS: No, no.

DR. CROSSON: No, you weren't?

[Laughter.]

DR. CROSSON: You were joking. The draft recommendations I don't see for discussion purposes until Monday of this week, and then, over the phone, once the staff has developed the recommendation, and Jim discusses it with me, then I determine, you know, whether or not this is actually what you're going to see as my recommendation or not. But they're not ready to be mailed out at the time that the information is sent to you, including me. So I don't see them either until the Monday of the meeting.

Okay. Yes. Well, so, Warner, let me think about this. If we could go forward with this -- I think you're saying that -- and you could help the staff by providing the information that you would like to see in the text,

would that be satisfactory?

MR. THOMAS: I think that would be satisfactory, and I -- you know, I guess what I get concerned about is, you know, I want to continue to understand the rebasing piece, and maybe I could understand that offline with the staff feedback.

DR. CROSSON: Okay. All right. So I think what I'm -- Pat?

MS. WANG: On the wording of the recommendation, I have been a little -- I would just urge to take a look so that it's consistent in the SNF section, the recommendation to transition in the PAC PPS was included in the recommendation, and it hasn't been restated in the other sectors.

So I just -- I got confused by not seeing it in here. I think the intent is that it's a recommendation for every sector update, but just -- I'm just mentioning it.

DR. MATHEWS: Yeah, and so the fact that the blended payment weight recommendation appeared in the same session as we discussed the SNF PPS updated recommendation was a matter of administrative convenience. The way it will appear in the chapter, once it's finalized in the

March report, is it will be a separate chapter ahead of all of the PAC silo chapters, and it will indicate clearly that, you know, it applies to IRF, home health, SNF, LTCH, and again, each of those chapters will cross-reference the preamble chapter.

DR. HOADLEY: People read, often, chapters in isolation. I think that's particularly important. And even the way it's structured on the website, where you can go in and just see one particular chapter. So I think, you know, you can do some of that with links and references back, but I think making that very clear is vital.

DR. CROSSON: Okay. Good discussion. I mean it, actually. I think we have a consensus to go forward with the recommendation. Therefore, we will bring it in January as part of expedited voting.

Evan, thank you very much for your presentation.

We'll now move to the public discussion, comment period. Do we have any of our guests who wish to make a public comment? At this time please come up to the microphone so I can see who you are.

[No response.]

DR. CROSSON: I see some people escaping but

nobody heading for the microphone. Therefore, we are adjourned until, yes, 8:00 tomorrow morning. Thank you.

[Whereupon, at 4:34 p.m., the meeting recessed, to resume at 8:00 a.m., Friday, December 8, 2017.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 8, 2017
8:05 a.m.

COMMISSIONERS PRESENT:

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

P R O C E E D I N G S

[8:05 a.m.]

DR. CROSSON: Okay. I think it's time to get going.

MS. RAY: Good morning. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2016, there were more than 390,000 Medicare fee-for-service dialysis beneficiaries treated at roughly 6,700 dialysis facilities. Total Medicare fee-for-service spending was about $11.4 billion for dialysis services in 2016.

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

We look at beneficiaries' access to care by examining industry's capacity to furnish care as measured by the growth in dialysis treatment stations. Between 2015 and 2016, growth in dialysis treatment stations grew faster than beneficiary growth. Between 2015 and 2016, more

facilities opened than closed; there was a net increase of roughly 250 facilities. Few facilities closed in 2015. There was a net increase in for-profit, freestanding facilities as well as facilities located in rural and urban areas. The roughly 40 facilities that closed were more likely to be hospital-based and nonprofit compared to all other facilities. Few patients -- about 0.5 percent -- were affected by these closures, and there is no indication that affected patients were unable to obtain care elsewhere.

Another indicator of access to care is the growth in the volume of services. We track volume growth by assessing trends in the number of dialysis fee-for-service treatments and dialysis beneficiaries. Between 2015 and 2016, the total number of dialysis beneficiaries grew by 1 percent while total treatments grew by 3 percent. In addition, there was also an increase in treatments per beneficiary of 2 percent.

We also look at volume changes by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of dialysis care. Since the Prospective Payment System was implemented in 2011,

dialysis drugs have been included in the payment bundle. Consequently, providers' incentive to furnish them -- in particular, the erythropoietin-stimulating agents (ESAs) -- has changed. ESAs are the leading dialysis drug class in terms of utilization. Before the start of the dialysis PPS in 2011, there were both clinical reasons and financial reasons for their overuse. As anticipated, after the PPS, ESA use went down significantly. Between 2010 and 2015, use of ESAs declined in aggregate by 51 percent. This outcome was expected and desired and has occurred according to researchers with some positive changes to beneficiaries' health status. Much of the decline occurred during the initial years of the PPS -- 2011 and 2012. Between 2015 and 2016, ESA use has continued to decline. In addition, we are seeing a shift in beneficiaries being switched to lower-cost ESAs.

Next we look at quality of care by examining changes between 2011, the first year of the PPS, and 2016. Mortality and readmissions are trending down, as well as admissions. Monthly use of the ED has increased between 2011 and 2016. The percent of dialysis beneficiaries using home dialysis, which is associated with improved quality of

life and patient satisfaction, has modestly increased from a monthly average of 9 percent in 2011 to nearly 11 percent in 2016. This is a good trend. However, the rate of growth since 2014 has slowed. Your mailing materials discuss a shortage of the solutions necessary to perform one type of home dialysis that began in the fall of 2014 and has continued since. One indicator that measures how well the dialysis treatment removes waste from the blood -- dialysis adequacy -- remains high.

Regarding access to capital, indicators suggest it is adequate. An increasing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized multi-facility organizations. Since 2011, the two largest dialysis organizations have had sufficient access to capital to each continue to vertically and horizontally expand.

Moving to our analysis of payments and costs, in 2016, the Medicare margin is 0.5 percent. The biggest difference across freestanding facilities is the difference between rural and urban facilities. The aggregate Medicare margin for rural facilities, which account for roughly 20 percent of facilities, is negative 4.9 percent. The lower

Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban ones. They have fewer treatment stations and provide fewer treatments. And smaller facilities have substantially higher cost per treatment than larger facilities, particularly overhead and capital costs.

The 2016 margin does take into account the revised low-volume payment adjuster and the new adjuster for all rural facilities that CMS implemented in 2016. We think that the revised low-volume adjuster is a step in the right direction although we have discussed approaches to better target the adjustment.

For this year's analysis, we also calculated the rate of marginal profit -- that is, the rate at which Medicare payments exceed providers' marginal cost. It is calculated by subtracting out capital costs from each providers' total cost per treatment. In 2016, the marginal profit is 17.2 percent, suggesting facilities with available capacity have an incentive to treat Medicare beneficiaries. This is a positive indicator of patient access.

The 2018 projected Medicare margin is 0.4 percent, roughly the same as the 2016 margin. Let's review some of the factors that the projection accounts for.

The first factor that the projection takes into account is the rebasing of the base payment rate. The Congress rebased the base payment rate to account for the reduced drug utilization -- particularly the use of ESAs -- that I showed you on Slide 6.

So for 2017 and 2018, this rebasing adjustment decreased the update by 1.25 and 1 percentage point, respectively.

This projection also accounts for a small positive regulatory change that CMS made in 2017.

And it also accounts for a small estimated reduction in total payments due to the ESRD Quality Incentive Program in both years.

Policy changes to occur in 2019 include the statutory update of the base payment rate, which is set at the ESRD market basket reduced by the productivity adjustment. There is also an estimated small reduction in total payments due to the ESRD QIP.

Here is a quick summary of the payment adequacy

findings. Access to care indicators are generally favorable. Quality is improving for some measures. The 17.2 percent marginal profit suggests that facilities with available capacity have an incentive to treat Medicare beneficiaries. The 2018 Medicare margin is projected at 0.4 percent.

So here is the Chairman's draft recommendation. It reads: The Congress should change the calendar year 2017 -- I'm sorry -- 2019 dialysis outpatient base payment rate by 1.3 percent. The intent of the recommendation is to update the base rate by the amount specified in current law, which is the ESRD market basket less the productivity adjustment. We are expressing the draft recommendation as a number; obviously, the market basket can change when the update is finalized by CMS, but for present purposes this is what we are intending.

In terms of spending implications, this draft recommendation has no effect on spending relative to the statutory update.

No adverse impact on beneficiaries is expected. This recommendation should sufficiently cover providers' cost increases and thus not adversely affect providers'

ability to furnish care. Given the large marginal margin, this recommendation is expected to not have an adverse impact on beneficiaries' ability to obtain dialysis care.

That concludes the presentation. We look forward to your questions.

DR. CROSSON: Thank you, Nancy.

We're open for clarifying questions. I see Kathy, David, Paul, Jack, and Rita.

MS. BUTO: So, Nancy, I just wondered if you could remind us -- I was trying to find it in the paper but didn't -- how home dialysis is paid for. Is it paid the same rate as in-facility or is there some reduction?

MS. RAY: No, it's paid -- for adults over the age of 18, it's the same base rate.

MS. BUTO: Okay. And you mentioned the beneficiaries meeting the adequacy of dialysis guidelines is still pretty high. Can you tell us what that percentage is or what the --

MS. RAY: It's in the high 90s.

MS. BUTO: Okay, so it's very high.

MS. RAY: Yes.

MS. BUTO: And I guess the question is: Has it

maintained at 90-plus percent pretty steadily since --

MS. RAY: Yes. Yes, that measure has.

MS. BUTO: Thank you.

DR. CROSSON: David.

DR. NERENZ: Thanks. Just a quick question on the 1.3 percent. I just want to make sure I understand how they match. If we can go back to Slide 11, just a semantic question. On this slide does 1.3 refer to the productivity adjustment or does it refer to the combination of market --

MS. RAY: The combination market basket minus productivity.

DR. NERENZ: Thank you.

DR. CROSSON: Paul.

DR. GINSBURG: Nancy, I'm a little baffled about this. It seems as though the Medicare margins are quite small, but yet we see a lot of sophisticated capital coming into the industry. Are the margin data reliable?

MS. RAY: Well, that's a good question. The Commission did recommend that CMS audit the ESRD cost reports, and the Congress did provide an authorization for CMS to do so, and that audit is still ongoing.

DR. CROSSON: I've got Jack, Rita -- Alice, on

this point?

DR. COOMBS: On this point.

DR. CROSSON: Okay.

DR. COOMBS: One of the things to pay close attention to when that comes in -- I don't know if you have access to weigh in on it -- is the labor units within the dialysis companies.

DR. CROSSON: Paul. Oh, I'm sorry. Jack.

DR. HOADLEY: Yeah, thank you, and thank you for the paper. On the recommendation, I'm trying to make sure I understood. You said you'd state it as a 1.3, but is the recommendation essentially to do the market basket, if you got a new number next month we would revise it?

MS. RAY: Right. So when CMS -- I mean, unless -- when CMS implements the payment update, they'll propose that next roughly July.

DR. HOADLEY: Okay.

MS. RAY: So the market basket will have been implemented probably three or four more times between now and when they drop the draft reg and then when they drop the final reg.

DR. HOADLEY: But our recommendation is saying

that it should be whatever that market basket is at that point in time.

MS. RAY: Exactly.

DR. HOADLEY: Yeah, I don't --

DR. MATHEWS: Jack, if I could jump in and just make a clarification on this point.

DR. HOADLEY: Yeah.

DR. MATHEWS: So you'll recall that during the initial implementation of the current 2 percent Medicare sequester, we had a lot of discussion here among the Commissioners about what we meant by saying a "current law update." Is it just the market basket, you know, with all the puts and takes, or is it market basket plus 2 to compensate for the sequester, that kind of thing? And the solution was to express the current law update in the form of a number rather than say "current law." So in this case, we are saying 1.3 percent, and that's probably the point estimate that we will stick with through the January meeting. But the corresponding rationale and implications underneath the boldfaced recommendation will make it clear that our intention is that the update would be consistent with current law.

DR. HOADLEY: Thanks. That helps.

On Slide 6, where you talk about the drug decline, do you have a breakout of how much of that you think is due to price versus volume?

MS. RAY: So this slide holds price constant.

DR. HOADLEY: Okay.

MS. RAY: So what you're seeing here is the drop in utilization.

DR. HOADLEY: Is the utilization.

MS. RAY: So what I've done is I've used the 20 -- I've multiplied every drug unit by its corresponding 2017 ASP.

DR. HOADLEY: Got it. Okay. Thank you. And I know you talked in the paper about the cost initiative program and some of the early results from that. But you also talked about the ESRD SNPs. Is there any effort to evaluate in any way what's happening with the ESRD SNPs to know whether that's a helpful development? I mean, unlike the demonstrations, there's not an automatic need to evaluate.

MS. RAY: That's a good question. I'll get back to you on that.

DR. HOADLEY: Yeah, I just wonder. I mean, how will we know if that was a good idea?

MS. RAY: Yeah.

DR. HOADLEY: And I don't even know what the baseline was.

DR. CROSSON: I've got Rita, Brian, Dana, Pat.

DR. REDBERG: Thanks for the excellent chapter. I'm wondering why all the drugs aren't in the bundle. Why are the Vitamin D and the calcimimetics excluded?

MS. RAY: Okay. Vitamin Ds are in the bundle. So phosphate binders and the calcimimetic, up until 2018, are still being paid by Part D. And the history behind that is CMS intended that those two classes be included in the bundle in 2014. Congress deferred the bundling of those drugs until, I guess, it would be 2025. But what happened with the calcimimetic is that a manufacturer introduced an injectable form of the calcimimetic, and so what that means under current law is that both the injectable and the oral will be included in the bundle, and that will begin on January 1, 2018. And those two products for roughly two to three years will be paid using a TDAPA, a transitional drug adjustment payment factor, for two to

three years while CMS gathers data so they can then figure out how much to put in the bundle. And then the drugs will be put in the bundle. That's the intent.

DR. REDBERG: Thank you. And I had another question. I noticed home dialysis had increased, which seems good for beneficiaries, but was slowed, you noted in the chapter, by a shortage of solutions needed. Is that an ongoing issue?

MS. RAY: It seems to be ongoing for one type of peritoneal dialysis. That's my understanding. I mean, we are trying to track this.

DR. CROSSON: On this point -- sorry.

DR. REDBERG: We've also talked before about the rates that -- eGFR when dialysis was initiated, and I'm just wondering if in the future when we look at it more closely we should look at profit status -- or maybe you already had that -- of facilities and why aren't they initiating. And also I'm thinking about the new facilities, sort of Paul's questions, that are coming on. And are they tending to do earlier or later initiation of dialysis?

MS. RAY: We can look at that.

DR. REDBERG: Thanks.

DR. CROSSON: Kathy, on that point?

MS. BUTO: Kind of on the same point. It's really about home dialysis.

Nancy, do we have any sense of the differences, if any, in the characteristics of patients on home dialysis versus those who are in facility or one healthier as a group than the other? Do we know? I mean, the ability to dialyze at home, sometimes without any assistance, suggests to me you might have a healthier population dialyzing at home, but I don't really know.

MS. RAY: Yeah. I guess, so I don't misspeak, I'd like to come back to you in January about the clinical differences in terms of their characteristics. In terms of their demographic, they do tend to be younger, and they do tend to be white versus minorities.

DR. CROSSON: Brian.

DR. DeBUSK: The ESAs in outpatient or in dialysis are packaged, whereas the same drugs in other applications, like oncology, aren't. Again, that's my understanding. Do we have a feel for the price differentials in how the manufacturers have responded to

the packaging request? I mean, could we calculate a differential between, say, the same ESA in an oncology application versus a dialysis application?

MS. RAY: I would have to get back to you on that. I mean, my hunch is I don't think we have that available data to do that.

DR. DeBUSK: Because the packaged ESAs wouldn't be subject to ASP reporting, would they?

MS. BUTO: Nancy, you could --

MS. RAY: Oh, yes. No. I mean, the ESAs that dialysis facilities furnish, that is a part of the ASP.

DR. DeBUSK: Okay. So that is incorporated in the ASP.

MS. RAY: Yes.

DR. DeBUSK: I just wonder if there's a way to back into that, and my question is, Is there a broader policy solution? I know Kathy has mentioned time and time again about packaging drugs into the procedure, and I just wonder if this is an opportunity to measure the efficacy of that approach while looking at the same drug in an oncology application and a dialysis application.

MS. BUTO: And I think there was a demonstration

or maybe even still is an oncology bundling demonstration. I don't recall whether the drug is actually bundled in, but I think the notion was to bundle it, wasn't it?

MS. RAY: So under the oncology care model, if that's what you're referring to, drugs are paid ASP+6. Yeah.

DR. GINSBURG: I think what would be fascinating is -- I presume in this bundle for ESRD, the ESRD providers are buying the drugs as best they can.

MS. RAY: Particularly the -- I mean, my understanding is particularly the two very large dialysis organizations. Yes.

DR. GINSBURG: That's right, that are in the bundle.

MS. RAY: Yes.

DR. GINSBURG: So, in a sense, it would be very instructive to -- I don't know if you can find out how much they pay, or at least either what they pay or how much is allowed for the bundling, creation of the bundle.

DR. MATHEWS: And, Paul, just on this point -- and Brian -- just to make sure I understand the question on the table right now -- I think I do -- Brian, your point is

that the same ESA can be used for dialysis where it is paid under the bundle, and it can also be used for other indications, such as oncology, where it's paid ASP+6.

Nancy, the payment under the bundle does not make an ASP+6 payment underneath the bundle; is that correct?

MS. RAY: That is correct.

DR. MATHEWS: Okay. And so what you are asking between the two of you is can we determine the price that the dialysis facility or the organization is paying for the ESA and compare that to the ASP+6 rate. Is that what you're getting at?

DR. DeBUSK: Absolutely.

And I think the question would be what if there's a 20 percent differential.

DR. MATHEWS: Understood. I just wanted to clarify what you were asking.

MS. RAY: Right. I mean, if you wanted -- okay. So I'm glad you did that, Jim, because I misinterpreted your question. If you want to compare the ASP+6 of an ESA versus providers' cost -- ESA cost per treatment as reported on their cost reports, that we can do.

DR. DeBUSK: Okay. So we could actually measure

the efficacy of packaging an expensive drug into a procedure.

MS. BUTO: Right. But I think that one of the things we're learning is that there was a lot of flexibility in dosing, right?

DR. DeBUSK: Mm-hmm.

MS. BUTO: And what happened was the volume of drug per treatment has gone down, as I understand it. The volume changes have been significant.

DR. DeBUSK: And probably the side effects as well.

MS. RAY: Yes, yes. That is correct.

MS. BUTO: So that to save money and maintain adequacy, there is a different level of drug that got you to the same result or a better result.

DR. DeBUSK: Agreed. I think there's a leading indicator here that we may be able to look at this particular policy.

I understand they're used differently, but it would be interesting to see how the manufacturers respond when they're responsible for an entire bundle. It's a larger payment.

DR. CROSSON: Jack wants to weigh in here.

DR. HOADLEY: Yeah. I mean, you also had evidence that there was some product switching, presumably as a result of the bundle. So given multiple alternatives for ESAs, they were making choice of product. So that's a part of what's going on too, right?

MS. RAY: Right. We've seen that within the ESA class and we've also seen that within the vitamin D class that there has been some product switching under the PPS.

For the ESA product switching, that's happened more recently with the launch of a third ESA.

DR. HOADLEY: And presumably, part of that is a price response that they're getting offers of lower prices, and so it would be interesting at least to see what we could learn about what's going on inside that.

DR. CROSSON: Amy, on this?

MS. BRICKER: Just for clarification.

We're asking the question of cost to the provider versus reimbursement?

DR. DeBUSK: We're asking how the same manufacturer would price the same product into two different markets that are in dramatically different

reimbursement schemes. ASP+6 is sort of that super-charged -- you know, the more you spend, the more you make, whereas this is a truly capitated model where there's a fixed payment with some adjustors. So it's up to the provider to really buy the best product at the best price.

MS. BRICKER: Yes.

DR. DeBUSK: And those are two very dramatic scenarios.

MS. BRICKER: Yeah. I just wonder if it would be skewed of to the point there's two large dialysis purchasers and how then you would compare the oncology space and the large purchasers there. I think you'd have to kind of sort through and normalize for those large --

DR. DeBUSK: For purchasing power. Yeah.

MS. BRICKER: Mm-hmm.

And also, Brian, I think the other missing piece here is that there is no cost report for the individual physician who is prescribing the ESA, so we don't know the acquisition cost to the non-ESRD situation. We know when Medicare pays, but we don't always know what that differential is between what Medicare pays and what they actually purchase the drug for.

DR. DeBUSK: Agreed, agreed.

And I think Nancy mentioned something that -- and I had not thought of this until you -- well, I hadn't thought of this, and then you said it, which was that we can look at the ASP. Then we can look at the cost reports from the dialysis centers, and in theory, once we know the rough ratio of what percentage of the ESAs are used in dialysis, we can back into a differential for non-dialysis use versus dialysis use, the pricing for that same drug, I think, couldn't we?

MS. BRICKER: But doesn't that get to Paul's point around the margin question? I mean, is this not where maybe the margins are with respect to the provider?

DR. CROSSON: Okay. I'm going to suggest we move on. I think this is a good suggestion. Nancy will try to get what information you can by January and put it into the report.

On this? I'm sorry?

MR. PYENSON: [Speaking off microphone.]

DR. CROSSON: Different. Okay. All right.

I'm sorry. I got you on the list, but Dana is next.

DR. SAFRAN: So thanks for this.

My questions have to do with the home dialysis. So it was interesting to see the uptake of about 2 percentage points and interesting to hear you say that the payment for Medicare is the same.

I'm wondering a couple things. One, do we know whether there's a difference in uptake, urban and rural? And what do we know about differences in cost of delivering the facility setting versus at home? Because I'm wondering, given my understanding of the literature -- I think you said this a little bit as well, that safer and certainly better quality of life, what Medicare might be able to do to encourage the adoption of home dialysis. And that sort of piqued my interest further when I heard that right now, uptake seems to be among those who may be just more aware of their opportunities, so what we can do.

MS. RAY: Right. So I will have to get back to you on the urban versus rural split.

One factor that does affect the uptake of home dialysis is your exposure to some sort of pre-ESRD program, whether it's -- and educational efforts.

In terms of cost of delivery, historically home

dialysis has been less costly to furnish. I think -- and Andy should chime in, but the cost reports, using the cost reports to try to get at that is somewhat difficult, I would say. It's challenging.

DR. JOHNSON: In particular, peritoneal dialysis is less costly, but home hemodialysis may not be when compared to inside --

DR. CROSSON: Okay. Pat.

MS. WANG: This goes back to the margin question, and I apologize if I missed it in the materials. What is Medicare as a share of total payer mix, and what is the all-payer margin?

MS. RAY: Okay. So Medicare fee-for-service treatments compared to all -- Medicare fee-for-service accounts for roughly 60 percent, 60 percent of all treatments.

In terms of the all-payer margin, this is very rough. Based on available information, it exceeds 20 percent, the all-payer margin.

DR. CROSSON: Pat.

MS. WANG: So the margin for 60 percent of the business is what you showed here for Medicare, and the

remaining 40 percent is driving a payer margin that is --

MS. RAY: Well, let me be clear. The remaining 40 percent includes Medicare Advantage, Medicaid, other government programs like the VA, and then commercial.

MS. WANG: Yeah. Okay. But that's --

DR. GINSBURG: I recall that's a major issue in the implementation of the ACA marketplace, has been movement of the ESRD patients to ACA commercial plans and dramatically higher reimbursements.

DR. CROSSON: Bruce.

MR. PYENSON: Nancy, I'd like to ask a question about Table 7, Table 7 in the materials. I've got a question. This is the financial results for the ESCOs, and this looks like a rather good result in the first year. And I think, if I recall correctly, compared to first-year results of ACO programs, broader MSSPs and others, this is really very positive. Is that your impression as well?

MS. RAY: Yes, that is my impression. For the first year, which included the period, I think, October 2015 through the end of 2016, the 13 ESCOs were, I think -- were positive. The results were very positive.

MR. PYENSON: So does this point to either the

evidence of ability to reduce cost or a rapid expansion of this program, perhaps making it mandatory?

MS. RAY: So CMS issued a second solicitation for more ESCOs, and so an additional 24 ESCOs have been included under the Round 2 of the program, so that will up them to 37 ESCOS, from 13 to now 37.

I think it remains to be seen in subsequent payment years how these ESCOs perform before answering your question.

MR. PYENSON: Thank you.

DR. CROSSON: Okay. Seeing no further questions, we will move on to the recommendation. Put up the Slide No. 13, if you would.

I'd like to hear comments on the recommendations.

Kathy.

MS. BUTO: I can support the recommendation. I wonder whether, given the information in the paper, we ought to consider adding some language around the disparity in the use of home dialysis, the disparity with African Americans versus -- or minority patients versus other patients, which seems to me to be an access issue. So as long as we're trying to get both at payment and access, I

think maybe we do it in the text, but we need to highlight that as an issue for the agency to address.

I understand that some of the other disparities in treatment are multi-factoral, but it sounds to me like home dialysis is one area where it's not clear why there's such a disparity.

The other thing I wonder about, but I don't have a suggestion on this, is the -- Dana was mentioning essentially is there a way to provide incentives for more home dialysis. It seems to me we're theoretically potentially overpaying home dialysis versus in-facility dialysis, and maybe that's what we intend to do in order to encourage more provision of home dialysis services.

But I remember when I was at the agency, we had a major legal issue around the provision of free staff with home dialysis because of the overpayment in the home dialysis setting, and it was very difficult to get away from a charge-based system, which at the time was a very different payment system from facility dialysis, which really overpaid home dialysis, to such an extent they could provide a free staff person.

So I think we just have to be aware that there

could be distortions. I don't know that it affects the recommendation, but it worries me a little bit. That we don't want to over-incent, if you will, home dialysis if it's not appropriate for all patients. It should be an option that's adequately paid, but I worry about the issue of patient characteristics and potential overpayment.

DR. CROSSON: Okay. So, Nancy, that's something you can do for the January write-up.

DR. GINSBURG: If I could follow up?

DR. CROSSON: Paul.

DR. GINSBURG: It seems to me that this is a very important policy issue. That with home dialysis having different costs, being for some types of patients superior as far as it -- and to have these issues ignored by our payment policy, which just blindly pays the same, it seems as though that's something we might want to work on in the future of coming up -- perhaps it's going to be complex because, as Andy mentioned, perhaps -- just depending -- there are different types of home dialysis. Not all are lower cost. Some may be higher cost, but it just doesn't feel right to have this all ignored by our payment system.

DR. CROSSON: Dana, one second.

So I'm getting a little confused as to whether we think -- I think I understand that we'd like to see more explication of this issue, and I agree with that. Are we hearing concerns that we think Medicare should be differentiating payment based upon whether it's home dialysis, it's peritoneal dialysis, because it costs less and therefore should be paying less, or do we think it's preferable for beneficiaries, so we should be paying more? I think I've heard both points here.

DR. GINSBURG: It could be either one. It's just a matter of we should find out.

DR. CROSSON: Got it.

[Laughter.]

DR. CROSSON: Dana.

DR. SAFRAN: Well, I was going to point to that confusion also and just mention two things that I think we should be thinking about. One is if we think about our support for and the movement toward accountable care and a global budget payment and wanting to incentivize care in the lowest cost setting, I think that I personally land in a place I'm not so opposed to for now, having payment be the same in both settings, even if it costs less to deliver

it in the home setting, in order to encourage care to be moved in that direction.

But it sounds like, to the point that Kathy underscored for my question, we need to do more to at least educate the whole population about the availability of this, say for much more convenient, et cetera, opportunity.

The other thing, which is really not relevant in the Medicare population, but I'll mention it because I think it has some analogy here, is in a commercial insurance world where we know we have dramatic overuse of C-section, but we pay the same for C-section and vaginal delivery. There are advocates in the field who are clinicians who say part of the reason is that it's a workflow issue. It's just easier to schedule C-sections and not worry about labor and so forth, and could you pay more, in fact, for vaginal delivery to sort of incentivize that?

So I just think this question of what actually do we think is the safer, more desirable form of care to see happening and factor that into our recommendations about whether there should or shouldn't be payment differentials is something that could benefit from some more explication

in the paper.

DR. CROSSON: Okay. Kathy and Alice and Jack on this point.

MS. BUTO: On this point, so, Jay, to answer your question, I think what Paul and I were both saying is I think we need to know more about the differences in the patient characteristics. I don't think we're ready to make any conclusion. But it doesn't feel correct to just say these should be paid the same without that information. We need to know more about whether there's some risk adjustment or something else that should be going on, or maybe a bonus payment for certain kinds of home dialysis, if appropriate. But we don't have that information, so it's hard to sort of come to a conclusion. But I just think a way of highlighting that in the paper and the fact that we'll be trying to look into it or that we think CMS ought to pay closer attention I think would be helpful.

DR. CROSSON: Exactly. So what I'm beginning to see here is that we're going to ask Nancy to put whatever information she has and can put together between now and writing the January report -- which is like tomorrow.

[Laughter.]

DR. CROSSON: You know, so that we can read that. But then also I think I'm hearing fairly broad interest in us taking a look at this more substantially when we can build it into the work flow.

Alice and then Jack.

DR. COOMBS: Yeah, so before Nancy goes off to do her homework, I just want to bring to the attention that the whole notion of our interventions for renal failure patients has changed over the years. As you know, we had a higher threshold for transfusions. We had a higher goal for hematocrits. That has changed dramatically, and that is part of the conundrum of this whole thing with ESAs versus transfusion, is that we've found that people with lower 'crits actually do better. So that's a piece of this declining utilization. It's not just some of the policies, but it's also the medical literature proving to be more fruitful in terms of directing the therapy, in terms of evidence-based guidelines.

DR. GINSBURG: I think that actually influenced the policy.

DR. COOMBS: Yes, yes. Despite us thinking that the policy drives the behavior, it is actually that there's

evidence that drives behavior.

For the differential, if there were -- I think for what we have right now, peritoneal dialysis is a wonderful means of treating dialysis patients. I think that the knowledge base and the whole convenience of peritoneal dialysis, while it appears to be very attractive, you have a catheter and you have to dwell at night. It's a big deal. It's not -- whereas the dialysis patient goes into the dialysis unit, they get a treat or a snack, and they watch a movie for three hours and then they roll out. There is this whole notion of the actual play that the patient has to interface with the peritoneal -- you have to be ultimately sterile because if you get peritoneal infections, it's a big deal. The patient's home in and of itself has to be adequate for peritoneal dialysis to work, and that means there has to be a certain infrastructure there.

In terms of the hemodialysis, back in the day we did something -- we reviewed the ambulance reports, and we found that some of the hemodialysis patients were taking the ambulance to the hemodialysis unit, so the cost of hemodialysis is layered on top of the transportation to the

dialysis unit. And I think that's something that we didn't really appreciate until we did that ambulance report -- I forget how long ago it was.

MS. RAY: That was a couple of years ago, and ambulance spending for ESRD beneficiaries, I didn't put it in your mailing materials. It has trended down in the last couple years, and part of that is because of the policies that have been implemented by CMS and by the statute. But it still remains high.

DR. COOMBS: Okay.

DR. CROSSON: I saw another hand. Was that Jack? And then Bruce.

DR. HOADLEY: Yeah, I guess I'm adding potentially more to your homework assignment for the weekend. But I wonder if the ESCOs or the SNPs have had any experience in -- because they are in that environment where they're getting more of a bundle, and whether they've got any experience in use of hoe dialysis.

MS. RAY: Right, so it remains to be seen. When CMS released the results of the ESCO, it's literally on this piece of paper, and they did not release the evaluation by services. So I think that's something that

we would very much like to look at.

DR. HOADLEY: So this is not the weekend homework. This is the next year's homework.

[Laughter.]

MS. RAY: Correct.

DR. CROSSON: Bruce.

MR. PYENSON: I'd like to voice support for Dana's comment on the ability to create bundles that have an effect on shifts. And, in particular, if we think that home dialysis is less expensive and a shift to home dialysis would reduce cost, it seems to me that cutting the reimbursement for these bundles would be a good policy because it would put pressure on the dialysis providers to become more efficient in that way. So it's not clear to me that increasing payment is consistent with good policy in this case.

DR. CROSSON: So, Bruce, are you speaking against the recommendation?

MR. PYENSON: Well, pending on what Nancy comes back with. It's not clear to me this is good policy to have that increase.

DR. CROSSON: Right, so, I mean, here's my

thought. We've had like three or four different areas of discussion here where we've asked Nancy to bring more information back in the January report. For the most part, they're helpful, but not from my perspective so far, not directly impacting our recommendation for 2019.

My own sense -- and push back, please, if you want to, but my own sense is that it would require, you know, more work than can be done between now and January with respect to the tradeoffs between home dialysis, a subset of peritoneal dialysis, hemodialysis, payment rates, et cetera, to be able to come forth in January with a different recommendation as opposed to us doing that moving forward. So I'm not sure that I think we can get to a different decision by January based upon the information that we're likely to have between now and then. So perfectly free to propose a different recommendation or an alteration to the recommendation, but I think in general we try not to make policy decisions for sure, but even policy-driven payment decisions kind of on the fly. So would you be -- again, not to put you on the spot, but would you be okay with this recommendation for this year?

MR. PYENSON: Your explanation makes sense to me.

DR. CROSSON: Okay. Thank you. Pat?

MS. WANG: I'm not going to object to the recommendation, but I do want to sort of go back to the conversation that we were having at the end of yesterday about how we look at situations where, you know, it's a 0.4 percent Medicare margin, but apparently a very high all-payer margin with very healthy access to capital and sort of try to rationalize that we're going here, and yesterday morning, you know, we had this whole discussion about hospitals that had a minus 9 percent Medicare margin and the update is very similar. I just think that we have to rationalize kind of why we look at these situations differently and, you know, this is in law. I don't think that I know enough about our approaches to say we shouldn't do this. But I do want to -- I have a little bit of concern that we're kind of doing this after what we just heard about all-payer margin and the healthy capital markets. It's just something seem a little off.

DR. CROSSON: And I agree with that. And as we said yesterday following the discussion at the end of the day, I think periodically we have to go through this, because it's very complicated and it's quite subjective.

You know, I think we're committed to, and have been for some time, to providing all the information about margins other than Medicare and also this term of art we've now developed, I think, called the "marginal margin," you know, which is -- and as we said yesterday, we fully recognize that using either of these two approaches may be helpful in coming to our decision, but it also may in some ways prejudice in one direction or the other, which may be different from the needs of the Medicare program itself.

So what I think we're committed to when we are able to get together with sufficient time to do this is to go over this again, not just simply from my perspective to say this is the way we used to do it, so we want to do it that way. But to make sure that this Commission going forward understands, you know, the pros and cons of adding some of this information into our decisionmaking process and comes to -- much as we can, comes to an agreement on how we want to think about, how we want to apply it, et cetera, et cetera. So we are committed to doing that.

I saw Kathy and Paul.

MS. WANG: Can I -- [off microphone]?

DR. CROSSON: Yeah, go ahead. I'm sorry.

MS. WANG: Yeah, I appreciate that, Jay. That's why, you know, I'm going to go with the recommendation that's up here. And as I said yesterday, I don't think that we're going to come out -- I'm not suggesting that there be like one rigid black-and-white, this is our position on how we assess the all-payer results. But I do think that to the extent that we make different decisions with that information, it should be intentional. That's all I'm asking, that we get the whole picture and that we go in X direction or Y direction with intent.

DR. CROSSON: Yeah. Thank you for that. I agree.

Okay. Paul and then Kathy.

DR. GINSBURG: I wanted to offer something to Pat about why I think we look at the hospital update decisions very differently here, because I think this Commission has a longstanding background of concern with its hospital update recommendations, that they have a profound influence on the level of costs incurred in the system. And the concern is that if Medicare pays hospitals very well, there will be a response of allowing costs to increase in the sense that Medicare perhaps has this function of having --

of disciplining hospitals or, to put it differently, just having a role in how expensive or inexpensive our hospital care will be. I think many of these other areas in predominantly for-profit enterprises, we're not so concerned about costs. We're assuming that, you know, given the benefits and given their incentives, they'll try to keep costs down. But I think that's what to me puts hospitals in a very separate place as far as just looking back a long time, long before I was on the Commission, in the Commission's thinking about it, you know, all the cost-shifting analysis done really is about that.

DR. CROSSON: Okay. Kathy.

MS. BUTO: And I want to come at it from the ESRD perspective. I think what's different about ESRD is that it's largely a creature of Medicare. I think Medicare created the industry in facility dialysis, and I'm not saying that's a justification for an increase, but -- in fact, I was surprised to hear it was 60 percent, 60-40. I do know that that 40 is very fragmented, so some of it is an artifact of the law that actually requires a delay in ESRD eligibility. Some of it is VA, some of it -- so all those other payers don't have the same leverage that

Medicare has, and so I think it's quite different from hospitals in that way. So I'd just add that.

DR. CROSSON: Okay. Warner, and then -- I don't want to try to adjudicate this issue again, but go ahead, Warner.

MR. THOMAS: So I can support the recommendation, but I would disagree with Pat, that it's just hard to sit here when you have a summary sheet that you've provided for us looking at all the disciplines, it just seems like there's some inconsistencies in how we are approaching this. And then they warrant another discussion with us to spend more time thinking long term.

I also would say that, you know, what's been done historically versus where we are today, we're in a very different world today than we were even five or ten years ago. And so I'm not so certain that how we thought about policy five or ten years ago is as applicable today where we're just seeing an acceleration of the amount of people that are in Medicare overall, and it's a much larger component of spend in all of these disciplines than it has been historically. So I think that's another thing we need to consider as we think about.

DR. CROSSON: Thank you. Okay. Seeing no more discussion, as I said a few minutes ago, I think we've asked Nancy to bring us back more information in a paper. I don't think that information will impact what I see as a consensus for the recommendation. And so I'm going to recommend that we come back with ESRD through an expedited voting process in January. And there will be two opportunities. We will have a brief opportunity for questions in January. And, in addition, as Jim pointed out yesterday, you will be getting the final report for external review, and so there's another opportunity if you have any questions or other comments on the new information that Nancy will be putting into the report. Okay. Thank you, Nancy and Andrew.

Now we will move forward to the next presentation.

[Pause.]

DR. CROSSON: Okay. Kim is going to take us through the analysis and recommendation for updates for hospice services.

MS. NEUMAN: Good morning. In 2016, over 1.4 million Medicare beneficiaries used hospice services,

including about half of beneficiaries who died that year. About 4,400 hospice providers furnished care to those beneficiaries, and Medicare paid hospice providers about $16.8 billion.

The hospice benefit provides palliative and supportive services for terminally ill beneficiaries who choose to enroll. To be eligible, a beneficiary must be -- must have a life expectancy of six months or less if the disease runs its normal course. At the start of each hospice benefit period a physician must certify that the beneficiary meets that life expectancy criteria. There is no limit on how long a beneficiary can be in hospice as long as they continue to be meets that criteria. A second requirement of the hospice benefit is that the beneficiary agree to forgo conventional care for the terminal condition and related conditions.

Before we go through our indicators of hospice payment adequacy, I'm going to review changes to the hospice payment system that occurred in 2016.

The Commission recommended, back in 2009, that the hospice payment system be changed. The Commission found that the payment system was misaligned, with long

stays being very profitable. This was because the payment for the most common level of care, routine home care, was a flat payment per day, whereas hospice visits tended to be more frequent toward the beginning and end of a hospice episode. So the Commission recommended changing the per diem payment for routine home care from a flat daily rate to a u-shaped payment throughout the episode, to better match the cost structure.

Starting January 2016, CMS changed the payment structure for routine home care and that change was directionally consistent with the Commission's recommendation.

There are now two daily rates for routine home care: a higher rate for the first 60 days and a lower rate for days 61 and beyond.

During the last seven days of life, hospices also receive additional payments for registered nurse and social worker visits. These visits are paid at an hourly rate and are paid on top of the regular daily rate.

CMS projected the new payment structure to be budget neutral in the aggregate but to redistribute revenues across providers. Provider-based, nonprofit, and

rural hospices were projected to see revenue increases because these providers tended to have fewer patients with very long stays.

So now we will go through our indicators of payment adequacy.

First, we have a chart showing the growth in the number of hospice providers. The green line is the total number of hospices. The total number of providers has been growing for many years and increased by 4 percent in 2016. The other three lines in the chart show the number of providers by type of ownership, and you can see from the yellow line that growth in provider supply is accounted for entirely by growth in for-profit providers. The number of nonprofits and government hospices has been on a slight downward trend.

The next chart shows growth in hospice use among Medicare decedents. Between 2015 and 2016, the share of Medicare decedents who used hospice increased from 48.6 percent to 49.7 percent.

Over the years, hospice use has grown most rapidly for the oldest beneficiaries. In 2016, 59 percent of decedents age 85 and older used hospice. As we've seen

in past years, minorities and beneficiaries in rural areas continue to have lower hospice use, but use has been increasing as well.

So this next chart gives us a more detailed picture of utilization growth. The number of hospice users grew about 3 percent in 2016 to more than 1.4 million beneficiaries. With the growth in the number of hospice users, we also saw growth in the total number of hospice days, reaching over 100 million days in 2016.

The bottom of the chart shows hospice length of stay among decedents. Average length of stay among decedents increased slightly in 2016, as we observed a slight increase in length of stay both at the median and the 90th percentile.

As you will recall, our prior work has shown that longer stays have been more profitable that shorter stays, and this next slide shows you that length of stay varies by observable patient characteristics like diagnosis and patient location, so that hospices that choose to do so have an opportunity to focus on more profitable patients. And consistent with that, we see for-profit providers having substantially longer stays than nonprofits, about

106 days versus 66 days, on average, in 2016.

When we look at margins later in the presentation, one factor that's going to contribute to differences in financial performance across providers is going to be length of stay differences.

So next we have quality information. In August 2017, Hospice Compare released the first public hospice quality data for individual providers. Currently, Hospice Compare includes seven process measures that gauge whether hospices performed certain activities appropriately at patient admission. Examples include documenting treatment preferences, and screening and assessing patients for pain.

Most hospices scored very high on six of the seven measures, and while the high scores are encouraging, they also suggest that these measures are or will become topped out. Other quality reporting efforts are underway but data is not yet publicly available.

The Hospice CAHPS survey surveys family members of hospice patients that have passed away, to get information about the care provided by the hospice. And Hospice CAHPS data are expected to be released in early 2018. CMS has also added quality measures of whether

hospices provide visits in the last days or week or life, and that will be forthcoming as well.

As we've discussed before, live discharge rates are also a potential indicator of poor quality or program integrity issues. We would expect some live discharges from hospices to occur, because sometimes patients improve and no longer meet the eligibility criteria, or because patients might change their mind and decide to return to conventional care. However, if a provider has a live discharge rate that is substantially higher than its peers, it may signal that the provider is not meeting patient needs or that the hospice is admitting patients that do not meet the eligibility criteria.

In 2016, across the entire hospice population, the percentage of discharges that were live discharges was 16.9 percent, up slightly from the prior year.

Some hospices appear to have outlier live discharge rates. In 2016, 10 percent of hospices had a live discharge rate of 53 percent or more.

So next we have access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall access to capital appears adequate. We continue to

see growth in the number of for-profit providers, which increased about 7 percent in 2016, suggesting capital is accessible to these providers. Reports from publicly traded companies and private equity analysts also suggest that the hospice sector is viewed favorably by the investment community. We have less information on access to capital for nonprofit freestanding providers, which may be more limited. Provider-based hospices have access to capital through their parent providers.

So next we are going to go through information on hospice costs and margins. First we have data on hospice costs by level of care for freestanding providers. There are four levels of hospice care. Routine home care accounts for the vast majority of days, but there are three other levels of care that are available in certain circumstances when the patient needs additional support.

Data on cost by level of care are now available because the hospice cost reports have been substantially revised, starting with freestanding providers in 2015. Prior to these changes, we were only able to estimate the cost per day for all levels of care combined, not separately by level of care.

Looking at the chart, the first row shows routine home care. For routine home care, freestanding providers had an estimated average cost per day of about $124, compared to a Medicare payment rate of $159. In contrast, for the other three levels of care, the estimated cost is higher than the Medicare payment amount.

These data suggest a potential need to rebalance the payment rates across the four levels of care, which is something that we could consider further in the future.

Next, we have Medicare margins. These margins include payments and costs for all four levels of care and are for all types of providers. Different from other sectors, we have historical margin data through 2015, because 2016 margin data are incomplete. So for 2015, we estimate that the aggregate Medicare margin for hospice providers was 10 percent, up from about 8.2 percent in 2014. A couple things to note. We exclude non-reimbursable costs from our margin calculations, which means we exclude bereavement costs and the non-reimbursable portion of volunteer costs. If those costs were included in our margins, it would reduce the estimates by, at most, 1.6 percentage points.

Next we have margins by category of hospice provider. Before we go through these numbers, one thing to keep in mind is that the payment reforms that occurred in 2016 are not reflected in the 2015 margins, but we will have a slide later with some information on the 2016 effects.

So, in 2015, freestanding hospices continue to have strong margins, 13.8 percent. Provider-based hospices had lower margins than freestanding hospices.

The chart also shows margins by type of ownership. For-profit hospices have substantial margins, 16.4 percent. The overall margin for nonprofits is 0.1 percent. Looking just at freestanding providers, the nonprofit margin is higher, at 5.0 percent.

One other point to note is that like other sectors we have calculated the marginal profit, which is the amount Medicare payments exceed the marginal cost of treating an additional patient. For hospices, the marginal profit is estimated to be 13 percent in 2015.

Next we show what's underlying some of the margin differences. On the left, we have the relationship between length of stay and hospice margins. And as you can see,

providers with longer stays had higher margins in 2015.

In the right chart, we show how margins increased with the percentage of patients in nursing facilities. There may be a number of advantages to the nursing home setting, including access to patients that have conditions associated with longer stays, economies of scale from treating patients in one location, and overlap in services provided by the hospice and the nursing facility.

So, as I said, our 2015 margin estimates do not reflect the 2016 payment system changes for routine home care. To estimate the effect of the 2016 payment changes, we compared 2016 actual payments to what we estimate 2016 payments would have been if the old payment system had continued. And as you see from the numbers on the chart, the new payment system led to modest changes in payments for provider groups. As expected, the effects varied by providers' length of stay. On average, payments increased about 3 percent for the 20 percent of hospices with the fewest long-stay patients while payments decreased, on average, about 3 percent for the 20 percent of hospices with the most long-stay patients.

The effects by category of provider, like type of

ownership, provider-based vs. freestanding, and rural and urban, are modest, but in the expected direction given the mix of patients these providers treat.

When the Commission commented on the hospice proposed rule for changes to the payment system, the Commission stated that the payment system changes were modest and left room for additional changes. So this is something that we could consider in the future.

So next we have our 2018 margin projection. To make this projection, we start with the 2015 margin, and we take into account the market basket updates, including productivity adjustments and additional legislated adjustments in 2016 and 2017, and the 1 percent update mandated in 2018 by the Impact Act. We also take into account the phase-out of the wage index budget neutrality adjustment and other wage index changes, and we take into account the implementation of the new payment system.

Taking all those factors into account and assuming cost growth consistent with historic trends, we project a margin in 2017 of 8.7 percent.

So to summarize, indicators of access to care are favorable. The supply of providers continues to grow,

driven by for-profit hospices. The number of hospice users and average length of stay among decedents has increased. We have limited quality data but those data are generally favorable. Access to capital appears adequate. The 2015 aggregate margin is 10.0 percent, and the 2015 marginal profit is 13 percent, and the 2018 projected aggregate margin is 8.7 percent.

So this brings us to the Chairman's draft recommendation, and it reads: The Congress should eliminate the fiscal year 2019 update to the hospice payment rates.

Given the margin in the industry and other payment adequacy indicators, we anticipate that providers can cover cost increases in 2019 without any increase in their payment rates. So this recommendation is expected to have no adverse impact on beneficiaries nor providers' willingness or ability to care for them.

So that concludes the presentation.

DR. CHRISTIANSON: Thanks, Kim. Questions for Kim? Brian, Jack, Rita. Okay. A lot of questions. Let's start with Brian and go around.

DR. DeBUSK: Thank you for a very well-written

chapter.

I have two questions. The first, you know, the 53 percent live discharge rate is fairly ridiculous. Well, again, miracle workers. But are there certain conditions that are more susceptible -- I mean, it does suggest, a 53 percent rate does suggest that there's some gamesmanship and possibly even a program integrity issue.

But my question is, are there incoming conditions that are more susceptible? You know, for example, say, you know, a Stage 4 pancreatic cancer, I don't see a lot of opportunity to gain hospice care there. But are there other conditions that are more susceptible to gaining? Could we identify them? Could we focus program integrity efforts in a more concentrated way?

And then my second question was, I noticed you mentioned some changes to the wage index. Do you mind elaborating a little bit on what they're doing and the impact of those adjustments?

MS. NEUMAN: Sure. So on the first point about live discharge rates, it is true that live discharge varied -- rates varied by diagnosis, and so there are some diagnoses, by nature of, I think, both the fact that some

conditions are more unpredictable and also that those conditions are then attractive to focus on. It means that you are going to see some variation in live discharge rates, both across the type of patient and then also across providers, in terms of how they choose to select patients.

DR. DeBUSK: Is there evidence that these providers may be target or focused, or try to go after these more nebulous conditions?

MS. NEUMAN: It's hard to sort of speak to how they're going about recruiting their patients. What I can say is that we have different providers that have very different mixes of patients.

You had a second question, which was on the wage index. So the biggest thing that has occurred, and it's been going on over a seven-year period, is there was this thing called the Wage Index Budget Neutrality Adjustment, and it had to do with switching from out outdated wage index to a more current one. And in the process, they agreed to give the hospices an adjustment. It basically increased their payments about 4 percent. And they kept that in place for a number of years.

And so CMS back -- I believe it started in 2010 -

- decided to take that extra payment away. And so it's been phasing out, and 2016 was the year where it got completely phased out. So after this year, we won't be talking about the sort of phase-out anymore. It's done.

DR. DeBUSK: So they got to use the raw wage index calculation before the budget neutrality requirement was imposed on it.

MS. NEUMAN: They got -- how it worked is they switched to a more accurate wage index but that would have led to lower payments, and so the government said, okay, we're going to get you to this more accurate wage index and we're going to compensate you because we know that -- and give you an extra 4 percent. And then, over time, we've taken that extra 4 percent away.

DR. CHRISTIANSON: Okay. Let's keep on going up this way, so Jack, you're next. We'll go around.

DR. HOADLEY: So I'm looking at Slide 15 on the margins, where you've got some pretty disparate margin comparisons in some of the categories. And then your discussion, a couple of slides later on what it would look like, or what the implications of the 2016 phase-in of the new system. Am I correct to read the numbers that you

showed there, which were about payment changes, not about margin changes, to suggest that these margin differences might shrink a little bit, say between freestanding and hospital-based, or for-profit and not-for-profit, but the basic pattern of some pretty wide differences would persist?

MS. NEUMAN: Yeah, that's correct.

DR. HOADLEY: Okay. I want to come back to that on Round 2.

DR. CHRISTIANSON: Okay. Dana, did you have any questions? No? Okay. Warner.

MR. THOMAS: Do you have any insight or can you come to any conclusions about the significant acceleration in for-profit hospice versus the flat and/or declining in not-for-profit or governmental?

MS. NEUMAN: So the sort of market entry of for-profit providers for a really sustained period of time has always raised the question of whether sort of the profitability available in this industry has been a draw for more and more providers.

DR. CHRISTIANSON: Is that it, Warner, or do you want to follow up? No? Okay. Rita.

DR. NERENZ: Obviously a draw for some certain types of providers but not all.

DR. CHRISTIANSON: Thank you, Rita.

[Laughter.]

DR. REDBERG: Any time.

DR. NERENZ: I just had the thought.

DR. REDBERG: Thanks for the great chapter. I'm curious. You mentioned in the mailing materials that there's a substantial increase in payments to the social worker and nurse in the last seven days of life. Is that applied retroactively, or how does that exactly work?

MS. NEUMAN: Right. So what happens is after the patient has passed, then they look at the claims and they find the last seven days of life, and retroactively they see what visits were provided by registered nurses or social workers in that period and then they pay the extra amount for those visits. So it is exactly retroactive.

DR. REDBERG: What is the rationale for that?

MS. NEUMAN: So the idea was that they wanted to provide additional money at the end of life to recognize the higher intensity of needs at that time, and there, at the same time, is concern that some hospice providers may

not be providing many visits at the end of life. There's some data that suggests that there is sort of variation in how much services is provided at the end of life.

So the idea was that if you paid fee-for-service for the nurse and the social worker visits with a cap, but paid fee-for-service in those sort of last seven days, that you would target the money better toward those providers that were furnishing services.

DR. REDBERG: I won't belabor it more, but it's hard to know what are the last seven days of life. So I just wonder how well that's achieving that effect, unless offering more services.

DR. MATHEWS: So I could weigh in a little bit here, if you don't mind.

DR. REDBERG: Sure.

DR. MATHEWS: So our work on hospice goes back for the better part of a decade here, and you've been around for a good half of that period of time. But we have established the fact that while Medicare paid an unchanging per diem rate throughout the course of a hospice episode, that costs incurred by the hospices were higher at the beginning of the episode when the patient was being taken

into a hospice care and then at the end when the intensity of interventions in the form of nursing care, social work because more substantial

So we made a recommendation back in 2009, 2010, thereabouts, to change the hospice payment system from a linear approach to one where the payment varied, higher at the beginning of the episode and higher at the end and lower in the middle. And CMS has tried to do that in the most recent revisions to the payment system. They pay a higher per diem rate for the first 60 days, a lower rate for the days thereafter, but obviously, you can't predict when the patient is going to pass and, thus, when those higher rates need to be put into effect.

So the notion of a retrospective per-visit payment for the last seven days is the agency's attempt to reflect the U-shaped distribution of hospice's costs, and it is not inconsistent with at least the conceptual approach that we identified a while back. Obviously, people can take issue with whether that's the best approach or whether there are alternatives, but it is an attempt to recognize the uneven distribution.

DR. REDBERG: Thanks, Jim. That's helpful.

And I do remember our discussions about the terminal. Maybe we can at another time -- I just wonder if there is any literature on it because we're all not great at predicting the end of life, and I wonder if there is any literature on actually asking nurses and hospice providers, do they think this is the last seven days, and then going back and looking at it, because the only way that would really work to increase visits is if we're really good at predicting that. And I'm just not that certain we are.

My other question, which I think is simpler, is just on Slide 13, and it's kind of related. But do you have any estimates for the number of hours in the routine home care, general inpatient care and inpatient respite care, which are -- you've given the average cost per day, but I'm wondering usually how many hours of care are we talking about in those categories.

MS. NEUMAN: So routine home care, how routine home care works is that it's a daily rate, and then they give a certain number of visits a week, depending on the patient's needs. So a patient might get four visits a week, and those visits tend to be maybe an hour, hour and 15 minutes, depending on the type of provider. So you

might get a couple nurse visits and a couple aide visits a week and roughly an hour-ish, about.

I don't have information for you right now on hours of care for general inpatient in terms of how much nurse care or aide care, that kind of thing, but general inpatient is not just those services but then also having the patient in a facility, which means sort of like hospital level-of-care kinds of standards. And so that's both the facility piece and the sort of service piece that's reflected in that line item.

Continuous home care, on the bottom, that's when you get -- it's paid at an hourly rate because you're getting at least eight hours of care in the home, and that tends to be somewhere between 16 and 20 hours of care, but again paid on an hourly basis.

DR. REDBERG: For just the routine home care, is that paid per hour, or is it just 124 if you've had any visit in that day, no matter how long it was, 10 minutes or 2 hours?

MS. NEUMAN: So routine home care is a daily rate paid, regardless of what services you receive on a day. There will be some days where you don't get visits, but we

pay that rate regardless, and the idea is that it's compensating for visits that occur when you're a patient but also for drugs and someone being able to call and ask questions, durable medical equipment, and the supports that go around these patients as well.

DR. REDBERG: Thank you.

DR. CROSSON: Questions. Bruce.

MR. PYENSON: Thank you very much, Kim.

In the ownership category, we split out for-profit and not-for-profit and some other categories. Anecdotally, I have observed that many home health agencies also overlap and provide services for hospice. Some of the services perhaps seem similar, and I'm wondering if it's possible to look at the overlap of ownership between home health agencies and hospices under the same corporate umbrella.

The connection there I think is -- of course, re recommended a decrease in home health, is I think the Chairman's recommendation, and here we have another set of -- another silo that's perhaps not such a silo. And we're also -- I think the Commissioner's recommendation is no increase.

So rather than viewing these as totally separate entities, I'd be very curious what the corporate overlap is. I don't know if that's possible to look at and whether my anecdotal observations have any merit.

MS. NEUMAN: So you're interested in the sort of providers that we have serving the hospice population and to see what share of them also provide home health services? So a provider-level rather than a beneficiary-level analysis?

MR. PYENSON: Correct.

Now, Kathy just pointed out to me on page 15, 11 percent -- I think that's of agencies -- are home health-based.

MS. NEUMAN: That means that they fill out a home health-based cost report, so that gives you a sense, but you could still fill out a freestanding hospice cost report but be under the corporate infrastructure of a company that has multiple lines of business including home health. So it would be pretty complicated to figure this out.

MR. PYENSON: Okay. Thank you.

DR. CROSSON: Amy.

MS. BRICKER: Thanks for the chapter. I found

this topic exceptionally fascinating and had a number of questions for clarification.

When we talk about length of stay and cost, is that the beneficiary level, meaning if I come in and out, enroll, disenroll, enroll, disenroll, are costs and length of stay just per enrollment period or actually tracked at the beneficiary level?

MS. NEUMAN: The length-of-stay figures that you see in all of our documents, we calculate a lifetime length of stay, and so we're tracking all the beneficiaries' days while they're a beneficiary in hospice, whether they come in and out multiple times. We just keep counting.

On the cost, can you say a little bit more about which costs you're interested in?

MS. BRICKER: Just that -- I think you've answered the question. You're looking at it from a lifetime from statistics associated with hospice episode, costs, or length of stay. You're saying you're following the patient if they're coming in and out of hospice and costs associated with them, caring for them.

MS. NEUMAN: Right. And the one exception I would say is that a lot of our data is sort of focused on -

- the cost data is focused on 2015, and so that data that you see here, like on this chart, this is 2015 costs, not looking at earlier years or later years.

MS. BRICKER: Do we know of the entities which are physician-owned?

MS. NEUMAN: We don't. I don't know. Is there a way for us to get at that?

DR. DeBUSK: [Speaking off microphone.]

MS. BRICKER: The Stark applies? Is that what you said? I'm just curious if we could get a -- if any are physician owned and what the attributes of those provider types are, associated with sort of what a standard -- the gold standard is for quality and all the things that we've talked about in the chapter around questionable practices, like live discharges or those that are hitting caps.

Okay. Last question. On that point, around those, in the chapter you talk about hitting the caps and more of the for-profit entities hit the caps than not. Is it the similar group that's also then in the 10 percent that have the high live discharge? Is there a correlation there between those two?

MS. NEUMAN: So hospices that exceed the

aggregate cap have a substantially higher length of stay and live discharge rate than other providers. So I haven't overlapped the groups literally, but statistically, live discharge rates are substantially higher. So, yes, it puts them at the end of that distribution of live discharges.

MS. BRICKER: Great. Thank you.

DR. CROSSON: David.

DR. GRABOWSKI: Great. Thanks, Kim. This was a great chapter.

I wanted to ask you about Slide 16, please. I wanted to ask you about, in particular, the high margins for the providers that are offering services in nursing homes. You offer a few explanations here -- potential economies around travel time, the ability to leverage nursing home staff, maybe it's a different diagnosis profile or longer length of stay.

I wanted to ask you about another explanation. I know several of the large nursing home chains own their own hospice, and how much of that is going on here and really gets at maybe what Bruce was pushing around, home health? I'm also worried about corporate overlap here, with nursing homes owning their own hospice. I don't know how frequent

that is, but I do know that several of the large ones own their own hospice. And how much of that is driving some of what we're seeing here?

Thanks.

MS. NEUMAN: We haven't been able to isolate that effect. That is a question, and people raised concerns about sort of this overlapping ownership.

I would say that we still see this pattern in nonprofit providers. So there could very well be something to the overlapping ownership, but there's also something more going on.

DR. GRABOWSKI: And just to follow up on that, there's also this overlap with assisted living, and I don't believe there's any assisted living companies that own their own hospice. So it's certainly something about the care there, but in a 2013 report, I know MedPAC suggested potentially making adjustments and payment across kind of care delivered in nursing homes versus elsewhere, and that's something that we may want to revisit at some point.

Thanks.

DR. CROSSON: David and then Kathy.

DR. NERENZ: Just to follow on that line of

questioning and maybe sharpen the point, is there a formal prohibition against double billing? Let's say you've got a patient in a, say, skilled nursing facility in hospice. First of all, can that situation occur, just in terms of program eligibility, and if it does occur, can the two different programs be billed for the same patient, same day?

MS. NEUMAN: So a couple of things. When you're looking at that chart, that is largely long-term nursing home patients, not skilled nursing facility.

DR. NERENZ: That's why I tried to phrase the question specifically --

MS. NEUMAN: Yeah, yeah.

DR. NERENZ: -- just because I'm trying to look for this in the Medicare program.

MS. NEUMAN: Right. So, technically, a patient can receive hospice and SNF at the same time if they're getting the SNF services for an unrelated condition. So there is some overlap. It doesn't happen often.

DR. CROSSON: Kathy.

MS. BUTO: I was just going to go back to David's question because I think these are essentially not Medicare

nursing home or SNF. It's Medicare, right? So were you trying to get at -- I was trying to understand your question. Were you trying to get at the issue of double billing or inappropriate referrals, I guess, to hospice?

DR. GRABOWSKI: Correct. So I don't think this is an issue, as Kim just noted, across the SNF benefit in hospice. It's more around the sort of long stay, and just this idea of this joint ownership issue. So it's really not about the SNF benefit.

Medicaid programs do adjust their payment when someone goes into hospice. Most do, anyway. They pay for room and board, but not the services.

MS. BUTO: One could argue that it's actually an efficiency or a service that ought to be provided by nursing homes because of the nature of the population. I'm just trying to get at what you were --

DR. GRABOWSKI: There's absolutely economies. It's just about getting the payments right, I think.

DR. CROSSON: Kim, I actually have a question. I apologize if I missed this in the material, but over the last few years, we've been taking a look at what I call "diagnosis creep," particularly in the area if dementia and

other neurologic diseases and its potential impact on length of stay. Is that continuing stabilized or what?

MS. NEUMAN: We have seen -- it's pretty similar, the diagnosis profile, from this year to last year. I think if we just -- if we categorize cancer and non-cancer, I think non-cancer climbed up maybe a percentage point. Maybe it's three-quarters now of all our patients are non-cancer, so it's gone up just a tad. So I think it has stabilized some.

DR. CROSSON: Okay, thanks.

So let's have the recommendation put up on Slide No. 20, and we'll entertain comments on the recommendation.

I see Jack.

DR. HOADLEY: So it seems like this is one of those areas that we talked some about yesterday where I think, David, you were the one that kept talking about "I wish we could do differential updates across some of the categories," and I think I've raised that same point a couple of years ago.

The payment reforms were supposed to help address that, and I think you said during the presentation that -- you kept using this term like what CMS did was

directionally consistent with our recommendation, suggesting that it was perhaps not fully reflective of what we recommended, and that potentially that was something to look at further.

So, I mean, I think the recommendation, as such, given the constraints that we operate under and disinterest in any kind of differential update is a sensible place to be, but it does suggest that we should be looking back at whether there's a way to say something further about the payment structure, if that's the better way, as it probably is, to sort of address this clear discrepancy between the profitability and some of the other characteristics for the different types of providers.

DR. CROSSON: Just a comment on that, and it has to do with perhaps this traditional but potentially artificial division in our work, which is we work a number of months in the year on policy issues, and then we work two months of the year specifically on update issues. For better or worse -- and I don't have a judgment on this per se, but the tendency has been over the years to say, well, if we feel like there should be differential payment, let's address that, as in this case, through some policy

recommendation, which is separate from our update recommendation. And then when we come to the update recommendations, let's make one update recommendation across the board taking into consideration the fact that we have either recommended or we have seen either CMS or Congress act on former policy recommendations that then shift that update and redistribute.

And I think the reason for that predates any thinking that I've done, but I think the reason for that is the acknowledgement that the process of doing differential updates is very complicated. Once you start saying, well, we're going to have this segment and that segment and this segment and that segment, then a lot of the discussion gets into whether the segments are appropriately distributed, whether issues have changed from year to year to year. And the process of doing the updates in this relatively constrained time frame that we have, which is two months -- let's do it in December and January -- becomes more complicated.

I think, to some extent -- I think we got at it a little bit yesterday, but in some cases, we may want to depart from that a little bit, and I think that's something

that over the next year or so, we should discuss.

Again, we've done it one way all the time, doesn't mean we have to do it, but there is -- there has been a rationale for doing it this way. And as a consequence, when we get into the December-January piece and we're just looking at the updates, it can be -- as you say, it can be very frustrating, "Well, why can't we do it differentially?"

We understand that, and we've tried to approach that through a different mechanism, through the other parts of our work, but that's not always satisfying, and it's not always effective.

DR. HOADLEY: We've probably come close on the physicians where we talk about primary care and specialty.

One of the challenges here is that sometimes the categories are maybe surrogates for something. I mean, we say for profit, not for profit, or we say urban and rural. Not all urbans are alike. Not all rurals are alike. And we're probably not comfortable saying, "Well, gee, we're going to give this update to urban hospices and this update to rural or for profit and not for profit." We'd like to get down to something that's more driven by the nature of

what they do than these sort of more artificial categories. The line between what's for profit and not for profit may be very clear on an IRS basis, but behaviorally, it's not always so clear.

DR. CROSSON: And it's exactly why it's complex.

Yeah. Kathy.

MS. BUTO: I was just going to say I think another way to go at this is to look underneath what's driving the difference. So if there's a higher percentage of live discharges, that may be -- and that's driving profitability, for example, or the kind of diagnoses that are, I guess, shown by the type of facility, we ought to look at that.

So I'm wondering -- I'm a little nervous about starting down the road of making a differential update when there's some underlying issues that maybe can get at that, and then I'm also aware of the fact that we're trying to move in the direction of site-neutral payments in other ways in order not to prejudice the site that's providing the service.

So I think we have to weigh all these things, but I would really like to see us get underneath some of these

differences as we consider things like a differential update.

DR. HOADLEY: It seems like the U-shaped payment model was exactly intended in that direction, and so that's why -- and I think you raised appropriately -- the issue of was it done as far as we might have envisioned, could it be done -- was it enough? Do we take another look and see whether there's a different way to tweak that?

Again, we've seen this in the PAC where the PAC proposals we had do, in fact, shrink some of the differences that are bothering us when we look at these summary measures.

DR. CROSSON: Okay. So I think, once again, here we're seeing a relatively uniform consensus in favor of the recommendation at this time, and so we'll bring this forward through expedited voting in January.

Kim, thank you very much. Nice presentation. Nice discussion.

So now we'll move on to our final presentation and discussion for the December meeting, and that's on the Medicare Advantage program.

[Pause.]

DR. CROSSON: Okay. Medicare Advantage program presentation in December and January is somewhat different from the others in the sense that we don't make an update recommendation per se. The Medicare Advantage payment program is set in law in a different way. But we do review the program, and in this particular case we will be making some recommendations of a policy nature as well.

So we've got Scott, Carlos, and Andrew again. Andrew has been doing a lot of work. And Scott, it looks like you're going to start out.

DR. HARRISON: Good morning. I would like to thank Emma Achola for her work on the chapter.

I am going to present our analysis of the Medicare Advantage enrollment, plan availability and bids for 2018. Then Andy will give you an update on risk coding intensity. Finally, Carlos will talk about MA quality, and will have the Chairman's draft recommendations on the quality stars and contract consolidation.

We haven't described MA payment policy in a meeting for a meeting for a while, so I think it's time to do it again.

Plans submit bids each year for the amount they

think it will cost them to provide Parts A and B benefits. There is a separate bid for part D drugs, but the MA plans just get paid for D as if they were standalone Part D plans. Each plan's bid is compared to a bidding target or "benchmark." CMS sets county-level benchmarks based on the county-level fee for service spending. These benchmarks range from 115 percent of fee for service in the lowest fee for service spending counties to 95 percent of fee for service in the highest-spending counties.

A plan's benchmark is its enrollee-weighted risk-adjusted average of the county benchmarks. Plans that reach certain quality bonus levels can have their benchmarks raised by up to 10 percent. Carlos will discuss the plan quality bonuses shortly.

If a plan bids above its benchmark, Medicare pays the benchmark and the beneficiaries make up the difference with a premium. If a plan bids below its benchmark, Medicare pays the bid plus a rebate, calculated as a percentage of the difference between the bid and the benchmark. The rebate percentage ranges between 50 percent and 70 percent, where plans with higher quality ratings are awarded higher rebate percentages. The rebate must be used

by the plan to provide extra benefits to the beneficiaries. These extra benefits can take the form of reduced premiums, reduced Medicare cost sharing, or additional non-Medicare benefits.

Now let's talk about enrollment. In 2017, MA enrollment grew 8 percent to 19 million enrollees. The 8 percent growth figure is higher than last year's 5 percent growth and higher than the average 7 percent annual growth we have seen over the prior few years. Now, 32 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans. Since 2007, MA enrollment has more than doubled and plans project continued growth for 2018.

If we split enrollment by plan type, enrollment in HMOs grew 5 percent while local PPOs had a big year this year, growing by 800,000 enrollees, or 19 percent. Regional PPOs, however, grew by only 3 percent. All of these figures are significantly higher than the 1 percent estimated growth rate in fee for service enrollment for 2017.

In 2018 Medicare beneficiaries have a large number of plans from which to choose and MA plans are available to almost all beneficiaries. On this chart you

can see trends over the last few years, but to save time let's just walk down the 2018, or right-hand, column. Ninety-nine percent of Medicare beneficiaries have at least one plan available. Forty-one percent have a private fee for service plan available, down again, and a continuation of the expected decrease resulting from pre-PPACA legislative changes.

The average number of plans available in each county remained at 10, but when weighted by the number of beneficiaries in each county, the number of average plan choices available to the average beneficiary is 20, which is the highest number during the seven-year period. Finally, the average rebate that plans have available for extra benefits in 2018 has increased to $95 per member per month, the highest level during this time period.

Using plan bids, we estimate that in 2018, MA benchmarks, bids, and payments, including quality bonuses, will average 107 percent, 90 percent, and 101 percent of fee for service spending, respectively.

While plan bids average 90 percent of fee for service, that number is kept down because HMOs are bidding 88 percent of fee for service, on average. The other plan

types bid much higher and local PPOs are bidding at 99 percent of fee for service, although that is down from 101 percent last year.

However, I would like to point out that SNPs, who have enrollees with the highest average risk, bid well below the risk-adjusted fee for service spending. But overall, Medicare is paying more than fee for service. This is due to the benchmarks averaging 107 percent. Quality bonuses, which are included here, raised the benchmarks by 4 percent, and the payments by 3 percent.

Finally, note that all the numbers on this slide assume that risk differences are properly accounted for, and next Andy might say that not all risk is properly accounted for. We'll see. Not to spoil his findings too much, but if the coding intensity was properly accounted for, payments would average 103 percent of fee for service.

And, finally, we find that payments for MA enrollees are roughly equal to payments on behalf of fee for service beneficiaries, if payments due to quality and excess coding are set aside.

Now Andy.

DR. JOHNSON: Medicare payments to MA plans are

unique to each enrollee. Payments are the product of two factors. The first is a base rate that Scott described earlier. The second is a beneficiary's risk score, which is a standardized measure of expected spending, and it adjusts the base rate by increasing payment for beneficiaries who are more sick and therefore expected to have greater health care expenditures, and vice versa.

The risk model includes information about each beneficiary's demographic characteristics and certain medical conditions. These conditions are identified by diagnosis codes and grouped into HCCs. Risk scores are the sum of the relative spending amounts associated with each demographic and HCC component. The more HCCs that are indicated for a particular enrollee, the larger the risk score and the larger the associated Medicare payment will be for that enrollee.

The components in the risk model are estimated using fee for service data, and therefore reflect the spending and diagnostic coding patterns in fee for service Medicare. Most HCCs are identified through physician and outpatient claims, which in fee for service Medicare tend to be paid based on procedure codes and provide little

incentive to document diagnoses for fee for service beneficiaries.

In MA, however, payment is tied directly to the number of HCCs identified, so there is a significant financial incentive to documenting all diagnoses. We have consistently found higher rates of diagnostic coding in MA compared to fee for service Medicare, such that enrollees of equivalent health status have higher risk scores when enrolled in MA, and therefore generate greater Medicare spending.

The divergence in MA and fee for service risk scores has grown year after year; however, this year we found that fee for service risk scores grew faster than prior years and the fee for service growth rate matched the rate of growth for MA risk scores. Risk scores for MA enrollees continued to be higher than comparable beneficiaries enrolled in fee for service Medicare, but the size of this difference remained roughly the same as it was in the prior year.

Our analysis of this issue is somewhat complicated by the transition from an old HCC model to a new model, where a blend of the two models was used for

payment in 2014 and 2015. The difference between MA and fee for service was increasing by 1 percentage point per year up to 2015. The first row in this table shows that the difference for the old model increased from 8 to 9 to 10 percent, and the last row shows that the difference for the new model increased from 7 to 8 percent.

In 2016, only the new model was used for payment to MA plans. The MA risk scores remained 8 percent higher than fee for service. An overall impact of 8 percent is a decrease from 10 percent for 2015. This decrease is due to the transition from the old to the new HCC model and the fact that fee for service risk scores grew faster in 2016 than in prior years.

Since 2010, CMS has reduced all MA payments to account for coding differences. In 2016, CMS reduced MA risk scores by the mandated minimum amount of 5.41 percent. After accounting for this adjustment, we find that 2016 MA risk scores were inflated by between 2 and 3 percentage points relative to fee for service, due to coding differences.

Finally, I will note that in 2016 it was the first year that encounter data was used, in part, for MA

risk scores and payment. The impact of encounter data was small and is reflected in the numbers presented here. I will be happy to discuss this topic more with questions.

Now I will turn it over to Carlos to discuss MA quality and contract consolidations.

MR. ZARABOZO: As part of the MA update, we usually report on year-over-year changes in MA quality. We look at individual measures and the star ratings that are intended to be a summary measure of the overall quality of a contract. The measures are reported at the contract level for star ratings that are determined at the contract level, so the MA contract is our unit of analysis.

However, the MA contract as a unit of analysis no longer provides sufficiently accurate information on MA quality, because of a practice we have been tracking over the past several years. In the past five years we have seen a wave of contract consolidations that combine one or more contracts into a single contract, thereby significantly changing the composition of enrollment in a contract. This limits our ability to make year-over-year comparisons at the contract level.

There are, at times, good reasons for MA

contracts to be consolidated. For example, if one company buys another company and both operate an HMO in the same county, it would be reasonable to combine the two contracts, though there could also be reasons for continuing separate contracts.

More often than not, contract consolidations have been undertaken to obtain additional bonus payments. In MA, plans receive bonus payments for contracts with a quality rating of 4 stars or higher on the 5-star scale. The bonus takes the form of an increase in the benchmark. New star ratings are announced in October of each year.

There is a timing issue that allows plans to maximize their bonus revenue through consolidations. MA bids are due in June of each year for the coming payment year. Bonus status is determined based on the most recently available star ratings. For the bids submitted in June, the star rating is the rating released the preceding October.

Because plans know the bonus status of each contract when bids are submitted, this prior knowledge allows companies to move contracts from non-bonus status to bonus status via contract consolidations.

After bids are submitted for the following payment year, CMS posts more up-to-date star ratings on the Medicare Plan Finder web site beginning in October.

In the past five years, there have been 140 contract consolidations, including 108 contracts moving from non-bonus status to bonus status.

4.1 million enrollees have been moved to bonus status—about 20 percent of total MA enrollment. Although the share of enrollment in bonus level plans is reported as being in the 70 percent range, the actual percentage is smaller because lower-rated contracts are being absorbed by higher-rated contracts through consolidation.

The highest level of such movement has occurred in the current cycle, with 17 contracts moved to bonus status, affection 1.4 million enrollees, or about 8 percent of the total MA enrollment.

Here is an illustrative example of how contract consolidation works. We begin with three contracts in three different, non-contiguous states, but only one of which has a bonus-level rating, at 4 stars. Currently in the Medicare Advantage program, there is no requirement that the geography that comprises an MA contract must be

made up of contiguous areas. In this example, the company uses the consolidation strategy to combine all three contracts under one contract. The surviving contract is the Maine contract, shown as contract #1. After consolidation, contract #1 includes all enrollees in three different states, Maine, Missouri and Hawaii, but the company will set up individual plans in each state so that each state has a separate MA bid.

Previously the company submitted three bids because there were three contracts; now they are submitting three bids under one contract. Every bid will have a benchmark based on local county rates with the 4-star bonus included.

In addition, during the annual election period going into the year when the three contracts are combined, Medicare Plan Finder will immediately show the Maine star rating of contract #1 as the star rating for beneficiaries looking to enroll in this contract in Missouri or Hawaii. This is true under current policy even though the Missouri and Hawaii contracts have an updated star rating that could have been shown on Medicare Plan Finder.

Although this is an illustrative example, the

configuration shown here is not unusual. The box in the lower left shows some of the state combinations that we see in this year's round of consolidations. The illustrative example, and the actual cases, highlight why using a weighted average of the stars of combined contracts is an unsatisfactory way of dealing with the issue of consolidation. A weighted average approach would drop the Maine contract to 3 stars and keep Missouri and Hawaii at 3 stars even though the Maine plan is operating at a 4-star level of performance.

The contract consolidations to boost star ratings give rise to a number of concerns. One of those concerns is the added program expenditures that are incurred when moving enrollees to bonus-status plans.

Another concern is the inaccurate information conveyed to Medicare beneficiaries looking at quality indicators in Medicare Plan Finder. A consumed contract immediately acquires the star rating of the surviving contract, even when the surviving contract had operated in a totally different geographic area. Then, in the following year, when quality results are based on results from combined geographic areas, the quality data is not

necessarily representative of the performance of the plan in the beneficiary's local area.

Finally, the consolidation process allows plans to gain an unfair competitive advantage in local market areas. If two different companies serve one market and only one has a 4-star rating based on its local area performance, it should have the difference shown in Medicare Plan Finder, and it should be able to offer a better benefit package because only that plan should be the contract that has a benchmark that includes bonus payments.

When contracts with low star ratings are consumed by higher-performing contracts, and the majority of enrollees are in the lower-performing contract, the combined contract is likely to eventually end up having a lower star rating. One could argue that this would make the consolidations to boost star ratings an issue of concern only in the short term.

However, what a company can do in such a case is to re-consolidate. That is, if a consolidated contract ends up having a star rating under 4 stars, what the company can do is have the surviving contract consumed by a different contract.

This slide illustrates how that would work. In this illustrative example, at the beginning of 2013, this company has 21 contracts. At the end of 2013, it decides to consolidate two contracts, number H0001 and H0002 under a 4.5-star contract, H0003. The following year it decides to have H0003 consume an additional 17 contracts, contracts H0004 through H0020. Eventually, at the end of 2017, because the large contract's star rating has fallen below 4 stars, that large contract is, in turn, consumed by a different smaller contract that has a 4-star rating. So a contract that was the result of a consolidation of 20 contracts disappears by consolidation with a much smaller contract that now is the surviving contract for what were originally 21 separate contracts.

Although this is an illustrative example, this scenario is what actually transpired in this year's round of consolidations when a 4-star contract with 50,000 enrollees consumed a 3.5-star contract with 800,000 enrollees. The larger contract that was being consumed had already consumed 20 contracts.

To address the problem of artificially boosting star ratings through contract consolidations, we propose a

solution whereby the consolidation does not have an effect on star ratings and bonus payments. The ratings would be based on the pre-consolidation configuration of reporting entities.

We would also reiterate a long-standing recommendation of the Commission, dating from 2005, which calls for defining geographic units at the local market level. Stars would then be computed at the local market level.

The Chairman's draft recommendation number one seeks to address the immediate problem. The draft reads: For Medicare Advantage contract consolidations involving different geographic areas, the Secretary should require contracts to report pre-consolidation quality measures and determine star ratings as though the consolidation had not occurred, until such time as quality is reported at the local geographic level.

The spending implication of this draft recommendation is that there should be savings relative to current policy.

As for the effect on beneficiaries and plans, for beneficiaries that improve the accuracy of information on

plan quality, but results in a lower level of extra benefits in some plans. For plans that would be reductions in bonus payments but it would level the playing field for contracts that compete against contracts that acquired their bonus status solely through a consolidation.

The second Chairman's draft recommendation would address the consolidation issues but also improve the reporting of quality in MA.

It reads: The Secretary should establish geographic areas for Medicare Advantage quality reporting that are accurate reflections of health care market areas, and calculate star ratings for each contract at that geographic level.

The implications for spending are uncertain, and depend on the distribution of star ratings in each year.

As for beneficiaries and plans, beneficiaries will have more accurate information on plan quality, and for plans, the draft recommendation would increase the reporting burden for measures that are based on medical records sampling or member surveys.

That concludes our presentation. We look forward to your questions and discussions.

DR. CROSSON: Okay. Thanks very much.

We have a report on the table, and we have two recommendations. Let's take clarifying questions.

Brian.

DR. DeBUSK: First of all, congratulations on a really well-written chapter, great work on really eliminating the cross-walking process. I think it's fantastic.

My first question is on page 6 of the presentation. The 107 percent payment or the inflation of the benchmark, could you walk me through just one time for my own edification the relative contributions of the different factors that get us to 107 percent?

For example, the quartile treatments don't add up to 100 percent. There's a little bit of bias introduced by the quartile adjustments. Then there's the quality bonus that would introduce an inflationary, and then there's the double-county bonuses that I think would be inflationary as well, but then there's also the fact that we calculate A-only spending, which would then actually pull the benchmark down a little bit.

Could you just walk me through the relative

contributions to get to 107 -- oh, and the coding adjustment. Could you just sort of walk me up and then back down to how we arrive at 107 percent?

DR. HARRISON: So the 107 here includes four points worth of quality. So, without quality, it would be 103.

DR. DeBUSK: Okay.

DR. HARRISON: So all of that is reflected by the quartiles. So the quartiles right now are at a -- if you just straight looked at the quartiles, you'd be at 103.

DR. DeBUSK: So 115 and 107.5, 195 --

DR. HARRISON: Right. When you enrollee -- not enrollee. Actually, this one is enrollee. When you enrollee-weight them, you'd get to --

DR. DeBUSK: Okay. Because you're applying 95 percent to the most expensive and 115 to the lease, so it does not introduce any bias.

DR. HARRISON: Right.

DR. DeBUSK: Okay. So quality is four.

DR. HARRISON: Yeah. And the A/B issue is not in here, and the coding is not in here.

DR. DeBUSK: Okay. So where's the other three?

DR. HARRISON: It's just that the quartiles themselves, if you were just to play it out, you'd end up at 103 because while it might have been nice for them to end it up at 100, they didn't.

DR. DeBUSK: Okay. So the quartiles introduce three.

DR. HARRISON: Yes.

DR. DeBUSK: And the quality introduces four.

DR. HARRISON: Correct.

DR. DeBUSK: And that's how we get to seven.

DR. HARRISON: Yeah.

DR. DeBUSK: Do the double-county bonuses --

DR. HARRISON: They're included in the quality.

DR. DeBUSK: Okay. So quality plus double-county is four --

DR. HARRISON: Right.

DR. DeBUSK: -- and quartiles -- sorry. I just -- for one time, I wanted to hear that.

My second question is --

DR. HARRISON: By the way, the quartiles probably also include -- they also include some cap reduction.

DR. DeBUSK: Okay. That's right.

DR. HARRISON: Remember there's this benchmark cap?

DR. DeBUSK: That's right.

DR. HARRISON: Yeah.

DR. DeBUSK: Okay. So quartiles plus cap net out to about three. Quality plus double-county bonuses net out to about four.

DR. HARRISON: Right.

DR. DeBUSK: And the fact that we're using A, incorporating A-only spending isn't factoring --

DR. HALL: Isn't in this, these numbers.

DR. DeBUSK: Thank you. It's nice for once to have it put to bed. I'll probably forget it by the next meeting. I apologize.

DR. HARRISON: That's all right.

DR. DeBUSK: On page 8, you make a reference to how the coding intensity in fee-for-service occurred at the same rate as MA did. Is there really any downside to us letting fee-for-service coding continue to improve? Because it seems like we would know more about the beneficiaries if it did, and it would decant off some of these MA overpayments, which I think is about $8 billion a

year. It would decant those off because we would be normalizing the model against a more accurate fee-for-service.

Could you speak to any downside? And also, why is the coding beginning to mirror MA? So, first of all, why, and is there any downside to this happening?

DR. JOHNSON: I'll start in the reverse order. I don't see any real downside. I think we've said that improving diagnostic coding and fee-for-service would be beneficial for both the beneficiaries and for this issue specifically.

As to why fee-for-service has increased in the last year, there's some speculation that there was some effect from the change to ICD-9 -- or ICD-9 to ICD-10, which was late in 2015, and there are some new payment policies in fee-for-service that we're going to look into, see if we can try and disentangle what effect those had, but that might include risk-adjusted benchmark in ACOs, risk stratification in the comprehensive primary care model, and some chronic care management codes, which require you to document that a beneficiary has multiple chronic conditions before you're able to bill for those

codes.

DR. DeBUSK: Thank you.

DR. CROSSON: Jon.

DR. CHRISTIANSON: I guess two questions. This is for Carlos.

Some of the information in the report talks about organizations, and doing the math, I get about 58 percent of the MA market and four organizations. Are any of the organizations particularly aggressive in terms of this consolidation?

MR. ZARABOZO: I'll say yes to that.

DR. CHRISTIANSON: Would you say more?

[Laughter.]

MR. ZARABOZO: I would say, looking at your list, the top two there --

DR. CHRISTIANSON: The top two.

MR. ZARABOZO: -- historically have been more.

DR. CHRISTIANSON: All right. So that's important. So it's not the small players that are trying to sort of advantage themselves.

MR. ZARABOZO: Often the small players cannot do this.

DR. CHRISTIANSON: What?

MR. ZARABOZO: Small players often cannot do this because -- I mean, if you're talking a real small player, they're just operating in a local market area.

DR. CHRISTIANSON: Okay.

MR. ZARABOZO: And they can't do that.

DR. CHRISTIANSON: And the second question is for Scott.

The past two days, we've been listening to the update recommendations, and we've been talking about implications for Medicaid. And it seems to always be preceded by for fee-for-service Medicare -- I said Medicaid; I meant Medicare -- for fee-for-service Medicare, which increasingly is not comfortable. I mean, we've got a third of our beneficiaries now in MA Medicare, and yet we're reaching our conclusions based on data for fee-for-service Medicare beneficiaries only.

So one thought is it's kind of a conspiracy theory that the three of you are in your offices, have the data for the MA, but you just don't share it with your colleagues. So that could be one possibility.

[Laughter.]

MR. ZARABOZO: We don't share it with each other.

[Laughter.]

DR. CHRISTIANSON: I like that even better.

So how can we get a more complete picture of what's happening in the Medicare program instead of just referring always to fee-for-service beneficiaries?

DR. HARRISON: What would you like to know? I guess I'm not sure what the question --

DR. CHRISTIANSON: Well, for fee-for-service beneficiaries, we know that certain fee-for-service beneficiaries get this service, don't get that service, and so forth, but for a third of the beneficiaries, we don't seem to know what's happening with them.

DR. HARRISON: Oh, that's good. I can punt this one to Andy on the encounter data.

DR. JOHNSON: I thought the question was addressed to you.

[Laughter.]

DR. JOHNSON: We continue to look at some of the encounter data with the hopes of addressing some of those issues, but to date, we haven't gotten as far as we would have liked. So we're continuing to look at that, and I

think -- I don't know. James, do you have any other -- Jim?

DR. MATHEWS: Yeah. So, if I understand the question -- and I'll repeat it, and you can correct me if I've misinterpreted anything -- you indicate that we look at utilization measures, spending measures for fee-for-service beneficiaries.

DR. CHRISTIANSON: Lots of things that are fee-for-service only.

DR. MATHEWS: Quality. Yeah, correct. And you're asking why we can't do that for -- inclusive of MA.

So I think we last looked at 2014 MA encounter data, and we determined that there were some issues with it that prevented its utility with respect to comparing MA payments to fee-for-service payments at the service level. It potentially has some utilization for being able to care -- compare MA utilization to fee-for-service utilization, and we're still exploring that.

But then we also determined that there were some potential issues with the completeness of the MA data with respect to whether or not MA beneficiaries were fully represented in things like IRF pie data or home health

OASIS data or MDS data in ways that they should be.

So we aren't sure that the state-of-the-art of MA encounter data would fully allow us to give a complete picture of the overall Medicare beneficiary population in a lot of these sectors.

DR. CHRISTIANSON: And I wanted to give you the opportunity to say all of that.

DR. MATHEWS: Okay.

[Laughter.]

DR. CHRISTIANSON: But we're not better off than we were many years ago, and we're making decisions based on pretty incomplete data in some cases when you have a third of the Medicare population where we don't see what's happening. That is increasingly disturbing to me as the rate of enrollment in the MA population grows.

DR. CROSSON: But you will dismiss the grassy knoll theory?

DR. CHRISTIANSON: Not yet.

[Laughter.]

DR. CROSSON: Okay. Let's move down this way. Pat and then Jack.

MS. WANG: I also want to commend you on a really

meaty chapter and particularly some of the transparency that was granted to the cross-walking phenomenon. It's amazing.

I wanted to ask you a couple of questions. You repeated or reiterated a couple of recommendations that MedPAC has made in the past to tier the coding intensity adjustment, whatever it is, to increase equity among plans. I wanted to ask you about that and also the recommendation on stars, the immediate action recommendation for 2018, whether that requires legislative action or whether CMS can undertake the coding intensity adjustment tiering on its own. Why don't we just start there.

DR. JOHNSON: Starting with the coding intensity adjustment --

MS. WANG: Yeah.

DR. JOHNSON: -- there is room in the law for the Secretary to address coding intensity above what it is currently doing. The law requires a minimum adjustment, which it has been applying.

Our recommendation from March 2016 did not formally discuss using tiers, but it was an option that was placed forward for addressing coding intensity that might

not be addressed by the two other parts of the recommendation, which were using health risk assessments or removing health risk assessments as a source of diagnoses and using two years of data.

That recommendation is still out there. It seems like it is within the Secretary's authority, but that's what we have.

MS. WANG: Okay, okay.

The other thing -- and maybe this isn't a legislative question so much as -- for the recommendation on stars, that would start with the 2018 stars, bonus year, for a cross-walk to contract to count the star ratings of each individual contract? Can CMS actually do that in 2018?

MR. ZARABOZO: Well, no. They can't do it for the bonuses payable in 2018 because that was the bidding process in June 2017.

Now, all of what we're talking about is secretarial discretion. So they determine how stars are assigned, whether or not people can consolidate, and what you do with the consolidation.

The proposed regulation that has just come out on

MA says what we'll do is a weighted average of the stars, but in terms of additional activities, as I mentioned, in October all of these contracts, whether consumed or not, got a new start rating because they submitted HEDIS data, for example, in June. They get a star rating, which as I said could have been used in January, as in this local area, this contract is now being consumed, this is how they performed.

MS. WANG: Okay. So just to clarify, then, the draft recommendation on page 17 for MA contract consolidations involving different areas, the Secretary should require contracts, blah-blah-blah.

MR. ZARABOZO: Right.

MS. WANG: I think in the paper, it said starting in 2018. Did I misread that?

MR. ZARABOZO: It may have said so in the paper, but 2018 in the sense of -- I mean, you could call it the consolidation cycle of 2018, that is the June 2018 bids for 2019.

But, no, they cannot affect the 2018 situation.

MS. WANG: So the soonest that recommendation would have a practical impact would be 2019 --

MR. ZARABOZO: Right, right.

MS. WANG: -- is when we'd see that. Okay. Thank you.

MR. ZARABOZO: Now, we didn't have a recommendation in May. I mean, this is the first appearance of the recommendation, so --

MS. WANG: I wanted to ask something that was related to what Jon raised about encounter data. The paper discusses the likelihood that encounter data would be more accurate in identifying risk scores, just because of the specificity of the information versus RAPS. Is there a reason not to recommend more of a -- the bigger phase-in of use relying encounter data? I know that there's some gaps for the areas that you described or that Jim described for IRF and all the rest. But do those really contribute to HCCs?

DR. JOHNSON: We have not found that they contributed significantly to HCCs.

The areas that Jim noted were mostly in the PAC sector, which are not used for risk adjustment.

MS. WANG: Mm-hmm.

DR. JOHNSON: We found that the risk scores for

using encounter data were slightly lower than RAPS, and in the paper, we discussed the reasons why that might be more accurate, is through the submission process.

MS. WANG: Okay.

DR. JOHNSON: An entire encounter has to be gone through a set of edits --

MS. WANG: Yeah.

DR. JOHNSON: -- and ensure that that encounter happened up front before it's used for risk adjustment, whereas that process is intended to happen after the fact in the RAPS part.

MS. WANG: Sure. Was there a reason, given what you just said, that you did not recommend greater reliance or faster phase-in to EDS?

DR. JOHNSON: We've heard from some plans that there is difficulty in the processing, and that some time is necessary to ensure that when encounters are submitted, if there is a need for them to be voided and replaced with a new encounter, there's some tracking processes that plans internally need to get up to speed on and might need some more time.

For that reason, the 2016 risk scores, which are

based on 2015 dates of service, CMS has included an extension to the amount of time they have to submit data, encounter data, for 2015 dates of service, and the idea is just a little bit more time, another year of processing and ensuring that when encounters are submitted, they're submitted once and accurate and then use them for payment.

So, at some point, I think we would support moving more towards encounter data for risk adjustment. As to when that is and when is enough time for plans to get processes in places sort of --

MS. WANG: Do you feel like based on the conversations that you've been having, because I think that you've been sort of poking at this -- more than poking -- digging -- that there is steady movement towards getting those processes into place?

DR. JOHNSON: From some small number of anecdotes, I would say yes, and from having reviewed some of the slides in question and answers that have come out from CMS on an EDS, encounter data in RAPS user group, that there are sort of a narrowing of issues, and that there is some learning going on.

I don't feel like I have a very close sense of

that, but from a 30,000 foot, it does seem like there's progress in the right direction.

MS. WANG: Thank you.

DR. CROSSON: Okay. So David and Brian wanted to come in on Pat's point -- and Jon too?

DR. CHRISTIANSON: No.

DR. CROSSON: Okay. Separate, okay.

All right. So David and then Brian.

DR. NERENZ: I was going to just extend Pat's question about the wording of what we have in front of us, and actually, I find I have two questions about the top part, so if it's appropriate to get into that.

As I read, I'm not sure I know what they mean. So, for example, you say, "We require contracts to report pre-consolidation quality measures." Well, it seems like they did. I mean, that doesn't change anything.

So I think what that must mean is that after consolidation, you want them to report the quality measures for the units that existed before consolidation. That's what that really means, right?

MR. ZARABOZO: That's right. That's what that means. As though the consolidation had not occurred, you

will continue to do what you had done in the past, in a sense.

DR. NERENZ: Okay. Well, I think I'd like, then, to see that wording cleaned up because it sounds like it's just saying they should do what they've already done.

So the second one, determine star ratings as though the consolidation has not occurred, but it doesn't specify how to do that. The consolidation takes multiple things and makes them one thing, but in the end, it is still the contract that has the star rating, so that it implies there's some method.

Now, you said weighted average isn't the right way to do it, but this suggests that there is, therefore, some way to do it.

MR. ZARABOZO: Yeah. So the example, the illustrative example of combining Maine, Hawaii, and Missouri would say you will have different stars in Maine, Hawaii, and Missouri, is all this says. It's not going to be -- it will list it as a contract, but that contract in Maine will have a different star rating than it will have in Missouri.

DR. NERENZ: Okay. Well, I guess I'd ask -- and

maybe the text surrounding this will make that entirely clear, but I guess I just want to make sure that that is precisely what we're talking about.

MR. ZARABOZO: Yeah. That is the intention.

DR. NERENZ: Okay.

DR. CROSSON: Brian.

DR. DeBUSK: I had a follow-up, too, to Pat's questions about the use of encounter data.

I know that you get a lower risk score when you use encounter data versus RAPS, and from what I understand, it's through the encounter data system's filters that dock out certain events. Is the benefit that we're going to enjoy more of a transient benefit, though? Because I would assume that the plans will learn how to load up the correct diagnosis into encounters that are going to pass through those filters. So is the benefit going to be transient, or is there a long-term benefit to moving to encounter data?

DR. JOHNSON: I would separate the two issues and say that for the coding intensity issue, encounter versus RAPS, there is some benefit in that having to submit and prove that an encounter happened on a specific date, with all of the information that goes along with that encounter,

up front is a more robust process than in RAPS, which is an attestation process. And so the impact on coding intensity might have some limitation going forward.

The second benefit is that under the current process of data validation for RAPS data, plans attest that a limited set of information is correct, and then there's supposed to be a RADV audit, which is a risk-adjustment data validation audit that happens later. And so far, a very limited number of audits have happened, and for 2007, there are some results. I think 2011 was the next year, and there are ongoing audits for years, payment years after that, but so far, they would address a limited number of contracts, about 5 percent of all contracts. And in any given year, you may or may not have that data audited versus encounter data gets a little bit more of a robust audit up front.

DR. DeBUSK: So there is a sustainable benefit to using it.

DR. JOHNSON: Yes.

DR. DeBUSK: Thank you.

DR. CROSSON: Okay. Let me see. We're still in questions. I had Dana and then Jack and then Bruce and

David.

DR. SAFRAN: Thanks. Two, I think, fairly quick, simple questions. One is, on page 4 where you show the growth in MA in beneficiary terms, I just wonder whether this growth is disproportionate to overall expansion of Medicare, because I just seem to recall the number "a third" enrollment in MA being a pretty constant, but am I remembering wrong?

DR. HARRISON: Well, people may round to a third but we've been going up about a point a year.

DR. SAFRAN: Okay.

DR. HARRISON: The other thing that we can't do in real time is the share of beneficiaries that have Part B that have MA is a good bit higher than that also.

DR. SAFRAN: Okay. Thank you.

And then my other question relates to the star program. I like recommendation 2 and kind of moving to the geographic unit, because, you know, that will really make for an informed beneficiary who's actually choosing the plan based on the quality that they're going to experience in the area where they live.

My question is, does the stars program already

have criteria around sample size requirements to be -- you know, measure by measure, sample size requirements in order for a plan's performance on that measure to count? Because, if not, we would have to, I think, recommend that along with recommendation number 2.

MR. ZARABOZO: Yes, and we talked about that, the issues of sample size, and so on the 2010 report about, you know, going to smaller units, essentially. But, of course, this contract consolidation issue, the sample size, as I mentioned in the paper, is 411 across 800,000 people, across 35 different states.

So this, you know, going to like state level or whatever local market area level, you would want that sample, the appropriate sample size for that area. And sometimes it may be too small. So we talked about using multiple years.

And also the stars, you do not have to have a rating in every single measure to get a star rating.

DR. SAFRAN: Yes.

DR. CROSSON: Jack.

DR. HOADLEY: Thank you, and thank you for a very rich report here. I've got three questions. Two are sort

of building off some of the things we've been talking about.

On the encounter data use in the risk adjustment, one of the things that you didn't mention here but it was in the paper is that CMS has actually reduced the share that encounter data is included in, the way they blended. Can you say more about -- I mean, is that essentially the same logics that you were talking about in terms of sort of our reluctance to go forward, or are there other specific things CMS has said about that?

DR. JOHNSON: I think CMS would put more weight on the issues with the submission process and tracking when an encounter needs to be voided and replaced, to make sure that there is the full and complete set of encounter data for risk adjustment, and that wouldn't affect inpatient, hospital outpatient, and physician claims, or physician encounters.

Some of the other issues that Jim addressed earlier were more on the PAC settings.

DR. HOADLEY: And I do wonder if you continued to keep a substantial share of the risk adjustment based on encounter data, that, in turn, creates an incentive to do

it. So I just wonder if dropping back to as low as I think it's 15 percent, sort of supports that incompleteness in other ways.

Second question goes to the contract consolidation, and you alluded, Carlos, in the Q&A, the CMS rule does call for the weighted approach. Is there anything else about what they've said in the rule that seems helpful to this conversation? I mean, I'm with you on the logic that that doesn't get us to the best result, and I think our recommendation approach seems better.

MR. ZARABOZO: Yeah. I was going to say, in an area where you -- I mean, if it's one county and it's two companies, then yes, their average certainly make sense. But on the consolidations, that was about it, I think, in the rule.

DR. HOADLEY: Yeah. Okay. And my third question I guess goes to some of the accounting things at the beginning of the chapter, and am I right? I think you had this in a note that Medicare or Medicaid plans, the MMPs, are not classified as Medicaid Advantage plans? Is that right?

DR. HARRISON: Correct. They're not classified as

MA.

DR. HOADLEY: It seems like it would be useful -- and this isn't a big thing -- to have a text box or something where we sort of both define that a little more clearly, but also just report on the number of plans that are MMPs and cost and pace the different categories that are not MA, and the number of people. I mean, to most of the public they are sort of all part of what people would think of when they think of MA, even if they're not technically classified. And so just being able to say that's another 1 percent or whatever it comes out to, and it could just be a text box, I think. Thank you.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you. The issues you've raised on stars I think have a profound impact on the extra benefits available or not, and, in particular, zero premium plans. And I think because of the importance to the market of zero premium plans, it would be useful to segment out the enrollment in particular. And I may have missed it in the materials, but it seems zero premium plans are addressed in some places here, but do you have those estimates?

DR. HARRISON: So you want enrollment in zero premium plans?

MR. PYENSON: Yes.

DR. HARRISON: The availability is in the table in your paper.

MR. PYENSON: Which table?

DR. HARRISON: Table 3 on page 18.

MR. PYENSON: Well, that's listed for special needs plans, unless I'm missing that.

DR. HARRISON: Got it. Thank you.

MR. PYENSON: Oh, you're welcome. But that's availability. Actual enrollment, I think zero premium plans -- non-zero premium plans are not attractive in the market.

DR. HARRISON: Uh-huh.

MR. PYENSON: So I think rather than the availability, the actual enrollment would be instructive to look at.

DR. HARRISON: Okay.

MR. PYENSON: Thank you.

DR. CROSSON: Okay. David.

DR. GRABOWSKI: Great. Thanks for a great

chapter. We've been talking about margins for a day and a half so I didn't want to let you guys off the hook. I wanted to ask you about the MA margin section on page 25. And I was particularly struck by how much larger they were for the SNPs, the special needs plans, relative to typical Medicare Advantage plans.

You've written a lot in the past about some of the D-SNP plans being coordinated with Medicaid, others not, and I'm curious if you have any insights into what the margins look like for those that are better integrated versus those that aren't. And, in general, do you have any thoughts on why the margins are so much larger for the SNPs, relative to the MA? Thanks.

MR. ZARABOZO: On the relatively more integrated, it's also a nonprofit versus profit, and so some of the relatively more integrated, or nonprofits, tend to have lower margins.

DR. GRABOWSKI: Negative margins, as you wrote.

MR. ZARABOZO: Yes, negative margins, yes. In terms of generally why they are profitable is -- the D-SNPs and I-SNPs are relatively profitable -- the D-SNPs that are not -- you know, the for-profit D-SNPs are also relatively

profitable. So I don't know that I have an explanation, but that is the situation.

DR. HARRISON: So one theory could be that the SNPs have higher acuity patients, which means they get paid more, and the profit margins on that could be a good bit higher.

DR. CROSSON: Jon and then Pat and Warner.

DR. CHRISTIANSON: A couple more quick questions. First, for Carlos. So you emphasized in the discussion of the advantages of the contract consolidation the higher payments you get with higher star rating. My understanding -- and I'm not up to date on this -- there used to be enrollment advantages as well with having a high star rating?

MR. ZARABOZO: Yes. A 5-star plan can enroll throughout the year.

DR. CHRISTIANSON: Yeah. So I think being kind of complete in terms of describing all of the possible advantages that accrue to consolidating in that way might be useful in the chapter.

The second thing is, I was wondering if, in terms of trying to assess how the plans are doing under Medicare,

have you ever looked at their public filings of their income statements and the profits that they report on those related to Medicare?

MR. ZARABOZO: Yes, and we did that when we started reporting on margins in MA, and tried to compare whether or not what we were getting was consistent with what was reported to the SEC, for example, or in state filings, NAIC type filings. The problem there is that sometimes they do not separate out the Medicare line of business. So they may have like government line of business, so it's difficult. But to the extent that we could confirm what we're finding with the SEC filings, they were consistent in the way we looked at margins.

DR. CHRISTIANSON: Okay. So it doesn't really -- you're saying it doesn't really give you any additional information that you would find useful?

MR. ZARABOZO: Right. Right.

DR. CHRISTIANSON: Okay.

MR. ZARABOZO: Pat.

MS. WANG: Thank you. This is a separate topic. On page 21, you showed a very interesting table about movement of the population into the different quartiles at

which the benchmarks are set -- 115, 107.5, 195 percent -- and what this basically shows, I guess, is that these quartiles were established as part of the ACA. And back then, at least in 2012, the average benchmark to fee for service spending was closer to 100 percent.

Because of the change in where counties are falling into these quartiles, the average benchmark, compared to fee for service, is projected in 2018 to be closer to 104 percent. I found the whole issue of the counties falling into different quartiles fascinating, you know, so counties that used to be in the highest fee for service spending quartiles are now in lower fee for service spending quartiles, and ones that were at the bottom have moved to the top.

So my question is, it seems to me, at least from the conclusion on the right-hand column, that it's kind of driving some inflation in the Medicare Advantage program, because it's raising benchmarks overall. Is there anything in this movement that you think is, you know, for a good reason, or is this just arbitrary? Is there something in the movement of the counties from quartile to quartile that we should try to preserve, or is this just random?

DR. HARRISON: I think at least some of it is random. If you look -- let's see. Do we have that? Yeah. Look at page 25 where we have the little quartiles, and you might notice sort of how narrow the ranges are, particularly in the middle two quartiles, of dollars spent. So --

DR. HOADLEY: I'm sorry. What page are you on?

DR. HARRISON: Page 25. It's like a stock-ticker chart.

DR. HOADLEY: 23? 23.

DR. HARRISON: Oh. Mine's 25. Okay. Sorry about that. And, you know, you'll see that it's maybe a $50 per month spending -- you know, window in the second quartile, and $70 per month. So random variation can push you over to the borders pretty easily. And we discussed this -- I lose track of time, but 5, 10 years ago we were a little worried about the way the quartiles we're set up.

Now I know in this last year we had some big cities move one tick, and the counties that moved back the other direction were much smaller. And, you know, I think there's some randomness now. So, for instance, if the counties were perfectly aligned, I think I got to -- it

would be like 104 1/4, is if it -- you know, if the populations of each of the quartiles were the same, that's where you'd end up. So we could move a little more --

MS. WANG: There's arbitrariness, though --

DR. HARRISON: Yeah.

MS. WANG: -- it sounds like. Okay.

DR. HARRISON: The penetration rates didn't look that different --

MS. WANG: Yeah.

DR. HARRISON: -- than, you know, percent of people in the counties in MA. I think this is something interesting, also, and I'd love to dig in a little more, and we'll see. But --

MS. WANG: Thank you.

DR. CROSSON: Warner.

MR. THOMAS: Just in reading the chapter I didn't see, and I might have missed it, information kind of comparing -- because there's a lot of comparison on the payment pieces -- on quality metrics or -- so is there any information kind of looking at quality metrics across the different types of Medicare payment lines?

MR. ZARABOZO: Oh, you mean comparing -- what we

typically do comparing HMOs to PPOs within MA? Is that what you're -- or MAs --

MR. THOMAS: Well, I think, you're comparing payment rates in MA to fee for service consistently. So do we look at quality measures, comparing --

MR. ZARABOZO: The problem with looking at quality measures is we don't have comparable measures, so to speak. But, for example, we do look at the caps, the beneficiary survey, and the caps results have been pretty much the same between fee for service and MA. So that's a relatively reliable comparison that's been consistent over several years.

MR. THOMAS: Is there any overlap on quality metrics between --

MR. ZARABOZO: Well, for example, the readmission measure. There is a readmission measure in MA, and you can compare it to fee for service readmission rates. The problem with readmission measure is that within MA you have other factors at play. For example, they waive the three-day hospital stay. So, again, even though it looks -- it may look like the same measure there, not entirely comparable between the two sectors.

MR. THOMAS: Okay. And then on the coding intensity, you know, it would kind of come to this conclusion around, you know, the coding intensity and the incentive around documentation for MA versus fee for service. Is there any assessment or insight into preventative care and proactive approaches in MA versus fee for service, as far as the delivery of care?

DR. JOHNSON: Not in this analysis at least. It's something we could look into more and get back to you.

MR. THOMAS: I just think these two areas are important to be considered if we're looking at kind of a status report of MA, because I think they're important components to the program overall, and we make a lot of comparisons. So, anyway, I'm going into round 2. I'll make that comment next round.

DR. CROSSON: Dana, on questions.

DR. SAFRAN: So I have a question that maybe has been answered before I joined the Commission, but I just -- and so you can tell me, we can talk about it offline if that's most appropriate. But I'm trying to get my mind around, with this issue that's come up about how counties have flipped and, you know, trying to understand why that

would be, where my head went was wondering whether ACO participation in this counties is where you have an ACO that's being very successful at reducing total medical spending, is that. And then where my head went was, okay, so if I'm a provider who is both an ACO and has risk contracts with an MA plan, you know, what are my interests, actually? Because I could be cannibalizing my own payments on the MA side if I'm successful on the ACO side.

So I just wanted to -- has this been contemplated and discussed before? If not, could we give that some thought and analysis?

DR. HARRISON: We'll talk with our ACO brethren and see if we can do any of that.

DR. CROSSON: Paul.

DR. GINSBURG: Yeah. I think what you raised, Dana, is an enormous issue, about the fact that, for the most part, ACOs are benchmarked on the ACO's historical experience, and, you know, MA is benchmarked on the county, all-county. So, in a sense, there are very strong incentives for particular providers to go the ACO or the MA routes, and I think people are very well aware of that, when it comes up in discussions about how to do ACO

benchmarking better, because I think, you know, the MA benchmarking to the county is the right way to do it. But this is a real problem.

DR. CROSSON: Bruce.

MR. PYENSON: In thinking about a number of the issues that you've raised here very clearly, the year-to-year fluctuations come up, and that comes up in a lot of places, for example, the year-to-year movement of stars, or consolidations, or the advantages of looking at stars over multiple years, or risk scores over multiple years.

And because of that I'm wondering if you have thoughts on what a two-year bid cycle would look like in this context. So to shift the process from this annual cycle and churning and populations moving around to a different system with a lot less of that, perhaps more risk but more stability in some ways.

DR. HARRISON: We haven't really thought about that, what the escalator clause would be and things like that, and whether plans would really be locked in for two years.

DR. CROSSON: Okay. So thank you for the questions. We've come to the period where we're going to

have a comment -- a set of comments. And this is a little different from some of the others because we really have two things on the table simultaneous. One is that this is a status report, and so we've had some suggestions already, snuck into the questions, about, you know, additional information or improvements to the report.

So I want to hear two things. Number one, those sorts of comments, like, gee, I wish you could further describe something in the report or add something to the report. That's number one. Number two, we have two recommendations on the table. We'll take those together. They are related -- quite closely related.

So in your comments, for those of you who want to make comments, you can think about either or both of those things -- the report itself and then the recommendations.

We'll start over here with Brian and we'll go down this way.

DR. DeBUSK: I do support both the Chairman's recommendations, as written. I think you have a very clever solution there to deal with cross-walking, and I think it's well thought out.

The one thing I hope we can make into the

discussion is a little bit more of a discussion around the benefits of fee-for-service continuing to code more like MA or more thoroughly and completely code the patient. It would be nice to see an elaboration of the benefits there, not just the mechanical benefit of decanting off some of these MA overpayments, but also the benefit to the program in general about having better insight and better analytics on the patients.

Thank you.

DR. CROSSON: Alice.

DR. COOMBS: I, too, support the recommendations.

One of the things that we talked about the last time we did the Medicare status report is that we looked at the racial distribution, and we were able to parlay it out that there was an over-distribution within the SNP programs. I still haven't been satisfied about the residual large component of MA beneficiaries and what that looks like overall, so if we could just kind of subtract that out.

DR. CROSSON: Thank you.

Paul?

DR. GINSBURG: Yes. I support both

recommendations.

I'd like us to go further in thinking about policy towards the star ratings. The star ratings has been a very successful program in the sense that the average star rating has increased, so presumably to the degree that the stars are measuring something that is worthwhile, it's improved quality in MA.

But this gain has come at enormous cost to the program. As you say, benchmarks are 4 percent higher because of the effect of star ratings, and I believe that we can keep these gains, perhaps extend them, without the huge expenditure of taxpayer and beneficiary funds, by recalibrating the star rewards. So, in a sense, we should -- at this point of time, when a four-star rating has become pretty common, we should not be giving rewards to achieve a four-star rating. We should be giving penalties for getting below a four-star rating. So, in a sense, this keeps the incentives the same, and it really -- it's, you know, let's -- we've had success. Let's live with the success by not paying for the success year after year after year, because we don't have to.

When we've used many incentives in the hospital

and physician payment systems, we start out with bonuses for providers to do something, and they transition over time to penalties for when the providers don't do that. And I think that way of thinking should come into the star program.

I think I've raised this once with the Commission before, but I feel very strongly about this. Don't know if it's suitable for this March report, but if not, I'd very much like it to be taken up for the June reports.

DR. CROSSON: So, Paul, two comments. Number one, what you're describing is very consonant with the position that the Commission took in 2004 when we were discussing the need for reduction in MA payment rates, and out of that discussion came the recommendation that while we as a Commission supported that, we also felt that there should be some acknowledgement financially of the higher-quality plans.

But having participated in that discussion, I clearly remember that it was much closer to what you're describing than the current situation. So to move back in that direction would be to, in fact, go back to -- at least from my personal point of view, it would be go closer back

to what we had originally intended when we originally suggested this notion.

I do need to talk to Jim and work with the staff as to when in the course of work we might address that.

Okay. Moving further. Pat.

MS. WANG: I want to offer some comments on the specific recommendations and some of the other elements of the report, but maybe try to put them into a broader context that sort of thinks about MA as being in need of modernization in many dimensions.

So the benchmark movement that we were discussing that you highlighted on pages 21 and 23, I think that all of the questions that have been asked are interesting, but I'm really wondering whether a better solution is just to go to one benchmark for all counties.

The quartiles may have had some appeal and some utility when the ACA was passed, but given the fact that everybody is redistributing quartiles, that it's causing inflation in the MA program, and that, as you point out, the dollar spread between quartiles is so small, why not just go to wherever it was, 101 percent or even 100 percent across the board, just get rid of the quartiles? I really

think that this is something that -- I'm not seeing the reason not to do that since we have really advanced a lot in time since these were put into place.

On coding, I appreciate the repetition of the different sort of recommendations that MedPAC has made over time. Using risk scores for two years previous might address part of your issue around some more stability in the program, and I actually think that's a good idea.

The introduction of greater equity into application of the coding intensity adjustment, I think is very important. If anything, I would add that there is a belief that the Secretary has discretion to do something, whether it's the tiering example that was given or something, to address that inequity.

I also would like to suggest the importance of encounter data is for risk score accuracy, but it is also to answer questions like Warner raised about what's actually going on in the MA program. You can't do that unless there's full encounter submission, and it sounds like the risk adjustment process kind of nudging the plans in that direction. But perhaps we can say something stronger in the report about really urging CMS to kind of

push that along, either by increasing the proportion of EDS that is included in derivation of risk scores or just otherwise -- because to Jon's point, enrollment is ticking up every year, and nobody really knows what's going on in the MA program because we can't do that until we have full encounter data. So I think that that's a very high priority.

I also would like to ask -- and I shared with some folks before. You know that I'm very interested in socioeconomic status adjustment. I think whether it's in stars or otherwise in the program, it's not sufficient yet, and it's more folks of dual status and more lower-income folks find MA attractive. I think that within the pot of money, there has to be an appropriate distribution. And SES, in my opinion, is not adequately explored yet.

Massachusetts Medicaid program, there was a paper in JAMA that I shared with some folks that recently looked at the introduction of SES factors into risk adjustment for Medicaid and found it to be more predictive of cost than the existing risk-adjustment system, so its' things like housing instability, residents in low-income ZIP Codes, things of that nature, you know, race, ethnicity. I would

ask that we consider opening that as a line of inquiry, particularly if the Massachusetts experience seems valid to you.

As far as stars is concerned, I hear what Paul and Jay are saying. I would ask us to look at the stars program. I mean, that is certainly a point of view. I think there's a lot wrong with the stars program, though, that has to be addressed at the same time.

I think that one of the issues that wasn't really noted -- the cross-walking is. Thank you. That's like a really great investigative report almost that you wrote there. It's possible that one of the things that causes that kind of pressure around stars is that there's a cliff, right?

So you can be three and a half stars and get zero quality bonus. If you're not four, you get nothing. So it's like really the stakes for plans to get to four stars may be creating bad behavior, but it's also extremely -- I don't personally think that that is the right way for the stars program to be structured and would prefer to see it scaled with higher amounts as you get higher in the star rating as opposed to this kind of all or nothing,

particularly because I think that there is not sufficient recognition for socioeconomic status adjustment in the stars. So until that is improved, I think it makes it very tough to say it's an all-or-nothing thing, especially for the beneficiaries who are on the lower-income scale.

The Chairman's recommendations, I agree with David about if you can be a little bit more specific about the first recommendations on stars, that would be good.

On the second, for using local payment areas, I also agree, and the conversation that Carlos and Dana were having was interesting because I didn't understand that what you had in mind was that CMS would actually compute new cut points by local area. That would be great, but I would add that if it's not feasible, because that's a lot of work, is that there's still a lot of benefit to using the national cut points, but identifying them at a local level. Do you know what I mean?

MR. ZARABOZO: We didn't really say anything about the cut points, so that's a different --

MS. WANG: Oh, okay, okay, okay.

MR. ZARABOZO: Yeah.

MS. WANG: There was another part of the report

that was not discussed here, which was trying to -- the desirability of moving a performance year close to the start bonus, which I really agree with. I'm sorry to say, though, that at least from my perspective, the solution in here, which is that plans would prepare two bids, because we wouldn't know what the star rating was, prepare two bids with different benefits, weighting for the result of stars, and potentially have to start preparing and printing two sets of materials to beneficiaries is administratively burdensome, to say the least. So I think it's a great goal, but I think kind of administrative -- operationally different.

MR. ZARABOZO: Yeah. The other option is to move the timing of things, to either get the stars more quickly determined or to move the bid timing. There are alternatives to that approach.

MS. WANG: Mm-hmm. Okay, okay.

That's it.

DR. CROSSON: Jack.

DR. HOADLEY: So I have a number of comments but first wanted to just sort of associate with some of the comments that Paul and Pat have made.

I think what this reflects is some of these parts of the program, the benchmarks, we're pushing towards 10 years of using that. The basic star bonus system has been in place for not 10, but a number of years now, and this is actually maybe a good opportunity since it takes us a couple of years -- or if not a couple years, takes us a cycle to work through these things to start to rethink or think about whether to reengage those particular programs.

I think the notion of -- I think Paul and Pat had slightly different themes on the stars. I think the notion of pushing harder on the encounter data is also something that makes sense, as Pat mentioned.

In terms of the status report aspects, I mentioned one during the first round. The second one I'll mention is probably not for this cycle, but it seems like it might be useful again to look at the extra benefits that plans provide, what variations there are in cost sharing. This might be particularly interesting if CMS goes through with its changes to meaningful difference and some of that to get a sense of what plans are offering that differs both from traditional Medicare and from each other in terms of both extra benefits and cost sharing variations. That's

probably a lot more than you could do by January.

In terms of the recommendations, I very much like where you're going with these. I think that the work, as several people have said, on the contract consolidation is really important work. I think what we're really seeing is what I consider an outrageous abuse of the existing rules by the plans that have done that, and I think even one of the companies bragged sort of in their statements to shareholders and to the market that this is one of the ways that they're improving their return.

But I think it's a harm to the taxpayer because it's costing dollars. It's a harm to beneficiaries in terms of the plan finder comparisons at least and really other aspects as well, and it's also a harm to the competition in markets.

A point was made earlier that local plans really can't do this, or smaller plans that are under one contract really can't do this. So I think it's really creating an unlevel playing field in the market, and that's a real problem as well.

So I think your solution, proposed solution is good. I agree that some of the wording could be more

precise and we make sure that -- I think the ideas you've had are right, and it's just a matter of making sure the words reflect that.

I mean, I know we can't do this, but I would love to do this retroactively and go back and recoup bonus dollars from plans. I'm sure that's not really possible, but that's -- if I could be the czar of this, that's what I would try to do.

On the second recommendation, I also agree with it. It's something I've believed in a lot time, both here -- and in Part D, there's similar issues. I think the fact, as was raised in the conversation, that the number of enrollees per unit could be small in some cases and have implications for sample size for some of the measures, but it's better, I think -- and I think somebody mentioned this. It's probably better to have some measures that we just can't compute because of sample size and go forward rather than have all of the measures computed on a much too aggregated kind of contract level.

I also think that doing it this way aligned much better with the notion that MA is a local product really. I mean, you're talking about -- even if it's a national

company, you're talking about a local network of providers, and a company that has a very robust network, doing very good things in one market may not be doing that and may have a much tougher time developing a network in another market, and so performance may, in fact, be quite different. And the notion that we're averaging that out into one score across whatever they've consolidated into is not as helpful. So I think there's a lot of advantages to moving to this kind of a geographic area.

I also think -- and I don't know if you had thoughts on this, but the notion that a lot of the contracts go across plan types, so that a PPO and an HMO could both be in the same contract in some instances. Is that not right? Even the local PPOs? I know there's somewhere -- aren't there somewhere where like SNPs and --

MR. ZARABOZO: SNPs can, yeah, but not --

DR. HOADLEY: So it seems like -- so maybe it's not as big a problem, but, I mean, it seems like even with the SNPs and non-SNPs, sort of lumping them together in one contract with very different kinds of patterns -- I mean, I know on the Part D side, you can lump an enhanced plan and a non-enhanced and basic plan together in one contract, and

most do. And again, the formularies can be very different. So if we carry this concept into the Part D world at some point, there's that issue here. I'm glad to hear it's not true across PPO and HMO.

And I think that's all of my comments. Thank you.

DR. CROSSON: Okay. Comments? I see Dana and then Rita and Kathy. Dana, Rita, Kathy.

DR. SAFRAN: Yeah. So just very brief. I am in support of the two recommendations. I like the comments that have been made about the encounter data and the importance of that as well as Brian's points about having the fee-for-service coding information track in parallel and the value of that. I think those are some important points.

On the issue that we've talked about relative to stars and that Pat raised around the cliff, it does strike me that while I wasn't here for the MIPS conversation yesterday, one of the things I was excited to see in the paper was the recommendation about moving to absolute performance targets, not relative ones, and I think included there, having a range of targets. But, in any

case, that, I think, has emerged as a best practice, and I'm mindful that across different parts of our Medicare programs, we handle quality in very different ways. So it would be nice to start to have some principles and try to line things up, and this would be a good place to start as we're commenting on stars. That cliff is problematic, and that the fact that performance is relative also is problematic, I know, and does lead to challenges, and maybe I would think more of this gaming because you can be improving performance and still fall behind in stars because of how much work other are doing. And so the benchmark moves quite significantly year by year on a lot of these measures. So I just think that some attention to that whole benchmark setting and how the incentive model is set up is a good thing for us to do.

Those are my comments.

DR. CROSSON: Warner.

MR. THOMAS: I do support the recommendations, both of them, with really to caveat David's comment to make sure we have the right specificity there.

A couple of comments on the chapters. I would just kind of echo Dana's point around the quality. I think

to do an assessment of a program but not have enough robust information about quality -- and I understand, you know, the measures are different and probably that needs to be a major component of that discussion as well, that, you know, the ambulatory measures need to be -- there needs to be similarity there so we can do comparisons. But, you know, I think the programs do operate differently as well.

The second thing is I would encourage us to think about whether there should be a discussion on the coding intensity that also includes information about, there are incentives to be much more proactive and much more thorough in doing preventative and wellness care in MA than there is in fee for service Medicare. And I think we jump to the conclusion that the coding intensity is just about coding, and is not about the delivery of care. And I would encourage us to maybe be mindful that that may not be the only reason, it may not be just about coding intensity. It may be the delivery of care is different in MA, and that there's a lot more prevention and a lot more care taken to being proactive versus fee for service Medicare. So I would just encourage us to consider that in that discussion.

The third is a concept I've actually talked about previously, with -- specifically with Mark Miller, but I'll bring it up here with the whole group. It's the issue of the auto-enrollment. So today, we essentially auto-enroll people into fee for service Medicare, but in many areas of the country MA is a more cost-effective model. And I would really encourage us to incorporate a component in here that in areas where MA is more cost effective, perhaps there should be the auto-enroll option.

And I know that's, you know, different. It doesn't mean people can't change and basically go into traditional Medicare. They would still have the same option, just like they do today. It's just that today we auto-enroll people into fee for service Medicare and then they can opt into MA. Why wouldn't we do the same thing in markets where this is a more effective, a more proactive option, to have people auto-enroll into MA?

So I would like to see us consider a discussion around that, especially in markets where it's a more cost-effective option.

DR. CROSSON: Rita.

DR. REDBERG: I also support the two

recommendations and some of the previous discussion on more specificity. I did also want to take the opportunity -- and I know we're already trying to do more outcome measures, but, you know, in the whole discussion of quality I am a little concerned that so many of the measures are still process measures that, to me, very imperfectly get at whether we're truly improving health of beneficiaries, and to also mention that we also have been very heavily weighted on things we do but not on things that we shouldn't be doing, and that we should have more low-value care measures in the quality measures, you know, on stopping screening at, you know, age 75 when the harm will exceed the good, you know, or other examples of that nature, because there's very little of that for right now, and I think that the problem is there's a lot of harm occurring in beneficiaries for things that are going to be of no benefit to them.

And then, finally, just related, you know, because one of the measures is the blood pressure control. I do have some concern about the new guidelines that were pretty controversial, and especially in the elderly where there's a much greater risk of falls with aggressive blood

pressure control. The guidelines contradicted earlier well done, randomized trials that showed aggressive treatment was not beneficial -- more aggressive treatment was not beneficial.

So just those concerns about quality, but I support the recommendation.

DR. CROSSON: Thank you. David.

DR. NERENZ: I support the recommendations and I echo Pat's comments and also a reminder about the wording clarification.

On this one, though, just a point about the term "market area." The text may want to go a little farther and talk about what do we mean by that, and I'm thinking that what we really fundamentally want to get after might be something that we call a "quality area" as opposed to a "market are" per se, that there may be regions in which quality is relatively homogeneous within, but sort of varying across, and that it's a little hard to get at that maybe.

But I'm thinking, as we go into this, we may find three definitions of geography that somehow don't fit perfectly with each other. So, you know, if we look at

things like Dartmouth Atlas and how they define geography, they have a certain way of doing that, and that's not strictly what we're talking about here but there are rules that define these areas.

Now we're really talking about problems that start with having stars at the contract level, and we're saying that's not good, and I agree. I don't want to, as a beneficiary, choose plans and see a contract level star rating. Okay, good. So that would suggest that we would want to define stars by plans, not contracts, but the area served by a plan is not necessarily synonymous with what we're talking about up here, unless we say that it is.

But then also I'm thinking within a plan, particularly one that has a wide geographic reach, there are probably variations in quality by geography within plans. And all I'm saying is that whatever we say in the text about this term "market area," we just need to be clear, what are we talking about? You know, some of our examples earlier suggested a state could be a market area, meaning -- I meant, the examples of the consolidation. We had Missouri, we had Hawaii. Okay. Well, is a state a market area -- yes or no? Is it smaller than a state?

Okay. I'm just asking. We need to be a little more detailed about what do we mean.

DR. CROSSON: Kathy, and then Bruce.

MS. BUTO: I support the recommendations with a greater specificity that has already been talked about.

I really like Pat's idea of looking at what would a modernized -- isn't it time to go back and look at MA? And I think that umbrella would allow us to think about things like Warner's suggestion about auto-enrollment. I think it would also potentially put us on the path to rationalizing better some of the movement we would like to see to more managed settings and a better payment system between fee for service and MA. And I really love Paul's idea of moving away from quality bonuses, with the cliff, as you describe, Pat, to something more like a penalty, but it would have to be after we get some of the SES factors and other important adjustments made.

I just think it's time to look at that. I really have to say I really don't like paying for quality. I think that Medicare should establish a level of quality expected, and then those who don't meet that quality standard either should not participate or there ought to be

other ways to express the program's interest in improving quality than paying for quality. It just has always been something I think is a problem.

So I think it is time to re-look at that, and if we could look at that in the context of the modernization, I think that would be a really useful exercise, and take us back to this issue of how do we begin to rationalize better between fee for service and MA.

DR. CROSSON: Bruce.

MR. PYENSON: I also support the draft recommendations, both of them. I also like Pat's idea of a comprehensive look. I think we've been fortunate in the choice, this year and last year, of looking at particular issues in Medicare last year -- Medicare Advantage last year -- the risk adjustment, and this year the contract stars issue, of picking things that could be looked at in relative isolation. But many of the things we have been discussing this morning have lots of moving parts and interactions, and I think Pat identified one of them, the unimaginable process of putting in two bids, for example.

So I think this is probably not an issue for the June report, even, but perhaps to be scheduled.

DR. CROSSON: Okay. And David.

DR. GRABOWSKI: Great. Thanks. I support both of the draft recommendations and echo a lot of the comments around the table around the need to improve data so we can make all the comparisons that we want to make, both in counter data and quality data.

Jim, I wanted to pick up on a thread you mentioned earlier. There are data right now, assessment data, that are collected in many of the -- for example, the post-acute care settings, such as the minimum data set, where you could merge that with the denominator file and actually tease out who's Medicare Advantage, who's fee for service, and begin to do some of the comparisons. Obviously risk adjustment selection is really important in making those kinds of comparisons, but we should rethink some of the existing data sources that we have and some of the potential comparisons we might make with a bit caveat being risk adjustment. Thanks.

DR. MATHEWS: Sure, and we can bring you up to speed on some of the detailed comparisons that we've done in the past. We have done this kind of exercise and we've found, you know, that we do not have MA -- or, I'm sorry,

say MDS data for an MA enrollee who the encounter data indicates had a SNF stay. And then we've had MDS data for an encounter -- or an MA beneficiary with no corresponding encounter record showing a SNF stay.

So we have sifted through it, and as Andy said, we're continuing to do so. But we can have a more detailed conversation offline if that's helpful.

DR. GRABOWSKI: Great. Thank you.

DR. CROSSON: Jack and Paul.

DR. HOADLEY: Two things. One, you know, I think a revisit of some of those encounter data in one of our sessions would actually be useful to know whether there's been progress. Obviously, if there hasn't been any progress it might be less useful.

I also wanted to just pick up on Warner's comment about auto-assignment. I see that as having a lot of problems. You know, it's one thing to think about, sort of conceptually, the notion of putting somebody in the traditional Medicare side or the Medicare Advantage side. Where it starts to get really complicated is you've got to actually put them in a plan, and then you have issues of aligning people with the providers that they're using and

risking putting people in a plan that doesn't cover their providers. There's been various attempts, including in the dual demo world, of trying to do, you know, so-called intelligent assignment, to try to put people in a plan that matches, and that's not been very successful to date, partly because of data problems. Maybe someday that will be easier.

But I just -- you know, I think it's important to think about those issues when we're sort of considering that kind of a possibility.

DR. CROSSON: Paul.

DR. GINSBURG: I just wanted to say that I'm really glad Pat brought up the interest in looking into the county quartiles. I know this was in the ACA, I think, when it was enacted. I don't know if MedPAC was involved beforehand in planning of that. But things have really change. I mean, obviously, the quartiles were put in as a way of encouraging that, you know, MA plans be available in more areas, which they weren't. And things have changed a lot, with the MA being such a larger part of the population. And we have experience with it, and it just may be a fruitful topic for us to work on.

DR. CROSSON: Okay. Thanks, everybody. This was a good discussion. I heard sort of three strains here. One was the general support for the recommendations, although I think David and others have suggested that maybe we need some work on the wording. I would agree with that.

And then we had some feedback to Scott and Andrew and Carlos about potentially improvements to or additions to the report. I think we will make that happen. And then a significant amount of discussion about maybe it's time for us to take a more comprehensive look, at least at some elements of the MA program. I heard certainly the stars program and I heard enthusiasm but I heard enthusiasm in different directions with respect to that. But I think that's something that we therefore should be doing.

The issue of the quartiles, the question of whether encounter data uses -- where it ought to be. The question of extra benefits, issue of auto-enrollment. So I think that is -- and this is not uncommon for us, you know, in the update process -- even though this is not really the update process, but it's part of the December/January process, you know, to have the time to reflect on a particular payment area and say whether or not we think, in

our policy work, there is a sufficient change in circumstances or change in the marketplace or change in something else that should, you know, have us going back, even to policy issues we've discussed in the past. And I think on the basis of the discussion it's pretty clear that it is a Commission consensus that we should do that.

So again, work with Jim and the staff to determine how we do that, whether we take them on all at once, or we do it sequentially, or what, and when we do that. But building it into the work stream going forward I think is clear.

Having said that, we need to change the wording of the recommendations, and I think we have maybe a few more additions to the report than we've had in some other areas, I am going to suggest that we not include this as part of expedited voting but we come back and have a second discussion and we actually look at the wording of the recommendations in January.

Okay. Seeing no other comments I think we are finished here. Thanks to Scott, Carlos, and Andrew again. You have stimulated the Commission, which is hard to do in the last discussion, of December, particularly.

Now we have time for public comment period. If there are any members, of our guests who would like to come up and make a comment about our discussions today, come forward to the microphone so we can see who you are. People are moving around. I see people running away from the microphone, actually.

So seeing no one at the microphone, we are adjourned until our January meeting in 2018. Good trips, everybody, and have happy holidays to all of you.

[Whereupon, at 11:30 a.m., the meeting was adjourned.]