MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 5, 2019
9:18 a.m.

COMMISSIONERS PRESENT:

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AGENDA PAGE

P R O C E E D I N G S

[9:18 a.m.]

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

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

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

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

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

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

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

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

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

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

services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We found that the number of encounters per

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

percent for other procedures.

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

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

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

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

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

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

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

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

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

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

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

the fee schedule.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Is there anything else you wanted to add?

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

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

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

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

DR. CROSSON: Okay. Thank you. Dana.

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

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

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

DR. SAFRAN: Yes.

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

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

play.

DR. SAFRAN: Thank you.

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

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

DR. CROSSON: Thank you, Dana.

Paul?

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

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

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

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

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

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

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

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

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

DR. PERLIN: Well, thanks for illuminating that.

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

either geographically or other demography?

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

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

MS. MARJORIE GINSBURG: Yes.

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

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

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

MS. BURTON: Of course, the MCBS does survey

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

MS. MARJORIE GINSBURG: And satisfaction rates?

MS. BURTON: Yeah.

DR. CROSSON: Okay. Bruce?

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

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

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

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

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

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

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

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

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

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

But in terms of the structure of the cost

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

MR. PYENSON: Thank you.

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

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

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

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

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

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

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

Paul?

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

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

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

[Laughter.]

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

DR. CROSSON: Kathy?

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

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

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

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

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

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

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

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

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

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

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

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

MS. BUTO: Yep.

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

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

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

MS. BUTO: -- for January. Yep.

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

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

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

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

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

DR. CROSSON: Jonathan, on this point?

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

DR. CROSSON: Okay.

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

DR. CROSSON: On this?

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

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

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

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

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

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

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

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

Warner?

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

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

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

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

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

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

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

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

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

Okay. Amol.

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

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

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

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

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

MS. BURTON: The beneficiary was stating this.

DR. CROSSON: On this point, Marge?

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

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

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

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

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

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

Okay. Sue.

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

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

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

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

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

MS. THOMPSON: 2014.

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

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

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

MS. THOMPSON: Thank you.

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

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

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

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

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

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

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

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

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

Anyway, the other question that I think underlies

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

Larry?

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

Second point, I should say I am in general in

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

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

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

And then my last comment is on a different

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

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

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

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

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

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

DR. PAUL GINSBURG: Yeah.

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

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

DR. CROSSON: No.

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

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

DR. CASALINO: Oh, that's helpful.

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

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

DR. CROSSON: Okay. Warner, last comment.

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

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

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

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

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

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

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

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

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

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

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

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

But encouraging greater use of ASCs should also

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Commission has wanted ASCs to collect and submit cost data since 2009, and the Secretary has the authority to require it. Therefore, we have a second recommendation: 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 have

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. PAUL GINSBURG: Kathy has a question.

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

DR. PAUL GINSBURG: Mic, Kathy.

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

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

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

The other question I have is --

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

DR. DeBUSK: Yes. Great point.

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

You know, we keep citing like spine injections

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

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

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

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

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

DR. DeBUSK: I totally agree.

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

DR. DeBUSK: I totally agree. Thank you.

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

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

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

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

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

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

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

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

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

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

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

DR. DeBUSK: Okay. Well, thank you.

DR. ZABINSKI: It's definitely doable.

DR. DeBUSK: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Bruce?

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

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

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

[Laughter.]

MS. BUTO: It makes it really daunting.

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

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

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

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

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

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

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

DR. CROSSON: Okay. Dana?

DR. SAFRAN: Thanks.

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

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

DR. SAFRAN: So what do we know?

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

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

DR. ZABINSKI: Okay.

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

DR. CROSSON: Karen, on this point?

DR. DeSALVO: No.

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

DR. DeSALVO: Lucky me.

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

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

that. That's a really interesting question.

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

DR. ZABINSKI: Yeah.

DR. DeSALVO: Yes.

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

DR. DeSALVO: Okay. Thank you.

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

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

[Laughter.]

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

DR. CROSSON: Paul has a comment.

DR. DeSALVO: Rats. Okay.

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

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

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

DR. CROSSON: Paul?

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

handle this in our update recommendation, though.

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

Brian?

DR. DeBUSK: Thank you.

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

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

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

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

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

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

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

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

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

Thank you.

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

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

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

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

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

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

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

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

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

On this point, Kathy?

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

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

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

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

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

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

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

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

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

DR. CROSSON: Jon?

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

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

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

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

Thanks.

DR. CROSSON: On that point?

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

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

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

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

because I think that's ultimately the right direction. That's the PAC PPS for acute care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. David and then Sue.

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

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

[Laughter.]

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

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

DR. CROSSON: Last word, Sue.

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

very supportive of getting access to their cost report data.

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

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

DR. CROSSON: Okay.

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

DR. CROSSON: Yes, Larry.

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

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

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

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

DR. CROSSON: What you have read?

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

DR. CROSSON: Yes.

DR. CASALINO: They would appear in the chapter?

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

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

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

this in the written report.

Paul, oh, sorry. Pat.

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

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

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

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

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

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

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

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

Dan, thank you so much.

[Pause.]

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

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

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

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

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

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

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

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

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

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

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

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

years.

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

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

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

A third indicator of beneficiaries' access to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

all-time highs

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Okay. Bruce?

DR. MATHEWS: Just --

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

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

said, over the long term everything is variable.

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

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

DR. CROSSON: In an empty bed --

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

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

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

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

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

[Comments off microphone.]

MR. THOMAS: Yeah, exactly.

[Laughter.]

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

All right. Where are we?

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

DR. CROSSON: Warner and then Bruce.

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

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

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

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

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

You can also look at it on the hospitals under

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

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

DR. CROSSON: Bruce.

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

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

of what fixed costs are.

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

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

[Laughter.]

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

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

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

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

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

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

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

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

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

Jim, did you want to make a comment?

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

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

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

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

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

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

DR. CROSSON: Marge and then Warner.

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: On this point?

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

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

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

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

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

DR. CROSSON: Payment.

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

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

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

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

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

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

[Laughter.]

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

DR. CROSSON: Pat?

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

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

So the 340B hospitals are making a profit on

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

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

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

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

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

DR. CROSSON: Larry? Did I miss --

DR. PAUL GINSBURG: No.

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

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

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

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

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

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

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

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

Karen, on this?

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

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

DR. CROSSON: That's correct.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

significant length of time.

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

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

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

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

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

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

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

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

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

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

[Laughter.]

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

DR. PERLIN: I'll wait.

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

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

DR. CROSSON: You okay?

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

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

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

DR. CROSSON: Where are we?

DR. DeSALVO: Separate topic. No?

DR. CROSSON: Did Larry already go?

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

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

[Laughter.]

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

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

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

But when we talk about relatively efficient --

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

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

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

And so I wonder if it makes sense, in thinking

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

all in. Thanks.

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

DR. PERLIN: [Off microphone.]

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

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

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

Amol and Bruce.

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

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

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

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

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

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

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

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

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

But, you know, the numbers speak for themselves

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

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

DR. CROSSON: Yeah.

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Paul, on this?

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

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

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

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

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

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

DR. CROSSON: Okay. Amol.

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

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

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

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

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

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

[Laughter.]

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

we think about this? Fixed costs, particularly.

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

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

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

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

DR. CROSSON: So we will examine this again

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

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

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

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

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

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

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

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

DR. NAVATHE: Yeah.

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

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

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

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

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

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

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

PARTICIPANT: [off microphone] Warner's proposal.

[Laughter.]

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

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

[No response.]

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

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

AFTERNOON SESSION

[1:35 p.m.]

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

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

DR. CARTER: Good afternoon, everyone.

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

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

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

Program spending totaled $28.5 billion.

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

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

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

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

The data presented here and in the chapter do not

reflect the new payment system.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

system.

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

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

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

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

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

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

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

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

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

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

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

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

DR. CROSSON: Thank you, Carol.

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

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

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

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

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

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

DR. CROSSON: Jonathan?

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

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

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

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

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

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

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

DR. CROSSON: Sue is next.

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

DR. CROSSON: Okay. Thank you, Sue.

Amol?

DR. NAVATHE: Thanks, Carol, for the chapter.

So you noted on page 29 of the writeup itself that small, meaning 25 to 50 beds, in low-volume facilities, bottom quintile total facility days, had low average Medicare margins. Those were the ones primarily with the negative margins.

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

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

question. And I haven't looked at it.

DR. NAVATHE: Okay. Thank you.

DR. CROSSON: Okay. Pat and then Marge.

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

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

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

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

DR. CROSSON: Marge.

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

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

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

And you had a third question in there.

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

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

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

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

David?

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

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

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

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

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

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

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

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

Other comments? Marge.

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

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

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

support Medicaid patients in SNF beds?

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

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

MS. BUTO: I'm going to let Jay take -- no.

[Laughter.]

MS. BUTO: I wanted to mention, Marge, I think my gut tells me no, we wouldn't do that, because why would you use Medicare, which is already in all sorts of fiscal difficulty to, in a sense, help subsidize, if you will, the sustainability of Medicaid beds. But having said that, I think there is an adjustment, or should be an adjustment, I think -- Carol, right? -- for dual eligible. So many of the Medicaid individuals are actually dually eligible, and that is totally in our purview, it seems to me, to be concerned about. But that's more about the methodology.

MS. MARJORIE GINSBURG: But they're not still in Part A. They're not being compensated.

MS. BUTO: No, but to the extent you were going to use Medicare payment anyway, my point is there is a way to adjust for the dual eligibles. I think they may already

get an adjustment for dual eligible status now?

DR. CARTER: No. There isn't one.

MS. BUTO: There isn't one. But that's a policy, you know, approach that would be different than just the update, I think.

DR. CROSSON: But there is higher payment particularly incident to hospitalizations and rehospitalizations. Right.

I mean, this is intentionally philosophical and I think, you know, it's becoming more and more -- it's always been, but it's particularly more and more an acute social problem, actually, provision of long-term care for the populations considered back in the 1960s, when the Johnson administration was working with Congress to draft the Medicare legislation. And because even then the projected cost, it was not put there.

It was put in the Medicaid program, and this is my assumption, that it was based on some idea that the real vulnerability was for the people with lower incomes who had no way, really, to support themselves or their elderly relatives, and that other parts of the population could figure out how to do that. And that's my belief, anyway,

of how the thinking was at the time.

There has been substantial change in terms of the burden that this creates, because people are living longer, a lot longer in some cases, and because of what appears to be -- and perhaps it's just related to that -- but what appears to be an increased incidence in dementia and Alzheimer's disease, the care of which can turn out to be, you know, beyond the capacities of even upper middle class families.

So your instinct is a good one. We need, as a society, a way of figuring out how to care for and pay for this phenomenon, which is only increasing. That said, I think, you know, traditionally we have, at this Commission, been, you know, for rightly or wrongly, sort of defenders of the Treasury as it relates to Medicare expenditures. And so even though there are subsidies, actually, that go both ways, between Medicare and Medicaid and Medicaid and Medicare, we've tended to not consider increasing that. If that's fair.

Yeah, David.

DR. GRABOWSKI: Yeah, I'm so glad, Marge, that you raised this, because this has bothered me as well.

Every one of those -- almost every one of those sort of long-stay Medicaid recipients is a dual, is a Medicare beneficiary, and I think our sort of underinvestment in Medicaid is leading to higher costs downstream for Medicare. And we've shown that in a lot of research yet, as Carol really noted, and I thought really did a nice job. It's not the way you'd ever want to fund this, with these separate programs. That's why I think some of the models that Eric has presented on in the past area really important here, the fully integrated dual eligible SNPs, the financial alignment initiative, their model PACE, where we could integrate the Medicaid and Medicare and actually offer a more complete product. I think that's the way to get at this, but I share your concern about we're using Medicare to cross-subsidize Medicaid. It's a fact that it happens. It's just -- it's not the way you'd ever want to design this system, with Medicare and Medicaid separate.

DR. CROSSON: Okay. Jon.

DR. CASALINO: On this point I think it's not -- it doesn't have practical relevance for our deliberations, but speaking as a physician, if you've ever spent time in the Medicaid part of a nursing facility that has a high

percentage of Medicaid patients, I always used to -- I hated to go there. Honestly, I felt like I was descending into like the seventh circle of hell. It was just unbelievable. And it's not the staff's fault. They're doing the best with what they have. And even under the best circumstances people who are severely demented, it's a very hellish thing to see. But these places are really, really horrible.

I don't think we can do anything about it here, although what you're saying, David, may argue a little bit differently. But it truly is -- if you haven't seen it, you would not believe it. It's painful to walk into such a place.

DR. PERLIN: My comment really triangulates with my colleagues, is that there are a lot of moving parts here, and, you know, David, you brought up the behavioral economics, and Marge, on the issues of cross-subsidization, and Larry also just commented on. You know, the premise behind our policy direction in post-acute care has been matching the acuity with the capabilities of the facility, but specifically geared to making sure that a patient was not in the higher level of care necessary in terms of the

expense.

At the same time, the premise of this economic argument is that, you know, the adaptations will include de-staffing, de-skilling, perhaps, to meet, you know, the change in reimbursement. It's going to be interesting to watch, and I think this is really a call for the importance of quality measures to be able to really watch what the effects are on the care and the care outcomes as we move these parts. Because the other part, related to the discussion of Medicaid, is the impact of waivers on the resources that are available for Medicaid patients that may even necessitate de facto more cross-subsidization. Thanks.

DR. CROSSON: Okay. Yes, Brian.

DR. DeBUSK: Actually, the discussion raised a question. You know, when you look at the PAC PPS, it was modeled off of the payments from the other, all four venues. You know, you're building one model. This subsidization that's just inherent in our SNF payments, in the PAC PPS, does that subsidization get undone, or is that swept up and captured in the model? Because I want to say it's the latter.

DR. CARTER: So the level of revenues are included, but they would then be redistributed in sort of setting the average payment.

DR. DeBUSK: But it would be redistributed based on patient characteristics.

DR. CARTER: That's right.

DR. DeBUSK: So you wouldn't inherently take money out of -- we're not going to undo this SNF subsidization through the PAC PPS, because the model was built around -- you know, you have to think, with $30 billion in SNF, home health is running, what, four or -- I mean, not -- no, no, no -- IRFs and LTCHs are running at a fraction of that. So the model is going to be home health and SNF are going to be what dominate the coefficients as well.

DR. CARTER: That's right.

DR. DeBUSK: So this overpayment, just again, for the record, this overpayment, if the PAC PPS goes forward, will have that subsidization built into the SNF payments, even though it will be based on patient characteristics, not necessarily on provision of therapy.

DR. CARTER: Right, but by the time -- and that's

all true -- by the time the PAC PPS is implemented, a lot of that redistribution should have already happened, right, because they're going to be happening internally within SNF, and Evan is going to tell you about the new payment system in his sector, and a lot of that redistribution should have occurred.

DR. DeBUSK: Based on the October 1st changes.

DR. CARTER: Well, and this starts in January of next year.

DR. DeBUSK: So this should cushion the implementation of the PAC PPS.

DR. CARTER: That's right.

DR. DeBUSK: That's what I was trying to get at and make sure that we weren't sort of tacitly undoing the SNF subsidy. So we aren't. Okay, good.

DR. CROSSON: Okay. Seeing no further comments I am going to assume support for the recommendation. Seeing no objection we will proceed with expedited voting on this issue in January.

Thank you so much, Carol. Excellent job.

[Pause.]

DR. CROSSON: The next issue is home health care

services, payment adequacy and updates, and Evan is going to take us through it.

MR. CHRISTMAN: Thank you. As you mentioned, we are going to look at home health, and as an overview of the presentation we'll cover the basics of the benefit, the current issues the Commission has identified, and the bulk of this presentation will review the payment adequacy framework and present the Chairman's draft recommendation.

As background, Medicare spent $17.9 billion on home health services in 2018, and there were over $11,500 agencies. The program provided about 6.3 million episodes to 3.4 million beneficiaries.

In terms of the payment system, the Commission has noted two problems. The first issue is the high level of payments. Medicare has overpaid for home health since the PPS was established. The fact that home health can be a high-value service does not justify these excessive overpayments. As discussed in the paper, Medicare margins have averaged better than 16 percent in the 2001 to 2017 period. These overpayments do not benefit the beneficiary or the taxpayer. For many years, the Commission has recommended payment reductions to address these

overpayments.

The second issue is an incentive in the current system. The current PPS uses the number of therapy visits provided in an episode as a payment factor. Payments increase as more therapy visits are provided. This trend, and the fact that more profitable agencies tended to favor therapy episodes, raised concerns that the financial incentives of the payment system were influencing the type of care provided, and the Commission recommended the removal of therapy as a payment factor in 2011.

As mentioned earlier, major revisions to the home health PPS will be implemented in 2020. The first is a policy that is consistent with our recommendation to eliminate the therapy thresholds. The second is the implementation of a 30-day unit of payment. Concurrently, CMS also plans to revise the home health PPS with a new case-mix system, known as the patient-driven groupings model, or PDGM, and other payment adjusters. These will be the most significant changes to the PPS since it was implemented

These changes are intended to be budget neutral but will redistribute payments among providers. Estimates

of the redistribution have some uncertainty because agencies have a history of changing coding and operational practices when the payment system is altered. But based on current patterns, CMS expects payments for nonprofit, facility-based, and rural agencies will increase, and decrease for for-profit, freestanding, and urban agencies.

CMS has also made a budget neutrality adjustment to payments in 2020 to offset expected changes in utilization and coding under the new system, and I will say more about that later.

As a reminder, here is our framework. It's similar to the ones you've seen in other sessions.

We begin with supply. As in previous years, the supply of providers and the access to home health appears to be very good. Eighty-three percent of beneficiaries live in a Zip code served by five or more home health agencies; 98 percent live in a Zip code served by at least one home health agency.

Turning from access to supply, the number of agencies was over 11,500 by the end of 2018. There was a slight decline of about 1.2 percent in 2018 relative to the prior year in supply, and it has been slowly trending down

since 2013. However, in the 2002-2013 period, the number of agencies increased by over 80 percent.

I would also note that the recent decline is concentrated in a few areas such as Texas, Florida, and Michigan that have been the targets of efforts to reduce fraud. These areas also experienced rapid growth in prior years.

Episode volume declined slightly in 2018, as it generally has since 2011. However, prior to 2011, volume grew significantly, and between 2002 and 2011, it increased by over two million episodes, or about two-thirds.

Per capita utilization is significantly higher than the earlier years of PPS. The number of episodes per 100 beneficiaries has increased from 11.3 episodes per 100 beneficiaries in 2002 to 16.3 episodes per 100 beneficiaries in 2018. Though per capita utilization has declined slightly since 2011, it remains high relative to the utilization that occurred in the earlier 2000s. And I would also note that the marginal profit of home health agencies in 2018 was 18 percent.

Our next indicator is quality, and I would remind you that we have observed a difference in performance on

measures based on data collected from home health agencies compared to quality measures based on Medicare claims data. And you can see that on this graph.

The first group of measures on the left are based on provider-reported data collected by home health staff at the start and end of home health care. The group of measures on the right are claims-based measures that use Medicare claims data to detect the incidence of hospitalization or emergency care use for home health.

The first group shows that the frequency of patient improvement in walking or transferring was steadily improving from year to year. In contrast, hospitalization and ER use rates have had a mixed annual trend, but have not changed significantly in most years and do not show the same substantial improvement as the functional measures.

The contrast in these two groups of measures is striking, and though many factors may explain them, it is important to keep in mind that differences in the methods of collection may account for some of the divergent trends.

Next we look at capital. It is worth noting that home health agencies are less capital-intensive than other health care providers, and few are part of publicly traded

companies.

Financial analysts have concluded that the publicly traded agencies have adequate access to capital in 2018 and 2019. In these years, the firms added capacity in the industry and acquired new businesses, and the all-payer margins for home health agencies are 4.3 percent.

Turning to Medicare margins for 2018, we can see that the margins for this year were 15.3 percent. The trend by type of provider is similar to prior years, with for-profits having better margins than nonprofits and urbans being a little bit higher than rural. These margins did not change significantly from the 2017 level.

The high margins in 2018 are notable because the Affordable Care Act mandated four years of payment reductions in 2014 through 2017. However, the reductions were offset 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 long expressed that the ACA reductions would not significantly lower margins.

The net effect is that, despite the ACA policies, average payment per full episode in 2018 is 7 percent higher than the average payment in 2013, the year before

rebasing began. In addition, the Medicare margins in 2018, the year after rebasing, were higher than those before rebasing.

This year we also examined the performance of relatively efficient home health agencies. Recall that we define "relatively efficient providers" as those that are in the lowest third of providers in cost, or the best performing third of providers for quality, without having extremely low performance on either measure. About 7 percent of agencies meet this standard.

Compared to other providers, efficient home health agencies had lower hospitalization rates. They typically had higher patient volume, and their standardized costs were 14 percent lower than other home health agencies, likely reflecting economies of scale from their larger size.

The average payment for efficient home health agencies was about 7 percent higher, and the relatively efficient providers had margins of 23 percent.

We estimate that margins for 2020 will equal 17 percent. This is a result of several payment and cost changes.

On the payment side, we included the market basket updates for 2019 and 2020. We assumed a nominal case mix growth of a half percent in 2019, and we included the rural add-on policy mandated by the Bipartisan Budget Act for 2019 and 2020.

For 2020, we assumed the case mix growth CMS expects to the new case mix system and other changes in effect this year, which it also offset with a budget neutrality adjustment, and I will talk about this more in a moment.

For costs, we assumed costs will increase by 0.75 percent per year in 2019 and 2020, which is higher than the recent trend.

Before I summarize our indicators, I want to explain a payment reduction for 2020 that is statutorily required by the Bipartisan Budget Act. Recall that three changes are happening as a result of that act: a new unit of payment, removal of therapy as a payment factor, and a new case mix system. BiBA requires that the changes be budget neutral.

CMS has projected that behavioral responses by home health agencies to the new policies will increase

payments by 4.36 percent in 2020, which would, in the absence of an offset, increase payments by about a $800 million.

Consequently, CMS will implement a 4.36 percent reduction in 2020. This reduction is necessary to offset the spending spike in 2020 due to the expected behavioral changes; it does not address payment adequacy. Our margin estimate for 2020 includes the 4.36 percent increase in average reported case mix expected by CMS, and it also includes the offsetting budget neutrality adjustment they made.

In effect, our estimate states that margins will be 17 percent, well in excess of costs, even with the other changes in 2020.

In summary, the indicators for home health overall are positive: 98 percent of beneficiaries live in an area with at least one home health episode; the episode volume is slightly decreased but is still high on a per capita basis; and agencies have positive marginal profits. The quality measures show the trends we've seen in the past with functional measures continuing to improve, but the rate of adverse events relatively unchanged, with the

caveats I noticed earlier.

Overall, agencies appear to have adequate access to capital, and Medicare payments are well in excess of costs, with margins of 15.3 percent in 2018 and the efficient provider having margins of 23 percent. And we expect the margins to increase to 17 percent in 2020.

This brings me to the Chairman's draft recommendation. The recommendation reads:

For 2021, the Congress should reduce the calendar year 2020 Medicare base payment rate for home health agencies by 7 percent.

In terms of implications, we expect that this would lower payments relative to current law. For beneficiaries and providers, access to care should remain adequate and should not affect the willingness of providers to serve beneficiaries, but it may increase cost pressures for some providers.

This completes my presentation, and I look forward to your questions.

DR. CROSSON: Thank you, Evan. And I'd like to congratulate you particularly for the chapter, which I thought was excellent, very clear, and I liked particularly

the beginning where you set the context for the considerations.

So we'll take clarifying questions. Brian and then David.

DR. DeBUSK: Thank you again for a really good chapter. It was really well written. Great read.

When you talk about the all-payer margins for home health care and for Medicare -- and I apologize if it was in the reading, but I did not see it -- what percentage of industry revenue comes from Medicare?

MR. CHRISTMAN: It's a little over 50 percent. It's around 55 percent of the action is Medicare revenue for the average agency.

DR. DeBUSK: Okay. So --

MR. CHRISTMAN: Fee-for-service. Sorry.

DR. GRABOWSKI: That's fee-for-service.

MR. CHRISTMAN: Yes, I'm sorry. Exactly. Thank you, David.

DR. DeBUSK: So it's a little over 50 percent fee-for-service, so probably 15, 18 percent of it is MA then, I would think, proportionally. Fifteen-ish percent?

MR. CHRISTMAN: Yes, right. I think that's right

based on the overall program, right, yes.

DR. DeBUSK: Is MA. And I'm sorry, David, I just stole your question because he and I were chatting. But what are the MA rates comparable to?

MR. CHRISTMAN: So the general consensus is that just about every other payer pays less to home health agencies for the services. That's on, you know, the Medicaid side, which is obviously a different set of services in many cases than what Medicare covers, but also on the MA side. And home health agencies have traditionally complained that the MA side does not pay as well.

I would say that over these ten-plus years I've been following home health for MA, I think that picture generally remains true, but it has changed in two ways, and one is, you know, ten years ago, agencies tried to divorce themselves from the MA business if they could, but many of them in the urban areas saw that the MA population expanded, and they would not be able to maintain the volume that they were used to having if they didn't get serious about the MA business.

And so we've seen in recent years agencies

serving more of that population, and we've heard anecdotally that some plans, they've been successful and the agencies have been successful in getting better rates. I don't think they would characterize them as favorable relative to fee-for-service, but I think today in general the complaint is they're paid less on a per visit basis than the fee-for-service business, but probably in many cases they're paid a little better than they were ten years ago.

DR. DeBUSK: Okay. Well, then a final question just to check some math. If 55 percent of the business is at 15 percent margin and 100 percent of the business is at 4.3 percent, it means that -- I mean, the non-Medicare business is somewhat negative, probably high single digits negative.

MR. CHRISTMAN: Right. Yeah, no, I think that's the implication. I mean, I think -- and I think that, you know, that's sort of been the case for many years. But the overall margins haven't changed that much, but, yeah, you know, we don't have a lot of visibility into what the different payers are doing on the other side of the ledger. And so, you know, I would guess it's a mix of people who

pay relatively well and others who don't pay at all.

You know, off the top of my head, I can't really tell you the exact role that Medicaid plays in that, but I would assume that that's a piece of it.

DR. DeBUSK: Thank you.

DR. CASALINO: On this point?

DR. CROSSON: Yeah, all right.

DR. CASALINO: Evan, do you have a sense of why in some sectors that we talk about Medicare pays so much less than other payers, but for home health, following up on Brian's math, seems to pay so much more than other payers?

MR. CHRISTMAN: Why does fee-for-service pay more than other payers?

DR. CASALINO: Yes.

MR. CHRISTMAN: I guess the simplest answer I have to that is twofold, I guess. I would just say in every year I've been here, the Commission has recommended a reduction to payment, and sometimes congressional policy has gone some in that direction and sometimes it hasn't. So that's one reason.

The other reason I would say is that if you look

at -- when the home health base rate was established, it was based on 1998 utilization, and when they implemented the PPS in 2001, the visits came down much more than they expected, and there's been a gap between payments and costs since 2001. And we've made efforts over the years to -- there have been cuts to Medicare payments over the years to try and close that gap, but they've never really come close. You know, that's why the margins have averaged 16 percent. So I guess sort of the two parts of your answer is, you know, we set the payments much higher than costs originally, and policies since then have not been adequate to bring the two into balance.

DR. CROSSON: David.

DR. GRABOWSKI: [off microphone].

DR. CROSSON: Oh, asked and answered. Other questions for Evan?

[No response.]

DR. CROSSON: Okay. Seeing none, we'll proceed with the discussion. You have the recommendation before you, which is to reduce the base payment rate by 7 percent for 2021. Kathy.

MS. BUTO: Can you tell us where you got the 7

percent? Where does that come from?

DR. CROSSON: More than 5.

MR. CHRISTMAN: I guess what I would say is that -- I think there's two things. One is the sense that there has been some persistence in these margins even though we've done -- you know, there have been efforts to reduce the payments in the past. Last year, the Commission recommended a 5 percent reduction, and this year I think what makes 2018 at least for me a little different is we're seeing the first year of data after the ACA policy, which was supposed to be a big change to home health payments. It was referred to as rebasing. The idea is we would recover this original sin of this big gap between the expected and the actual visits. But because of the way that policy was written and implemented, that was mostly -- it didn't have a serious effect.

And so I think what we're saying is the industry has come out of this period where their payments were supposed to undergo a big adjustment. It didn't have an effect, and since we can see in 2018 they're basically in as good or better shape than they were in 2013 before rebasing, it's time for some more serious action. I think

that's...

DR. MATHEWS: One additional point to amplify what Evan just said. You'll note the margin projection for 2020 is actually expected to increase to 17 percent. That margin projection does take into account all of the statutory and regulatory factors that govern increases in payments to home health, including the prospective case mix adjustment that CMS has made as the new payment system gets implemented.

I think Evan has been extremely conservative in making his projections, and if I were to bet Evan's salary on it --

[Laughter.]

DR. MATHEWS: -- it would be a safe bet to say that margin might end up being a big higher.

MS. BUTO: I was going to say, why not go to 10?

DR. CROSSON: We have a bid on the table.

[Laughter.]

DR. GRABOWSKI: Jay, can I -- oh, sorry.

DR. CROSSON: I'll take that as an editorial comment at the moment. Okay.

DR. GRABOWSKI: Yeah, I was just going to also

say I'm supportive of 7 and, much like Kathy, could even go higher, and I just wanted to emphasize I can't ever remember -- and, Kathy, you've been doing -- with CMS, do you ever remember kind of working in a behavioral adjustment into a policy where we know they're going to up -- we know there's going to be this creep, why not take it right off the top?

MS. BUTO: Yeah.

DR. GRABOWSKI: And there may be other examples of that; it may be common. But I'm not used to seeing --

MS. BUTO: Yeah. It's done.

DR. GRABOWSKI: It's done, and it needs to be done here, and that's telling.

DR. CROSSON: Okay. I'm getting a sense of general support for this recommendation, so we will bring this forward in January through the expedited voting process. Evan, thank you again. We'll move ahead.

[Pause.]

DR. CROSSON: Okay. We are going to move along to the third presentation of the afternoon, and that's the update recommendation for inpatient rehabilitation facilities. We have Jamila and Dana here to present.

Dana, are you the same Dana that sits over there?

[Laughter.]

DR. CROSSON: Jamila, are you going to start?

DR. TORAIN: I am.

DR. CROSSON: All right. Thank you.

DR. TORAIN: Good afternoon.

Before we start, I will outline today's presentation for inpatient rehabilitation facilities, also known as IRFs.

First, I will briefly review Medicare's payment system for IRFs. Next, I will give a quick overview of some continuing concerns we have about the system. Then I will present our payment adequacy analysis and recommendation.

In general, we see a continuation of trends we observed last year, when you'll recall we recommended a 5 percent reduction in the IRF payment rate.

After illness, injury, or surgery, many patients need intensive rehabilitative care, including physical, occupational, or speech therapy. Sometimes these services are provided in IRFs.

To qualify as an IRF, facilities must meet

Medicare's conditions of participation as well as several additional requirements.

In addition, for a stay to be covered, there are certain patient requirements that must be met that are outlined in your paper.

Per-case payments to IRFs are based on patients' condition, level of impairment as measured by the IRF, age, and comorbidity.

In 2018, Medicare accounted for about 59 percent of IRF discharges, and the average length of stay was 12.7 days.

We have concerns with the IRF payment system. For example, how IRFs assess their patient's functional status affects their payments. In previous research, we have 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 patients were coded as being more impaired on average.

Second, we have observed that high-margin IRFs have a different mix of cases than other IRFs do. This suggests that some case types may be more profitable than

others.

To assess payment adequacy for IRFs, we used the same framework you've seen in earlier presentation. We'll start by considering access of care, which includes analysis of the supply of providers, volume of services, and marginal profit.

We first look at the supply of IRFs. In 2018, there were 1,170 nationwide, a slight decrease from 2017. However, despite this decline in number of facilities, the total number of IRF beds edged up slightly, with a little more than 37,000 bed in 2018.

As you can see in the facilities column on the chart, only 25 percent were freestanding facilities, but these IRFs tend to be bigger, so they accounted for about half of Medicare discharges in 2018. So even though the total number of facilities declined slightly in 2018, the total number of freestanding facilities continues to grow.

The number of for-profit IRFs is also growing steadily. Overall, 34 percent of IRFs were for-profit, accounting for 56 percent of all Medicare discharges.

We move on to beneficiary access to care. In 2018, there was an increase in the volume of IRF cases and

the number of cases per fee-for-service beneficiary.

Payments per case also continued to increase. If we look at marginal profit, we see a robust 41 percent for freestanding IRFs and 20 percent for hospital-based IRFs, meaning that both sets of providers have an incentive to serve additional beneficiaries, assuming that they qualify for IRF-level care.

In terms of quality, we find some improvement in our risk-adjusted quality measures. The rate of potentially avoidable readmissions during an IRF stay was 2.6 percent in 2018 and 4.8 percent during the 30 days after discharge, both improving slightly from 2012.

We saw improvements in the share of patients discharged to the community rising from 74.4 percent in 2012 to 76.4 percent in 2018.

We also saw improvements on gains in motor function and cognitive function over this period, but remember that function scores are provider-reported and affect payment, so should be viewed with some caution.

Turning now to access to capital. 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, close to half of these facilities are owned or operated 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 expanding its business to include the purchase of home health agencies and hospice providers and entering in joint ventures with acute care hospitals to build new IRFs. The all-payer margin for freestanding IRFs is a robust 10.7 percent.

Moving on to discuss payments and costs, we find that payment have been increasing faster than costs since 2010, with payments rising a cumulative 19.6 percent since 2010 and costs rising a cumulative 13 percent. You will note that cost growth was particularly low from 2010 to 2015, averaging just 1.2 percent per year.

These differences in per-case costs and payment growth have led to steady rise in aggregate margins for IRFs, which climbed from 8.6 percent in 2010 to 14.7 percent in 2018. For the past three years, aggregate IRF margins have remained above 13 percent.

Financial performance varies by type of IRF. Freestanding IRFs have margins of 25.4 percent, while hospital-based IRFs have an aggregate margin of 2.5 percent.

The primary driver of profit margins is cost, which tend to be lower in freestanding and for-profit IRFs.

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

First, hospital-based IRFs are more likely than freestanding IRFs to be nonprofit, and so they may be less focused on reducing costs to maximize return to investors.

They also have fewer economies of scale. Hospital-based IRFs tend to be much smaller than freestanding IRFs, and they have fewer total cases. Their occupancy rates are also somewhat lower, 61 percent in hospital-based IRFs versus 69 percent in freestanding.

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

Finally, hospital-based IRFs may assess and code their patients differently, contributing to differences in payments for similar patients.

Next, we will examine relatively efficient IRFs. We find that these IRFs had better performance on quality metrics, with readmission rates 11 percent lower and discharge rates to SNFs that were 27 percent lower than other IRFs.

Relatively efficient IRFs were also larger and had higher occupancy rates than other IRFs, leading to lower costs.

Payment rates, however, were similar between both groups, but with the large cost difference, Medicare margins were much higher in the relatively efficient group, 17.8 percent in 2018 compared with 1.1 percent for other IRFs.

The mix of cases was also different, and we have discussed this before as relatively efficient IRFs have a smaller share of stroke cases and higher share of other neurological condition cases. Freestanding and for-profit facilities were disproportionately represented in the relatively efficient group, but there were some hospital-

based facilities as well.

We note that the results of the efficient provider analysis must be interpreted with caution due to our concerns about the accuracy of IRFs' payment patient assessments, which in turn determine payment amounts.

Our projected Medicare margin for IRFs in 2020 is 12.7 because we expect cost growth to exceed payment growth in 2019 and 2020. Payment growth will be limited because payment updates for fiscal years 2019 and 2020 were set in statute at below-market basket levels, 1.35 percent and 2.5 percent respectively. And though cost growth in this industry was very low from 2010 to 2015, cost growth was higher from 2016 to 2018, and we expect this higher level of cost growth to continue with costs rising faster than the payment updates in 2019 and 2020.

In summary, we found that the IRF payment adequacy indicators were positive.

With regards to beneficiaries' access to care, IRFs continue to have capacity that appears to be adequate to meet demand.

With regards to quality of care, our risk-adjusted outcome measures have improved slightly over time.

With regards to IRFs' access to capital, these facilities maintain good access to capital markets. The all-payer margin for freestanding IRFs is a robust 10.7 percent in 2018.

With regards to Medicare payments and IRF cost indicators, they were positive. In 2018, the Medicare margin was 14.7 percent, and we project a margin of 12.7 percent in 2020.

So, to summarize, we observe capacity that appears to be adequate to meet demand and that providers should have an incentive to take more Medicare beneficiaries that qualify for IRF-level care, given the strong marginal profits for both freestanding and hospital-based facilities.

That brings us to the update for 2021. As we did last year, the Chairman's draft recommendation reads "For 2021, the Congress should reduce the fiscal year 2020 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent."

To review the implications, relative to current law, Medicare spending would decrease because current law would give an update of 2.9 percent instead.

We anticipate no adverse effect on Medicare beneficiaries' access to care, given IRFs' high profit margins, although the recommendation may increase financial pressure on some providers.

The Chairman's draft recommendation will also include a reiteration of 2016 recommendations.

The first one addresses concerns about coding. MedPAC recommended that CMS ensure payment accuracy through focused medical record review, and we encourage the Secretary to reassess provider integrator reliability across IRFs.

The second recommendation addressed differences in the profitability of case mix groups. MedPAC recommended that CMS pay for a higher share of the cost of outlier patients who are extremely costly by expanding Medicare's IRFs' high-cost outlier pool. These outlier payments would tend to go to hospital-based and nonprofit facilities.

These recommendations were intended to be short-term fixes until improvements can be made to the IRF payment system.

With that, I will close. I am happy to take any

questions. Thank you.

DR. PAUL GINSBURG: Thank you very much for the clear presentation.

We'll take clarifying questions now. Jon?

DR. PERLIN: Yeah. Let me thank you really for a thoughtful chapter and great job presenting.

This really gets sort of in reference to the second of last year's recommendations. Since you've noted systematic differences between the patients and inpatient facilities, freestanding, would there be utility in looking at most efficient providers in two categories inpatient against inpatient, inpatient against freestanding, given that systematic difference in the complexity of patients?

DR. TORAIN: Yes. So that's something we can consider. We haven't looked at -- I think there was a previous recommendation in the past to break down the efficient provider analysis, but that is something that we can consider.

DR. PERLIN: Thanks.

DR. PAUL GINSBURG: Amol?

DR. NAVATHE: On that point, actually one of my comments was going to be to just look at it based on the

case types as opposed to the type of facility, per se, which would allow some heterogeneity and the hospital-based versus not but would try to normalize, sort of like we do peer groups, except we do peer groups based on the case.

MS. KELLEY: Yeah. And that's something that we are intending to look at is differences in profitability across case types to try to dig down a little bit deeper to see what's going on there.

DR. PAUL GINSBURG: Pat?

MS. WANG: I'm kind of interested in the same subject and so struck by -- it's great that you called it out on Slide 12 to talk about the difference and the difference in margins.

DR. PAUL GINSBURG: Pat, I'm having trouble hearing.

MS. WANG: Sorry.

Persisting over time. I just wanted to follow up on the same questions of inpatient versus freestanding, not-for-profit versus for-profit, because the margin difference over time has widened, and there's market movement in the sponsorship of the IRFs.

I guess one question, because I just don't remember -- and it's great that Carol Carter is still here. In the PAC PPS work, if that were fully implemented, would there be a narrowing of the margins or a change in the margins as between freestanding and hospital-based, for-profit versus not-for-profit? I don't remember. Very small? Very small. Okay. That's interesting.

So you highlighted and people talked about the different conditions perhaps that are being treated that may drive some of this. I wanted to ask if an IRF is hospital-based and the hospital is a teaching hospital, are there IME adjustments to the IRF stay?

DR. TORAIN: Yes, there are.

MS. WANG: There are, okay.

Is it the same basis? Like is it considered freestanding like in turn resident's bed ratio is like the whole enterprise?

MS. KELLEY: It's not the same formula, same application of the formula, that's used in the IPPS, but it's a similar payment adjustment.

MS. WANG: Okay. Are there other things that you have thought of that would explain the vast disparity in

financial performance between these different auspice, for-profit, not-for-profit, freestanding versus, you know, acute care hospital sponsored?

DR. TORAIN: So cost is a large driver; in particular, the direct cost to the hospital and therapies being very specific. And so cost is really what -- it's specifically in the period of 2010 to 2015, we observed that freestanding for-profit, the payments were like 14.9, and the cost itself was 4.1. So that's really the driver of the margins.

MS. KELLEY: One of the interesting things that we've seen in this industry is that particularly over that earlier period that Jamila referred to, we've seen increasing case mix in freestanding for-profit facilities, but cost growth has been very low and even negative in some years, which again kind of lends to our interest in sort of what's going on with coding in this industry.

DR. DeSALVO: Just on that point, they were later in the cycle than others in adopting electronic health records. So there may have been some bump that they gained for coding intensity from using technology.

MS. KELLEY: I hadn't thought of that. Thank

you.

DR. CROSSON: Amol, Larry.

DR. NAVATHE: So I couldn't help but notice that the IRF admission rate or number of admissions is going up. Whereas for SNFs, it's going down. I'm somewhat embarrassed to admit that I didn't realize that was the case. I don't know, David or others, if you have observed that in the past.

I was curious if there was any sense of what is explaining that divergence when we, I think, generally have felt that there's quite a bit of overlap that has existed between the types of patients that can go into those facilities.

DR. TORAIN: So we noticed, too. And so during fiscal year 2018 there was a program implemented by CMS called the Targeted Probe and Educate, with the overall goal of decreasing the number of claims denials through education. And so basically if an IRF is identified as a higher-error IRF, the Medicare administrative contractors will contact that specific IRF and give them an opportunity to rectify their claims up to three rounds, and most IRFs do not make it to the third round. And so we think that

what we're seeing, really, is just more claims being accepted during that time.

MS. KELLEY: The other thing, I think we've seen, I think, exactly as Jamila has said, cases may have gotten a one-time boost as some claims kind of pushed through that otherwise would have been held up. But we also think the less focus on claims denials and the attempts to deny fewer claims has perhaps provided an opportunity for some IRFs to admit patients that are more on sort of, maybe on the line of whether or not they qualify for IRF care, because they may be less concerned about denials, in general. So we suspect it's kind of those two things going on at the same time.

DR. MATHEWS: And if I could add one more factor. If you will recall from the hospital session this morning, we do see a very small decline in inpatient hospital admissions, I think 1.6 percent between 2017 and 2018. And inpatient admission being a prerequisite for SNF, it would be expected that the decline in inpatient admissions would have a ripple effect on SNF.

DR. CROSSON: All right.

MS. KELLEY: And I just would add one more thing,

that I think we saw when you were looking at the types of cases that were increasing, what we saw is a larger than expected increase in the number of cases with debility. And that is kind of a catch-all category of patients, not stroke, not neurological, and more the type of patient you might think would be admitted to an IRF if perhaps they didn't have a hospital stay and so couldn't go to a SNF.

DR. CASALINO: Excellent presentation and paper. Thanks. I think I know the answer to this but maybe you could just lay it out explicitly. So the first bullet point recommendation you have up there about conducting focused medical record review, I mean, you could say that in pretty much any session we're having today, and particularly it may be the afternoon sessions. Is this -- I don't mean this as a critical question, but to make sure I understand it -- is there something really special about IRFs that makes us call it out here, and not for the other sectors?

DR. TORAIN: Part of the case mix classification system, that motor score that's a part of giving the patient the -- or placing the patient in a CMG, is provider reported in the IRF system, and so it is very subjective.

So we put it there specifically because of that part of the case mix system that is very subjective. And so that's why we pointed out more so than other sectors.

MS. KELLEY: And I'll just add to that, that although the functional scores are part of the home health and – well, different functional scores but function as assessed by the provider are a part of the SNF and the home health payment systems as well, in both those other payment systems there have been other incentives driving behavior, such as additional payment for providing more therapy. So for providers who are looking to capitalize on those types of incentives, the goal has been to increase the amount of therapy that patients receive.

In the IRF payment system, we've seen sort of a different incentive focused on, and here it seems to be much more focused on function. And I think I'll just remind us of the analysis that Carol did last spring, where she looked at discharge assessment for patients who used two PAC services in a row -- discharge from one PAC provider to another, and she looked at the discharge assessment from the first PAC provider and the admission assessment for the second PAC provider.

And what she found was quite a bit of misalignment, if you will, between the two. And interestingly, it did not seem to be in kind of a random way. The discharge assessment from the first provider, which would have been used, in part, to measure quality improvement, was relatively high, so showing, you know, a high improvement, and the admission assessment for the second PAC provider tended to be lower, which is where payment was established, at the admission, with the admission assessment of the second provider.

So, you know, there does seem to be some behavioral incentive here that we're kind of seeing in action.

DR. CASALINO: But stronger for IRFs than for home health?

MS. KELLEY: At this time, and I'll just remind you that we are moving to payment systems in home health and SNF that, we are happy to say, are no longer reliant on provision of therapy but they are going to be more reliant on patient characteristics, such as function.

DR. CASALINO: Yeah. Actually, that is what I was thinking. We might want to think about that more in

the future for these other sectors. And is the intention to make these two recommendations, again, along with the payment update recommendation, or is this just for us to see?

MS. KELLEY: Last year we reiterated -- the last two years we've reiterated these along with our updated recommendation, and the Chairman's draft was to do the same this year.

DR. CROSSON: Paul?

DR. PAUL GINSBURG: Yes. This was -- I've been reading the chapters in order and this was the third one on post-acute care, and it started to dawn on me about issues which come up, you know, in all of these different settings. And, you know, I was wondering if the staff might think about, after the meeting, whether to construct an introductory chapter to these next three or four, which just, you know, explains some of the issues that cut across that each one has to deal with, and then it can be referred to as the chapters go through.

DR. MATHEWS: Yeah, so in the past we have done, you know, what we've referred to as PAC preamble chapter, where we are dealing with specific cross-cutting issues.

For example, we looked at quality measurement a year or two ago, and as we were working up our unified PAC PPS work we did PAC preambles a couple of times. We could do the same this time around if there were select issues, but at the moment we would have to think about it.

DR. PAUL GINSBURG: Sure. It is certainly up to you. I was thinking provider reporting is the one thing that really struck me, and it may be you don't gain enough.

MS. BUTO: Jim, I would also throw into that same preamble eligibility, which I don't think we highlight enough. For example, in home health, homebound, the IRF has certain specific criteria. SNF requires three-day prior hospitalization. I mean, it helps to set the context for the fact that I think we tend to think of the PAC PPS as being the ability to go across these settings, but as long as these other criteria are still there, we just need to be aware that there are some sort of barriers to that kind of, I don't know, I guess site-neutral payment, if you will, even for the same kind of patient. So if there's some way to highlight that, I think it's helpful.

I had to go back and look to see whether homebound was even still a criterion, because I think

people tend to think of home health as one of the easier post-acute care benefits to access, and in a way it is, but that's because they do not enforce the homebound requirement.

MS. MARJORIE GINSBURG: Isn't the definition of homebound pretty loose anyway?

MS. BUTO: Actually, it's pretty specific and pretty tight, but it's not enforced.

MS. MARJORIE GINSBURG: Okay.

MS. BUTO: I mean, things like you can go to church. I mean, very specific as to what constitutes being able to leave home or not leave home.

MS. MARJORIE GINSBURG: But it does make you think that the true definition of homebound is so strict that nobody would qualify for home care.

MS. BUTO: Right, or very few people.

DR. CROSSON: Okay. Okay.

DR. DeBUSK: The exchange between Lawrence and Dana, actually, just to clarify, the PAC PPS that we've been working on, I remember most of the patient characteristics that fed into the model. I don't remember assessments. Were assessments big inputs into that model?

MS. KELLEY: No, we don't -- the model that we developed does not have a functional component to it.

DR. DeBUSK: Yeah, I didn't remember one. Now the model, though, that CMS has switched to in October for SNF, and it will in January for home health, does that have assessments in it, or is it truly patient characteristics?

MS. KELLEY: It does use the SNF and the home health assessment tools, yes, which include a functional component.

DR. DeBUSK: So it does pick up increased vulnerability to -- what did you call it? -- behavioral incentives or something. Because I remember we don't use the gaming word anymore. Behavioral incentives, right?

MS. KELLEY: I would say yes. I'm looking at Carol, and yeah, we are agreeing.

DR. DeBUSK: So the change, while it is an improvement away from therapy, it does expose us to some risk for behavioral incentives on the coding side, but if we move to the PAC PPS we will be okay because those inputs aren't -- so the transition to the PAC PPS addresses that really in all three venues.

MS. KELLEY: Right. I mean, I would just say --

you're absolutely right in your characterization of that, and I would just say that I think, you know, for many years the Commission talked about the need for good, functional assessment for post-acute care patients, because, you know, that seems to be the ideal,to see functional improvement for most -- or many patients. Not all patients will improve.

But I think, you know, what we're seeing over time, as we look at the assessment data more closely, is, you know, we've started to have more and more concerns about the data. And so I think ideally we would -- in an ideal world we would still want information on patients' functional status, even in a PAC PPS. I do think that would help if we had some objective measures. That would help differentiate for some patients. The question is how we can get there.

DR. DeBUSK: So the changes that are in effect now are really around getting us away from dependency on therapy as a payment.

MS. KELLEY: Correct.

DR. DeBUSK: Determination of payment. But we still have the glitch, if you will, that we still have some

assessments in the current model. But again, the PAC PPS is a step in that next direction, but philosophically, we're moving away from provider -- basically provider assessment.

MS. KELLEY: Well, yes, and I would just add that, you know, the term "assessment," the assessment tools do carry information on them that's not about function. There are some special services that might be important for payment, for example, a patient who is using a ventilator or receiving particular types of expensive antibiotic therapy, and that information is on an assessment tool and could be useful, and it is information that we did use in our PAC PPS.

DR. DeBUSK: Thanks. Great.

DR. CROSSON: Jon.

DR. PERLIN: Thanks. I want to go back to Paul's comment about a preamble, and I realize that has, you know, a lot of implications in terms of effort. But the point behind that is that we're working with a presumption that there is a continuum of progressively intense services, and the most appropriate venue is the, you know, lowest appropriate for the level of care needs.

And, you know, in that regard, I think the framing, as we think about this progression of complexity, to have the different puts and takes that Kathy and Marge had alluded to earlier. But also, you know, when I think about what are the other issues that could skew where a patient goes? It's really availability in a particular service area.

And so I wonder if, as part of our thinking about more of a continuum further out, we don't really need to think not just about availability of SNFs in a market, about availability of IRFs or LTCHs, et cetera, but rather what is the convergence across some sorts of service areas, so we understand, you know, the impact of geographical availability in terms of the ability to match level of need with level of service. Thanks.

DR. CROSSON: One sec, because I actually have a question, and this may be an appropriate time to build on what Jon just said. And I apologize because I'm pretty sure I've asked this before. But IRFs are not available everywhere. We know that, or I believe we know that where they are not available, acute care hospitals provide the same or similar services under the IPPS. Do we have any --

I'm sorry?

DR. TORAIN: And SNFs.

DR. CROSSON: And SNF. Okay. But maybe just for the moment focusing on hospital based, acute care hospital-based services, do we have any way of estimating how much more the Medicare program is paying for XYZ services in an IRF compared with what it pays in an acute care hospital?

MS. KELLEY: It's a really difficult question to answer, because it's very hard to control for placement issues and selectivity. It is true that an IRF patient might stay longer in an acute care hospital if it is, you know, a true post-acute stay, but the patient also could go to a SNF in some areas, and it's very difficult for us to control for that when we do an analysis like this.

You know, we might be able to -- what do you think, Carol? We might be able to do some sort of look at it, but I don't know. I think we would have to have so many caveats to an analysis like that, that I don't know that it would be as useful as you would like it to be.

DR. CROSSON: Okay. And I won't say why I'm asking the question. How's that? Pat.

MS. WANG: This might slide into a round two sort

of thing but let me just ask the question. I think it's really significant that, you know, you've repeated and called out these two recommendations in a response to some of the other questions. You've noted that there's always a concern, but it's a little heightened here, because of the nature of the IRF pie.

To what extent is the update recommendation a blunt instrument to get at this, because this hasn't happened? If this were in place, do you think the update, like the margins would look different, and do you think the update recommendation would be different? And, you know, full disclosure, I am, what I said before, where the overall margin is close to 15 percent, but it's 2.5 percent in not-for-profit, hospital-based, and 10 times that in freestanding for-profit.

The disparity, given the concerns that you raise here, you know, I'm just -- so I guess the question is, could you just confirm that you haven't been able to sort of thread a needle in the update factor recommendation that all these things have happened and you still, for the revised margin, feel like a 5 percent cut is appropriate, or is this kind of in lieu of these other things happening?

MS. KELLEY: So I think the thing to do is to think about this in two sort of different buckets. If we had -- if we felt that costs were better, or evenly aligned -- or rather if we felt that payments were evenly aligned with costs across different types of patients, we would see higher -- I think we would see higher margins in hospital-based and nonprofits than we currently do, in the absence of any behavioral change. But that would be moving money across patients. In terms of an aggregate, we wouldn't see any change in the total amount of money in the system. So the average margin, the aggregate average margin would still be high. So the update recommendation deals with that second factor.

MS. WANG: Okay. And you're looking at it in the aggregate, because just assuming that that hasn't happened, this aggregate update factor is going to affect the sectors quite differently, given the current state.

DR. MATHEWS: Pat, let me see if I can take a stab at answering your question, just from a slightly different angle. I agree with everything that Dana just said, this might be more helpful to you.

So in the past, other post-acute care sectors

we've looked at have had very high margins, SNF and home health being case examples. And when we have dug into the payment systems, we have been able to find specific factors in the payment systems where certain types of cases were more profitable than others, and we were able to make recommendations in the way the payment systems operated such that we could justify an across-the-board reduction in payments, 5 percent.

Here we see, you know, very stark differential performance across different types of IRFs, but we have yet to find the thing embedded in the payment system that allows us to say here is how to fix the payment system and that's why you can cut payments by 5 percent.

And so in lieu of finding that key, we are using these kinds of recommendations as safeguards. So, for example, increasing the outlier pool. This is a very, very blunt instrument, but it does serve to protect those IRFs who have legitimately high cost case who might really be adversely affected by a 5 percent cut.

And so I think earlier on Jamila or Dana used the term, you know, "short term" or "stop gap" or "Band-aid." That's what these recommendations were designed to do.

And, you know, among ourselves, the next task we have underway -- and by "we" I mean Jamila – is to start digging into the payment systems the same way we've done for SNF and home health.

Does that help get at what you're....

DR. CROSSON: Okay. Seeing no more questions, we'll move to the discussion phase. And we have the recommendation on the table, but I guess the amendment, if you want to call it that, or add-on would be the question of whether to reiterate the 2016 recommendation. So we'll take those two issues together, and looking around, I'm assuming support. So we will then take this in expedited form for the January meeting. Thank you so much, Jamila. Excellent work. Thank you, Dana, as well.

Okay. Our last presentation and discussion for today is on the update for long-term care hospitals. Stephanie and Carolyn are here, and, Carolyn, it looks like you're going to begin. You have the floor.

MS. SAN SOUCIE: Good afternoon. Today we are here to discuss how payments to long-term care hospitals should be updated for fiscal year 2021. Using the established framework, we will evaluate the adequacy of

Medicare payments to LTCHs. I'll begin with some background on LTCHs, the implementation of the dual-payment rate structure, and the first part of the payment adequacy framework. Then Stephanie will conclude with the remainder of the framework as well as the Chairman's draft recommendation.

I will start by summarizing some background information that was included in your mailing materials. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute-care hospitals. Additionally, LTCHs must have an average length of stay for certain Medicare cases of greater than 25 days.

As you'll recall, the Pathway for SGR Reform Act of 2013 changed the way LTCHs are paid, establishing a dual-payment rate structure. Cases meeting the LTCH PPS criteria are those that are preceded by an acute-care hospital discharge and either spent three or more days in the ICU of the referring acute-care hospital or receive prolonged mechanical ventilation in the LTCH. These cases are paid under the LTCH PPS and will be the focus of a lot of the analysis we will walk through.

All other cases, those not meeting the LTCH PPS

criteria, are paid a lower site-neutral rate. The policy began in fiscal year 2016 and is being phased in over four years. Until fiscal year 2020, cases that did not meet the LTCH PPS criteria were paid a rate equal to 50 percent of the site-neutral rate and 50 percent of the much higher standard LTCH payment rate. Beginning this fiscal year, these cases are paid the reduced rate.

Care provided in LTCHs is expensive. Total Medicare spending on care furnished in 374 LTCHs was approximately $4.2 billion in 2018. This total spending accounted for payments for just over 100,000 Medicare cases.

The average Medicare payment per case was about $40,000 across all cases and approximately $47,000 across the cases meeting the LTCH PPS criteria discussed on the previous slide.

I will now turn to the question of how payments to LTCHs should be updated for fiscal year 2021. 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.

To begin, we'll focus on beneficiaries' access to

care.

While we apply the framework on the prior slide in the same manner for LTCHs, we expect substantial changes from the implementation of the dual-payment rate structure given the financial disincentive for LTCHs to continue taking Medicare beneficiaries not meeting the LTCH PPS criteria. Because of the reduction in payment, the extent to which LTCHs are able to alter their admission patterns toward cases meeting the LTCH PPS criteria determines facilities' financial performance under Medicare. Because some LTCHs have dramatically altered their admission patterns in response to the policy consistent with the goals of the dual-payment rate structure, we isolate some of our analyses to the LTCHs with more than 85 percent of their cases meeting the LTCH PPS criteria in 2018.

Approximately 38 percent of LTCHs met the 85 percent threshold in 2018. All of their Medicare stays account for 37 percent of total Medicare stays that year. Please note that this is a correction from Table 11-8 of the mailing materials. We will specify when we consider this subset of providers during the presentation.

We find the number of LTCH cases has been

declining since 2012. The reduction in volume has not been consistent across case types over the past six years. The number of cases meeting the LTCH PPS criteria remained remarkably stable over time. Most of the attrition of LTCH use we have seen since 2015 came from a reduction in cases not meeting the LTCH PPS criteria. As you can see, the number of these cases declined rapidly from 2016 to 2018. As a result, the share of LTCH cases meeting the LTCH PPS criteria has increased since 2012.

The number of LTCH facilities has been decreasing since 2012. There was a 6.4 percent reduction in the number of LTCHs from 2012 to 2017 and a 5.1 percent reduction from 2017 to 2018. We also found additional closures occurring in 2019.

In 2018, LTCH occupancy rates averaged around 63 percent, a three-percentage-point drop from 2016. This suggests that LTCHs had ample capacity in the markets they served.

Medicare marginal profit across all LTCHs was 16 percent in 2018, up from about 14 percent in 2017. The marginal profit for LTCHs with a high share of Medicare beneficiaries meeting the LTCH PPS criteria was 18 percent

in 2018. Therefore, we contend that LTCHs have a financial incentive to increase their occupancy rates with Medicare beneficiaries who meet the LTCH PPS criteria.

Now Stephanie will take over the rest of the payment adequacy framework, starting with quality of care.

MS. CAMERON: Not unexpectedly, given differences in patient severity, unadjusted rates of direct LTCH to acute-care hospital readmissions, death in the LTCH, and death within 30 days of discharge from the LTCH varied depending on whether or not the case met the LTCH PPS criteria, but were generally stable over time.

In 2018, for cases meeting the LTCH PPS criteria, 10 percent were readmitted to the acute-care hospital directly from the LTCH, 16 percent died in the LTCH, and 13 percent died within 30 days of discharge from the LTCH. By comparison, cases not meeting the LTCH PPS criteria have lower rates of readmission and mortality.

CMS publishes data for several outcomes measures including rates of various infections. Publicly available data for several of these measures spans more than one year and thus can be used for some analysis. In 2018, the standardized infection ratios for all four infection types

listed on the screen were lower than expected after adjustments for certain risk factors, consistent with 2017,

Moving on, we will now discuss the third piece of our payment adequacy framework, access to capital. Access to capital allows LTCHs to maintain and modernize their facilities; however, given the last decade of policies that have limited industry growth, including moratoria on new facilities and the implementation of the dual-payment rate structure, the availability of capital is limited across the industry. Major chains have been diversifying their portfolios and have been strategic in their purchase, sale, and closure of LTCH facilities in more competitive LTCH markets. These major industry shifts have reduced the need for capital. We expect major industry changes to continue until after the dual-payment rate structure is fully phased in.

LTCHs' access to capital also depends on their all-payer profitability, which was 2.2 percent in 2018 up from 0.2 percent in 2017. LTCHs with more than 85 percent of their Medicare cases meeting the LTCH PPS criteria had an aggregate all-payer margin of 4.5 percent in 2018.

And, lastly, our final factor of the payment

adequacy framework is Medicare payments and costs. We continued to find the difference in cost growth across LTCHs following the implementation of the dual-payment rate structure.

For example, across all LTCHs we found small increases from 2015 to 2017; however, cost growth increased 2.7 percent in 2018, likely due to increases in the share of patients meeting the LTCH PPS criteria.

On the other hand, for LTCHs with a high share of cases meeting the LTCH PPS criteria, larger growth in cost occurred from 2015 to 2017, averaging 3.6 percent annually. For these LTCHs, from 2017 through 2018, we saw cost growth stabilize at 1 percent. These trends are not unexpected given the large range of admission strategies following the partial implementation of the dual-payment rate structure. LTCHs that substantially increased the share of cases meeting the LTCH PPS criteria had higher cost growth; once the share of those patients stabilized, cost growth also stabilized.

Even with a 2.7 percent increase in costs, in 2018 the aggregate LTCH margin increased by 1.7 percentage points to negative 0.5 percent. Consistent with prior

years, financial performance in 2018 varied across LTCHs. For example, for-profit LTCHs had the highest aggregate Medicare margin at 1.3 percent compared to nonprofit LTCHs at negative 11.7 percent.

LTCHs with a high share of Medicare cases meeting the LTCH PPS criteria have historically had higher margins, in part due to the case mix and relatively high profitability of Medicare cases admitted. In 2018, the aggregate Medicare margin for these LTCHs was 4.7 percent, a two-percentage-point increase from 2017.

Looking more closely at the characteristics of established LTCHs with the highest and lowest margins, this slide compares LTCHs in the top quartile for 2018 margins with those in the bottom. More than half of the LTCHs with the highest Medicare margins in 2018 also had more than 85 percent of their Medicare cases meeting the LTCH PPS criteria. Therefore, many, although not all, of the attributes of the highest-margin facilities overlapped with those LTCHs with a high share of cases meeting the LTCH PPS criteria.

As you can see, high-margin LTCHs tend to be larger and have higher occupancy rates, so they likely

benefit more from economies of scale. Low-margin LTCHs had standardized costs per discharge that were almost 50 percent higher than high-margin LTCHs. High-margin LTCHs are more likely to be for-profit.

We project that the aggregate Medicare margin for LTCHs with a high share of cases meeting the LTCH PPS criteria will increase in 2020. Our projection of the LTCH margin for fiscal year -- excuse me, decrease in 2020. Our projection of the LTCH margin for fiscal year 2020 focuses on these LTCHs which align with the goals of the dual-payment rate policy -- encouraging LTCHs to admit the most medically complex cases requiring specialized services. We expect significant changes in LTCHs' costs as the dual-payment rate structure is fully implemented and LTCHs continue to increase their Medicare admissions toward cases that meet the LTCH PPS criteria.

However, once an LTCH has reached a threshold of Medicare cases that meet the criteria, we expect changes in cost will become increasingly stable and reflect cost growth levels consistent with those prior to 2016. Using historical levels of cost growth, we project a 3.7 percent Medicare margin for LTCHs with a high share of cases

meeting the LTCH PPS criteria in 2020.

In sum, occupancy rates across the industry have decreased slightly. Although growth in the volume of LTCH services per beneficiary declined, this decline is in large part from the implementation of the dual-payment rate structure and LTCHs admitting more patients meeting the LTCH PPS criteria which aligns with the goals of the policy.

In terms of quality, unadjusted mortality and readmission rates appear to be stable while the adjusted infection rates continue to be lower than expected.

The effect of fully implementing the dual-payment rate structure will continue to limit industry growth and access to capital in the near term. The aggregate margin for LTCHs with a high share of cases meeting the LTCH PPS criteria increased to 4.7 percent in 2018. Our projected margin for these LTCHs in 2020 is 3.7 percent.

There is no statutory update for Medicare payments to LTCHs; however, CMS historically has used the LTCH market basket as a starting point for establishing the LTCH update. Therefore, we make our recommendation to the Secretary.

With that, the Chairman's draft recommendation reads: For 2021, the Secretary should increase the fiscal year 2020 Medicare base payment rate for long-term care hospitals by 2 percent.

This 2 percent update is expected to reduce federal program spending relative to the 2.8 percent expected regulatory update, given current projections of market basket and productivity.

We anticipate that LTCHs can continue to provide Medicare beneficiaries who meet the LTCH PPS criteria with access to safe and effective care.

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

DR. CROSSON: Thank you, Stephanie and Carolyn.

We're now open for clarifying questions. David and Jonathan.

DR. GRABOWSKI: Thanks for this presentation and report. I wanted to ask about the dual-payment rate structure. Reading the chapter and then seeing this presentation, I think it seems like it's working as intended. And to the extent that you wanted to criticize, as you said, beneficiaries' access to care has been limited, but limited in the ways that the policy was

intended to limit that care, and similar with access to capital.

So have there been any unintended consequences of the dual rate structure? Because this seems very, very positive.

MS. CAMERON: So I think it really frankly depends on who you speak with. You know, from our perspective, the policy is working as intended. I think from the industry perspective, I think for the most part folks we've talked to -- and you'll recall we did a mandated report on this last June. We've been to, I think, over 15 different cities and seen various LTCHs in those areas. So the people we've talked to have been relatively on board with kind of the intent of the policy, and I think in general the criteria seems like it's in the right direction.

I think where there have been concerns it pertains to wound care, and there was one study -- and we referenced this I believe in our June chapter -- that did show an associated increase in readmissions, I believe, with patients receiving wound care at other non-LTCH facilities. But that has been the kind of one area, and I

think when the Commission originally recommended this back in 2014 and based on the work that was done long ago in a kind of PAC-PRD and by, you know, the RTI analysis, wound care was not something that was included in the recommendation. But that has been, I would say, like the one primary concern that we have heard from industry.

DR. CASALINO: On this point, Jay. So fewer patients, fewer non-LTCH patients are going to the long-term care hospitals. Is there a sense of where they're going? And wherever that is, if we know, is that a good or a bad thing?

MS. CAMERON: So I think this is a very tricky question, and, you know, kind of following up on what Dana said about the difference between the IRF and the PPS, I think, you know, some of the patients are staying in the hospital a little bit longer. Their stays may have been extended a few days, and then they're subsequently discharged to a different post-acute care setting. Once they are stable enough and able to go to a SNF, for example, perhaps they go to that setting.

I think something to keep in mind is the volume of these patients is very low when you compare them to the

volume of overall hospital patients and the volume of patients going to SNFs. So hospitals have close to nine, ten million patients. We are talking about 100,000. You think about how many patients go to SNFs. It's a very small share. And so these patients are very difficult to track when you think of who would have gone to an LTCH. But for the most part, you know, our understanding is they're staying in the acute-care hospital potentially a little bit longer, and then they're discharged to other post-acute care settings.

DR. CROSSON: Jonathan?

DR. JAFFERY: Yeah. So thanks to you both for a great presentation and a clear chapter.

Two questions. The first is just to clarify. The phasing period from the 50-50 split over four years, was it progressive or was it 50-50 for four years and now it will be 100?

MS. CAMERON: So it was 50-50 for four years, and it's moving to 100. But it's on an individual hospital's cost reporting year. So we haven't really seen many facilities go to 100 percent yet, even though technically we're in fiscal 2020.

DR. JAFFERY: Okay.

MS. CAMERON: It will be later this year.

DR. JAFFERY: Yeah. Okay, great. Thanks.

Then thinking about the two ways to get the standard, the new standard LTCH PPS, so the three days in an ICU and the 96 hours of mechanical ventilation, have you tried to sort out if there are any differences in those two patient populations in terms of costs or outcomes or anything like that? I ask because it strikes me that there may be a greater degree of heterogeneity in the folks who had an ICU stay -- ICUs are very different at different hospitals and whatnot -- versus the mechanical ventilation.

MS. CAMERON: We haven't looked at this specifically.

There was a study published last year by folks -- Jeremy Khan was one of the authors -- up in Pittsburgh looking at the variation in outcomes for ventilator patients at an LTCH, and the variation was quite wide, and I think wider than you would expect. And there is going to be additional research kind of thinking about best practices that we're hoping is going to be published in the next year. So, hopefully, next year, we'll have a more

satisfying answer, but we haven't looked specifically kind of at the variation in outcomes for those two populations.

DR. JAFFERY: Thank you.

DR. CROSSON: Okay. Seeing no further questions, we'll move on to the discussion phase. We have the recommendation before you for a 2 percent increase. Any observations?

[No response.]

DR. CROSSON: Seeing none, I am interpreting this is general -- I saw something. Jonathan?

DR. JAFFERY: Let me just -- I am in general support of the recommendations.

The only thing I'm -- so I've said this before at different meetings, but I'm still struggling with where LTCHs fit in, in this post-acute care spectrum, and is it really post-acute care? I think about 30 percent of people actually dying in the stay or 30 days after discharge. I just continue to struggle with that.

So I think the way that I was thinking about addressing that in the context of our discussion this afternoon kind of goes back to Paul's comment about maybe a preamble. if that is something that the staff is able to

get to and looking at the different post-acute care settings as we're going into a unified PAC PPS, maybe there's some ways we can start to think about how it's really different maybe from the other settings, and is it really going to fit in with that, or do we need to think about something a little bit different about where is LTCH's role really? So that's my comment.

DR. CROSSON: So the patient characteristics that would fulfill the criteria that are currently used for LTCH, I think you're saying might not fit in other post-acute care settings, by and large.

DR. JAFFERY: Correct. Yeah.

DR. CROSSON: And I think that's right, but some would.

DR. JAFFERY: Yeah. And does it mean that maybe LTCHs are on a spectrum with actual acute care hospitals and there's some other way to address how do we take care of patients who need prolonged mechanical ventilation or wound care or other things that maybe are through some other outlier, payments, and can address some other --

DR. CROSSON: Right. Or we could see the evolution of a higher quality or a higher set of

capabilities, for example, in skilled nursing facilities as a consequence of this.

I'm sorry. Brian and Amol.

DR. DeBUSK: I was going to say to your point, I think there's some history here, and I'm going to guess that Kathy and Paul could probably tell us right off the top of their heads. But we even created LTCHs, I think, because there were like maybe 40 hospitals that didn't fit back in 1982, that didn't fit the DRGs. So we created that separate payment area, but then we went back and acuity-adjusted the DRGs. I remember reading some history about that. We added acuity adjustment to the ACH, the acute hospital DRGs.

MS. BUTO: The history I remember is trying to eliminate LTCHs as a provider type, and then it went into a moratorium and so on. I think they really do have a niche, though, with mechanical ventilation and those kinds of patients. Just like IRFs, they aren't everywhere. There are some places where there are no LTCHs. It goes back to the issue of putting this in context because these patients, there is some overlap, but there is a lot of non-overlap with some of these patients.

DR. DeBUSK: To more specifically answer Jonathan's point about that, I think it was maybe you and I. I was asking you at some point, could you just take the DRGs, the severity-adjusted, the MS-DRGs, just add a couple of extra levels of acuity or length? I mean, they work off the same DRG table, anyway. They're just in a different base. The base rate is just like four times more expensive.

The question is, could you sort of pack those back into -- this is a little outside the payment update conversation, but could you pack the LTCH codes back into the acute care hospital DRG schedule by just adding, say, a Level 4 and a Level 5 to some of these severity levels in the DRG?

MS. BUTO: We probably could. I don't know, Brian, but I think the hope is that with the PAC, unified PAC PPS, that we'll see some of this sort out into the appropriate settings, or there will be units in a way that are providing PAC services, maybe within an acute care hospital. So I think the road we're on toward a unified PAC is a good way to get to that next stage, whatever it is.

DR. CROSSON: I'm not sure who went first. Amol and then Jon.

DR. NAVATHE: Related to the point, it also sort of touches on Larry's question. What I was wondering is would we -- I guess this is a speculation, so I'm curious to hear your speculation. Would a potential unintended consequence in some sense be that we see more outlier cases in short-term acute hospitals, and is that something that we possibly track in some way or query on to try to better understand?

MS. CAMERON: So it is a potential that you could see additional outlier cases. Again, I think that when you just think about the sheer low volume relative to the rest of acute care hospital cases, it's very difficult to detect any changes and then attribute it to this policy in particular.

Again, it's 1 percent of PAC cases here. So I just really caution kind of those types of analyses. It would be very, very difficult to detect change.

DR. CROSSON: Jon?

DR. PERLIN: Yeah. I want to come back to this notion of matching level of care needs with level of

service offered. Taken to its fruition, a PAC PPS has an implication that it really is less related to the nomenclature around the facility and the capability of what that facility offers.

Jay, you have just pointed out the regional differences and the availability of IRFs. SNFs adapt. There are regional difference obviously in LTCH and other settings evolved as well.

Which again points to the data for the sort of explanation of continuum that Paul pointed out. I just want to go back from the highest acute to the least acute on the home health. Ironically -- and this is perhaps from a provider perspective -- it's in some ways more difficult to access home health by virtue of the rules around it.

I want to go back to an earlier conversation we had in which -- Kathy, you have just pointed out the fact that home health has evolved. The original notions of homebound are pressed. Is this a moment where we really think about the utility?

I think in an earlier discussion, Karen and Sue pointed out that, gosh, home health has such high utility, not just post-acute, but really as a preventive service,

and if the utility is to keep patients healthiest out of acute care environments, et cetera, then this may be the time just as we think about this comprehensively to think about making sure that we can access those lower levels of service so the higher levels of service aren't necessary, notwithstanding the obvious benefit to patient.

Thanks.

DR. CROSSON: Okay. Thank you, Jon.

Seeing no further discussants, I am once again making the assumption that we have support for the recommendation. Therefore, in January, we'll bring this forward through the expedited voting process, without objection.

Carolyn, Stephanie, thank you very much. Excellent work.

We now have an opportunity for a public comment period. If there are any of our guests who wish to make a comment about the business before the Commission this afternoon, please come forward to the microphone.

[No response.]

DR. CROSSON: Seeing none, we are adjourned until 8:30 tomorrow morning.

[Whereupon, at 3:43 p.m., the meeting was adjourned, to reconvene at 8:30 a.m., Friday, December 6, 2019.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 6, 2019
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
PAUL GINSBURG, PhD, Vice Chair
KATHY BUTO, MPA
LAWRENCE P. CASALINO, MD, PhD
BRIAN DeBUSK, PhD
KAREN B. DeSALVO, MD, MPH, Msc
MARJORIE E. GINSBURG, BSN, MPH
DAVID GRABOWSKI, PhD
JONATHAN B. JAFFERY, MD, MS, MMM
AMOL S. NAVATHE, MD, PhD
JONATHAN PERLIN, MD, PhD, MSHA
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Okay. I think it's time we can get started.

We apologize for the noise. You're actually not on an airplane. That's some strange noise that apparently is going to be fixed soon. That's the theory, anyway.

I'd like to welcome everybody to the Friday's session of our December MedPAC meeting. This morning, we have a continuation of yesterday's work, which is our annual work on payment updates, and we have two presentations. And then we will do our annual status update on the Medicare Advantage program.

So the first presentation is on outpatient dialysis service. Nancy and Andy are here, and Nancy looks like she's going to begin. You have the floor.

MS. RAY: Good morning. Today we are going to talk about the outpatient dialysis payment update for calendar year 2021.

First, I'll discuss some background on this payment system. Then we'll walk through the payment adequacy analysis, and we'll end with the Chairman's draft

recommendation

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2018, there was roughly 395,000 Medicare fee-for-service dialysis beneficiaries treated at 7,400 facilities. Total Medicare fee-for-service spending was about $12.7 billion for dialysis services.

This slide highlights the recent changes to the ESRD prospective payment system, PPS, and the payment for certain drugs, equipment, and supplies outside the payment bundle.

Beginning in 2018, calcimimetics have been paid outside the bundle under a transitional drug add-on payment policy, a TDAPA. Later in the presentation I'll come back to the effect of the TDAPA on Medicare spending and cost.

In 2020, the add-on payment for drugs, the TDAPA, will be expanded, and a new add-on payment policy for ESRD equipment and supplies will begin.

So let's move 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 2017 and 2018, growth in dialysis treatment stations grew faster than fee-for-service beneficiary growth.

Between 2017 and 2018, more facilities opened than closed. There was a net increase of roughly 320 facilities. Few facilities closed in 2017. There was a net increase in for-profit, freestanding facilities, as well as facilities located in rural and urban areas. The roughly 70 facilities that closed were more likely to be hospital-based and nonprofit, compared to all other facilities.

Few patients, about 0.4 percent, were affected by these closures. Our analysis suggests that affected patients were able to obtain care elsewhere.

Another indicator of access to care is the growth in the volume of services, trends in the number of dialysis fee-for-service covered treatments, and fee-for-service dialysis beneficiaries.

Between 2017 and 2018, both grew at similar rates

of less than 1 percent, and average treatments per beneficiary remained steady in both years. The 18 percent marginal profit suggests that providers have a financial incentive to continue to serve Medicare beneficiaries.

Each year, we also look at volume changes by measuring growth in the volume of dialysis drugs included in the PPS payment bundle. Since the PPS was implemented in 2011 and these drugs were included in the payment bundle, providers' incentive to furnish them, particularly the erythropoietin stimulating agents, ESAs, has changed.

Between 2010 and 2018, use of ESAs has declined by nearly 60 percent in aggregate, with some positive changes to beneficiaries' health status.

Expanding the payment bundle in 2011 is an example of the how Medicare used payment policy to decrease spending and improve health outcomes.

In more recent years, since 2015 and 2016, we see substitution among the ESAs for the lower-cost product, which is consistent with the goals of the PPS.

Now we look at quality by examining changes between 2013 and 2018. One indicator that measures how well the dialysis treatment removes waste from the blood,

dialysis adequacy, remains high. The percent of dialysis beneficiaries using home dialysis, which is associated with improved quality of life and patient satisfaction, increased from 10 percent to 12 percent in this five-year period.

Hospital admissions has modestly declined, and mortality and the percent of hospitalized beneficiaries with a readmission have held steady. These are all good trends.

On the other hand, the percent of dialysis beneficiaries with at least one emergency department visit increased.

Regarding access to capital, indicators suggest it is positive. An increasing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized dialysis organizations.

Since the start of the dialysis PPS, the two largest dialysis organizations have had sufficient access to capital to each purchase mid-sized dialysis organizations. There are new entrants to the dialysis sector in recent years, including CVS Health that is

currently running clinical trial for a home hemodialysis machine. The 2018 all-payer margin was 20 percent.

So now let's talk about providers' financial performance under Medicare. This slide shows the Medicare margin under the ESRD PPS since 2011.

In the early years, the increase in the margin is chiefly a result of the decline in drug use. The decrease in the margin between 2013 and 2017 was due to the rebasing of the base PPS rate to account for the decline in drug use, as I showed you on slide 7.

The increase in the Medicare margin between 2017 and 2018 is a result of the TDAPA for calcimimetics that began in 2018, and in 2020, the TDAPA will expand and there will be a new add-on payment for equipment and supplies.

So, in 2018, the Medicare margin was 2.1 percent.

Between 2017 and '8, the TDAPA has increased the Medicare margin across all of the facility types listed on this slide by 2 to 3 points.

Even with the TDAPA effect, we still see the difference in the margins between rural and urban facilities. In 2018, the aggregate Medicare margin for rural facilities, which account for 17 percent of

facilities, was negative 2.8 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.

I would like to point out that in 2018, however, the majority of treatment volume was furnished at positive-margin facilities.

So let's review the factors that the 2020 projection accounts for. It accounts for the increase in revenues based on the net payment updates in 2019 and 2020.

It also accounts for the increase in payments due to regulatory changes made by CMS to the outlier payment policy in both years.

It also accounts for the decrease in payments from the reduction of the TDAPA payment in 2020 from 106 percent of ASP to 100 percent of ASP.

And, lastly, to accounts for the small estimated reduction in total payments due to the ESRD Quality

Incentive Program.

The projection does not account for the expanded TDAPA or the new equipment add-on payment that will begin in 2020, which might improve providers' financial performance.

The 2020 projected Medicare margins is 2.4 percent, a small increase from the 2018 margin.

So here is a quick summary of the payment adequacy findings. Access to care indicators are generally favorable. Quality is improving for some measures. The 2020 Medicare margin is projected at 2.4 percent.

So now we come to the Chairman's draft recommendation, which reads for calendar year 2021, "The Congress should update the calendar year 2020 Medicare end-stage renal disease prospective payment system base rate by the amount determined in current law."

This draft recommendation has no effect on spending relative to current law. We expect beneficiaries to continue to have good access to outpatient dialysis care, and we expect continued provider willingness and ability to care for Medicare beneficiaries.

Thank you.

DR. CROSSON: Okay. Thank you, Nancy.

We'll now take clarifying questions for the presentation.

Brian?

DR. DeBUSK: First of all, thank you for a great report, well written. It was a good read.

I had a question, though, about page -- and this is TDAPA, basically on TDAPA. On page 39 of the mailing materials, you talk about the calcimimetics basically reversing the Medicare margin from what would have been minus 2 percent to 2.1 percent, so about a 4-point swing, correct?

MS. RAY: It's about a 2- to 3-point swing, depending upon --

DR. DeBUSK: Okay.

MS. RAY: -- the facility type.

DR. DeBUSK: Okay. Yeah. So I was looking at 2.1 and without it, okay, minus 2.

But then I noticed on page 36, you were talking about that the calcimimetics was about 6 percent of cost per treatment.

MS. RAY: Right. So what happened with the

calcimimetic -- now, the calcimimetic increased Medicare payment by $26 per treatment on average. It increased providers' cost roughly by $19 per treatment -- I'm sorry. Total cost per treatment increased by $19 per treatment.

I don't know specifically the -- using cost reports, I can't identify specific calcimimetics cost because it's included in a bigger category.

If I do a rough estimate, however, because that category has been declining since 2014, I would roughly estimate the calcimimetics increased providers' cost by $15 per treatment. So you're looking at -- and, again, that's a really rough estimate of $15 in cost for calcimimetics compared to $26 in treatment.

DR. DeBUSK: Okay. I was just --

MS. RAY: In payment.

DR. DeBUSK: I was just curious, and again, the analysis is excellent. I was just curious about how a 6 percent cost, source of cost, could swing margin a full 4 percent unless you were shedding something completely. Maybe there was another drug they weren't using and still being paid in the prospective bundle for.

Is the TDAPA payment -- I mean, it's a separate

ASP plus 6 payment on top.

MS. RAY: In 2018 and 2019, it's 106 percent of ASP.

DR. DeBUSK: Okay. And then it goes to 100 percent.

But I'm back to -- and, again, I'm trying to make the numbers tie because it seems like we have a scheme setup here where -- a systems setup here where anytime a new TDAPA drug is introduced, if it's a substitute for anything that could possibly be in the bundle, it would be economically unwise not to adopt the new drug, whether it's better or not.

MS. RAY: Right. So there is no calcimimetic already in the bundle.

DR. DeBUSK: Okay.

MS. RAY: When it goes into the bundle, these two drugs will be the first two calcimimetics -- the oral and the injectable.

I am not a clinician. The only thing I can say is when you look at page 20, table 4, the percent change, they will be included in the category, in the therapeutic class that includes vitamin D agents.

DR. DeBUSK: Okay.

MS. RAY: And those three vitamin D agents declined between 2017 and 2018. That's not totally unusual because dialysis drugs under the PPS have been declining.

DR. DeBUSK: So it's unclear how much the effect of bundling, the ongoing bundling of drugs and the ongoing decline, how much of that decrease is coming from that and how much of that is there possibly a calcimimetic that's pushing another drug out of this bundle or into lower use.

MS. RAY: Again, I don't know if calcimimetics substituted for vitamin D, and 2018 is the first year for calcimimetics paid under the TDAPA.

DR. DeBUSK: Okay. Again -- and I'll leave it at that -- I'm just a little confused that 6 percent of your cost could swing 4 percent of your margin unless you're getting something for free.

MS. RAY: I mean, it also increased Medicare spending by 11 percent between 2017 and 2018.

DR. DeBUSK: Okay. Well, thank you, and again, great report.

DR. CROSSON: Yeah. On this point? And you're next, anyway.

MS. BUTO: Yeah. Nancy, I thought I read in the mailing materials that a drug in the bundle, if a new drug came along, would not be eligible for the add-on payment, that there was something already in the bundle, and I wondered if that applied to oral forms of drugs that are in the bundle that are not oral, for example. But isn't that right that if there's something in the bundle, there's an add-on, even if it's the next generation of the drug in the bundle?

I'm watching your body language, but I'm not getting an answer.

[Laughter.]

DR. JOHNSON: I am having trouble with the microphone.

So the first version of the TDAPA policy was just for drugs that were outside of the bundle currently.

MS. BUTO: Right.

DR. JOHNSON: Then there was a revision to the policy that included TDAPA payments for drugs that were already included in the bundle for two years. There was a slight difference as to how much the -- the effect on the base rate. So if a drug outside the bundle was included

through the TDAPA, the base rate will ultimately be updated at the end of the TDAPA period, but --

MS. BUTO: Updated meaning reduced to account for the new?

DR. JOHNSON: Likely increased, but it would account for the new mix of drugs that are now in the bundle, a set of services and drugs in the bundle. Now there's a new one. So it's going to be updated to reflect that new set.

For drugs or categories that are already in the bundle, the drug would just be included in, and the bundle would not need to be updated because it's already one of the categories included.

DR. DeBUSK: On that point, that's sort of what I got from the updated TDAPA rules. This is a question, I promise, but if you'll walk me through this, just to make sure I understand.

Let's say there's an oral drug in the bundle that's $10 and an injectable version comes out that's $25. During the TDAPA period, I enjoy the benefit of that $10 drug's cost being integrated into the bundle, but I get the ASP payment, now ASP plus 100 going forward, for the $25.

But then when they go to rebase the bundle, they're going to say, "Oh, the net spending change was $15. Let's update the bundle $15."

DR. JOHNSON: A couple points. If a drug is getting a TDAPA payment, it is correct that the base rate is now lowered, even if that drug is in the category that's already included in the bundle.

Your specific example about an oral drug, there's a special rule that the law says that oral-only drugs would not be included into the bundle until 2025. So it would be an addition of an injectable that would trigger that drug no longer being oral only to be included in the bundle.

And your last point was about cost.

DR. DeBUSK: Well, so my thought was during the TDAPA period, I would enjoy the, say, $10 that was built into the bundle for the drug, even though I'm no longer buying the drug.

DR. JOHNSON: That's correct.

DR. DeBUSK: But I would receive the TDAPA payment for the $25 drug.

DR. JOHNSON: That's correct.

DR. DeBUSK: Now, again, at the end of the TDAPA

period, they're going to look at the cost report, and they're going to adjust the net, or are they just going to add the $25? Would they add $25 or $15 at the end of the period?

DR. JOHNSON: If the drug is in one of the functional categories that's already included in the bundle, there would be no update to the base rate. It would just be included in the set of drugs, and the base payment rate would stay the same.

DR. DeBUSK: Oh. So they would have to start eating the cost of that $25 drug?

DR. JOHNSON: Unless the cost of the drug changed to the provider, meaning manufacturers lower their cost, prices.

DR. CROSSON: Well --

MS. BUTO: Are you finished?

DR. CROSSON: Brian, are you -- so you're finished for the moment. Kathy, do you want to comment on this?

MS. BUTO: No. I want to actually ask a quick question.

DR. CROSSON: You're on the list, yeah.

MS. BUTO: I actually have another question.

DR. CROSSON: Okay. So -- but Brian still doesn't have an answer, I think, to his question.

MS. BUTO: Right. Clearly an area that requires us to better understand what's going on, I think.

DR. CROSSON: Go ahead.

MS. RAY: So I have a secret slide.

MS. BUTO: A secret slide.

[Laughter.]

DR. CROSSON: You have to know the magic word.

MS. RAY: Yeah. So maybe this will help clear up some of the questions about the TDAPA. So I'm going to say that there's like three different kinds of TDAPA for a drug. There is the TDAPA for the oral-only drugs that's just calcimimetics and phosphate binders, and according to the statute, they stay covered under Part D until 2025, but they will be put into the PPS earlier if an injectable form is approved by the FDA. That is what happened with the calcimimetics. So that's why the calcimimetics are in the bundle. They are paid 106 percent in 2018 and 2019, and ASP thereafter.

MS. BUTO: And Nancy, once it's in the bundle, no

additional --

MS. RAY: For calcimimetics and phosphate binders, there will be an additional payment. CMS said that in the final rule, I think, in 2011, because they did not account for those dollars in 2011. So that's the second column.

Now the second TDAPA, that's given for -- and that began in 2016, so that could have happened since 2016, but it hasn't -- it's for a drug that doesn't fit into one of the 11 functional categories, what we call therapeutic classes, of drugs already in the PPS payment bundle. If a drug in a new functional category was approved by the FDA, it would be paid at ASP. CMS would pay it for at least two years, and then they would reevaluate the base rate, again, because it's for a new functional category. It's not already in the bundle.

The third category of TDAPA, that begins in 2020, and that's for drugs that fit into an existing functional category. It's essentially any new drug, except for generics and a couple of other kinds of drugs that I listed in your mailing materials. So this could be a biosimilar, let's say, for EPO. That would get a TDAPA for two years.

It would be paid at 100 percent of ASP. But after the two-year period, it would be folded into the PPS without a change in the base rate.

Now the last column is the add-on payment for equipment and supplies, and I'm not going to try to say the name of the acronym because I'm just not. Payment is based on manufacturer's invoices, 65 percent of invoices. The add-on for equipment and supplies does have a requirement that it has to be substantially better than what's already in the bundle, so it uses the substantial criteria from the inpatient PPS.

MS. BUTO: So the one where it fits into an existing functional category that has the two-year external ASP --

MS. RAY: That's the TDAPA, yeah.

MS. BUTO: Right, and gets folded in at no additional adjustment to the bundle.

MS. RAY: Right.

MS. BUTO: But during that two years --

MS. RAY: There is no offset to the base rate.

MS. BUTO: That was the question. Okay. That's the question I think you were trying to get at.

DR. DeBUSK: That's what I was trying to clarify. So again, you used EPO as an example. I mean, in theory, if a biosimilar comes out for at least two years, you're going to get double-paid simply by adopting that new -- I mean, even if it's more expensive, I mean you could launch the biosimilar at higher than the reference biologic, enjoy the two years of payment, and similarly, if it were at less than the reference biologic, at the end of the TDAPA period you're still going to enjoy the differential of the lower rate. I mean, we sort of created a process where it would be foolish not to adopt a TDAPA drug, whether it worked or not.

MS. RAY: Well, according to providers, though, particularly for drugs that fit into an existing functional category -- and I'm just going to tell you what I have heard from providers -- again, you would have to -- you know, if the manufacturer does not -- if it would be necessary -- it might be necessary to have to switch a patient back to a product that's already in the bundle if the price that the manufacturer set was not changed, once it went into the bundle, let's say. And, you know, that is a clinical decision and that might affect providers'

willingness to put a patient on a new product, if they know, down the road, they may have to switch the patient.

DR. DeBUSK: Thank you.

DR. CROSSON: And/or, I mean, it seems to me that the combination of these two mechanisms, what Brian described, which is, let's say, excess margin for a period of time, and then potentially, assuming that this drug, which is now in the bundle, is really effective and the patients need to take it but they can't negotiate the price down, then we're going to see perhaps more variability in margin over a period of years than we might expect or want.

MS. RAY: That might be the case, although manufacturers do have an ability to react to changes in Medicare payment policy, as we have seen.

DR. CROSSON: Paul. Sorry.

MS. BUTO: So I think, if I'm understanding, there are two effects that happen. One is there is little price competition between the biosimilar and the drug that's already in the bundle, that why should there be, really, when they are essentially getting the payment in the bundle, and then the add-on. The other thing that happens, it strikes me, is that, I don't know if it was

designed this way, favors using the biosimilar, at least initially, right? Because once they're available --

MS. RAY: The TDAPA for drugs that fit into an existing functional category, now that applies to both drugs and biologics. So it would incentivize, all other things being equal, that drug being paid under the TDAPA, yeah.

MS. BUTO: Yeah.

MS. RAY: It doesn't necessarily have to be a biosimilar. That was just my example.

MS. BUTO: Right. No, but I'm just thinking about our general -- there are two conflicting things going on here, I think.

DR. CROSSON: Kathy, forgive me. I know you have another point, but Paul wanted to --

DR. PAUL GINSBURG: Yeah. I just wanted to say, this seems like actually a very effective way of favoring biosimilars. To the degree that a biosimilar comes in with a lower price, the provider gets a bonus for two years for using it and then they're already set when it becomes part of the bundle.

MS. BUTO: They don't even need to come in with a

lower price.

DR. PAUL GINSBURG: But if there's not a lower price then they couldn't use it as part of the bundle.

MS. RAY: But I'd just like to point out that in either late 2015 or early 2016, a new EPO biologic, EPO Beta, was approved. At that time it was put right into the bundle, and we saw provider movement towards that lower-cost new biologic. So the PPS, I mean, that's an example of the PPS working to incentivize the use of a new product that came in at a very competitive price.

DR. CROSSON: Yeah, I'm sorry, Kathy. One more time. Jonathan wanted to come in on this point.

DR. JAFFERY: Yeah. So first of all, in general, I think, Nancy, your last point was an important one, is that to the extent that these are -- first of all, they're often not biologics. We're talking about lots of less commonly biologics or biosimilars. But to the extent that we're talking about drugs that, for the most part, are equivalent in their effectiveness, the PPS system inherently incents providers to do that.

The other thing I would just point to, if we think about the injectables, in particular, and you think

about maybe a large dialysis unit deciding to switch every year, every two years, based on payment policy, you know, that's not very dissimilar than just switching a formulary. And I think that in some ways, you know, assuming that providers believe that this IV vitamin D is just as effective as this IV vitamin D, for example, the ability to switch patients may be easier in that setting than if you're writing a new prescription, because these are given three times a week on dialysis and patients don't actually have to physically take them. It's a nurse or a tech comes up and injects it during the dialysis treatment, and they don't know if it's necessarily EPO A or EPO B.

DR. CROSSON: Okay. Thank you.

DR. DeBUSK: On that one point, I mean, it does appear that we've created an incubator for biologics and new drugs, but we've also given them a dominant strategy of launch at the highest possible price you can, enjoy the cost plus TDAPA period, and the moment that you're about to get integrated back into the bundle, bring your price down to parity, certainly not below, because they've already switched to you because they've been receiving a premium. So it seems like that would be the dominant strategy a

manufacturer would use.

DR. CROSSON: Okay.

MR. PYENSON: And Nancy, if I'm reading this right, as me-too brands come out, each successive brand would be eligible for TDAPA. Is that correct?

MS. RAY: Yes. As long as it's not a generic or one of the other kinds of approvals that I included in a footnote. But yeah, if a new vitamin D agent came on the market, yes, it would get the TDAPA for two years, and then it gets into the base rate, and no change to the base rate. And then if another new vitamin D comes along, the same thing will happen. According to the -- when CMS expanded the TDAPA, their rationale was to incentivize the development of new technology.

DR. CROSSON: Okay. Kathy, finally it's your turn.

MS. BUTO: So back to Slide 4, or any of the slides that deal with quality parameters, we have dialysis under quality, dialysis adequacy and anemia management, home dialysis use and mortality. I'm wondering whether we have any information or data on adverse outcomes, or even sort of -- you mentioned the use of ER visits going up.

What do we know about those? I think of those as sort of the equivalent of ambulatory sensitive conditions. Do we know anything about that or of the principal reasons why people on dialysis go into inpatient care?

MS. RAY: Right.

MS. BUTO: I mean, in order to really evaluate quality, just looking at the use of home dialysis, doesn't strike me as one thing that really helps us determine what the quality is.

MS. RAY: Sure. I understand.

MS. BUTO: That's the reason behind my question.

MS. RAY: I don't know the reason for the ED visits. What I can tell you is that hospitalizations, a good chunk of, and for January I can give you a little bit more precise than a big chunk of them, is due to cardiovascular reasons and infections.

DR. JAFFERY: And that's been true for decades.

MS. BUTO: Mortality has really not changed over the last 10 years or so?

MS. RAY: Yeah. Yeah. There was a little bit of decline in the early part of this decade, but it's sort of steadied out in the last five years.

DR. JAFFERY: It hadn't really budged at all for many, many decades, and then it came down a little bit.

DR. CROSSON: Paul.

DR. PAUL GINSBURG: Yeah. I've got two questions. One, which Jonathan might be the best one to answer it, would be, you know, it's interesting how we've put in different incentives on facilities that affect drug choice, but you'd think physicians would be prescribing these drugs but physician payment is separate. And could you give me a sense if there are a lot of these decisions just made by the facility rather than a physician, or how many of them are customized to a patients and the physician makes?

DR. JAFFERY: Yeah, great question, and, I mean, I do think that the incentives aren't there for the providers in this setting. It doesn't matter either way. So that sort of gets back to my formulary comment, I think to the extent that there are certain particularly injectables, or actually exclusively injectables, because otherwise you're writing a prescription that they wouldn't get filled in the dialysis unit. But if they're injectables, the dialysis unit, the facility may decide

that we're going to go with this vitamin D or this calcimimetic.

DR. PAUL GINSBURG: I see. Thank you. Same question is do we have any information on what rates are used by MA plans when they pay for dialysis?

DR. JOHNSON: We've looked into that a little bit. We could do a more comprehensive look. It seems like this question has come up a few times. In general, I think the MA plans pay a little bit more than fee-for-service. We've looked at the range of payments that the fee-for-service PPS would make and many of the MA rates are within that range. A few are quite a bit higher. But it still could be that within that range the MA payments are higher than fee-for-service. But it is not nearly as high as the commercial rates.

DR. CROSSON: Okay. I have Dana and Amol.

DR. SAFRAN: Thanks. I have a couple of questions, all quality related. So I was under the impression -- but I'm not sure I'm right so that's why I'm asking -- that dialysis facilities were routinely collecting quality-of-life data from patients, so systematically tracking something like SF12 or SF36. Is

that correct?

MS. RAY: Patients fill out a CAHPS.

DR. SAFRAN: So patient experience --

MS. RAY: Yes.

DR. SAFRAN: -- but not their functional -- like not functional health status and well-being.

MS. RAY: To my knowledge it's not required by Medicare. Now if they are doing it, it could be that they're just doing it on their own.

DR. SAFRAN: Okay. Thanks. Second question is, do we have any -- understanding that there are differences in the underlying clinical status of patients who are candidates for home dialysis, I'm curious what we know about differences in some of the quality measures that you've reported here, like, you know, emergency room, hospital, et cetera, to the extent that we can adjust for case mix differences.

MS. RAY: I'd have to get back to you on that. I mean, an important caveat to that is that home dialysis patients -- there are real differences in the demographics of home dialysis patients versus in-center patients.

DR. SAFRAN: Yeah.

MS. RAY: They tend to be younger. They tend to be white. But I can try to get back to you with some information in January.

DR. SAFRAN: Thank you. And my last question is, has the program ever contemplated a quality component of payment for dialysis?

MS. RAY: There is the ESRD quality incentive program, the QIP, and that subtracts up to 2 percent off of the base rate for facilities that don't achieve the necessary score. So that has been in place since 2012.

DR. SAFRAN: Great. I'd love to learn more about that program, so thanks.

DR. CROSSON: Amol.

DR. NAVATHE: I just wanted to pick up on the home dialysis thread of questions. So a couple of questions in that regard. One is, do we have a sense of rates of home dialysis in other settings, so MA, VA also, for example, as a reference benchmark?

DR. JOHNSON: Not offhand, but that's something we can look to in the MA sector.

DR. NAVATHE: Okay. Thanks.

MS. RAY: What we could easily bring to you is a

national rate of home dialysis. That data is available from U.S. Renal Data System. We'd have to look into it, you know, sector by sector, though.

DR. CROSSON: I believe I recently saw, for one large integrated delivery system located in the state of California the number was 30 percent.

MS. RAY: Yes, it was.

DR. NAVATHE: Jon, do you have a sense of what it has been historically in the VA?

DR. PERLIN: This is really an interesting question because obviously the technology is changing, and I refer to our nephrologist on the team over here. But I'm not sure what the numbers are specifically for hemodialysis, not peritoneal dialysis. Historically, obviously, a lot of home dialysis has been the peritoneal.

But what's changing the dynamic, in, ironically, both in-hospitals and dialysis centers and at home, are these new low-volume dialysate processes, that don't require the large volumes of water, et cetera. And so this is something where I think Nancy referred to the entrance of CVS into the dialysis arena. I think these new technologies are going to change the locations of dialysis

to potentially make the smaller centers more effective, and the smallest center, obviously, one that is potentially best for patients is home, when possible.

DR. NAVATHE: Yeah. That makes total sense, and that's, I guess, the spirit of my thought and line of questioning here.

Another question is just relating to the cost. Do we get any specific information? Do we have a sense of the underlying cost differences? Obviously, it's cheaper to provide home dialysis or peritoneal dialysis, but do we have a sense of the cost difference of doing that?

DR. JOHNSON: A few studies have suggested that the peritoneal dialysis is cheaper than in-center hemodialysis, and home hemodialysis is maybe slightly cheaper but roughly the same.

I think the two next discussions that happen is how are the costs being allocated. Usually, that analysis is done via cost reports, and there's a lot of questions as to whether or not all of the costs associated with home are correctly allocated to the right categories.

The other trend that seems to be happening is that some of the machines and equipment are becoming more

advanced and also more expensive, so it's unclear that if there has been -- if home dialysis has been cheaper, whether or not that will continue to be the case.

DR. NAVATHE: So last question is I think part of the reason that I'm interested in getting more information, if we could either collect more information or make a recommendation to collect some of this information, is related to Jon's point, which is home dialysis is changing. There's a lot of evidence, one, in other countries, it's certainly much higher in terms of the proportion of dialysis on average has tended to be cheaper. It's higher quality of life and a lot or at least more independent-supporting, in some sense, and could change the dynamic of how ESRD patients live and interact with the community and their potential for work, et cetera.

And so if I think about it from a marginal -- if I channel my inner Brian and think about it from the operator's marginal incentive, it seems like the marginal incentive is to try to get people under PPS into the home dialysis, but we're seeing some increases in those rates but certainly not rapid. And if we can better understand some of the cost structures and get more information on

this, maybe we can understand some of the frictions. Some of them may be cultural, and Jonathan could tell us about that.

But I think it would be helpful to be looking a little bit down the road and, therefore, collect information so we can kind of arm ourselves in that regard.

DR. CROSSON: Kathy? On that question?

MS. BUTO: On the same point -- I'm sorry?

DR. CROSSON: Go ahead. I'm sorry. I think I missed, Larry, but go ahead.

MS. BUTO: Oh, it's on the same point. I wondered whether we have any information on the factors that lead to success or that are critical for home dialysis to be successful.

So I assume that at least one of them might be the availability of a caregiver or partner to help with that, with the process.

I mean, I think cost isn't the only thing that's important here in understanding it. So if there are any data or an assessment of factors that make home dialysis a more successful approach, I think that would be helpful.

DR. JOHNSON: I think Nancy has put together some

of that before. We can bring that and maybe update to the extent that it's needed.

DR. CROSSON: Larry?

DR. CASALINO: Going back to Dana's line of questioning, quality of life is a big deal for everybody but especially for dialysis patients, I think, and I'm just curious about why we don't -- is the data not available to look at patient experience measures as one of the quality things that we've had that we look at in these annual reports.

MS. RAY: We can certainly look into analyzing the CAHPS data and bringing that for you.

DR. CASALINO: I think that would be good because really it can vary so much, and it's really huge.

DR. CROSSON: On this?

DR. JAFFERY: Yeah, maybe to the last couple points, a few things.

Can you bring up my secret slide? No, I'm just kidding.

[Laughter.]

DR. JAFFERY: So there is a Kidney Disease Quality of Life survey that's specific to --

MS. RAY: Yeah.

DR. JAFFERY: It's called the KDQOL or whatever.

MS. RAY: Yeah.

DR. JAFFERY: And I thought that it was mandated, so we can check into that.

MS. RAY: It could be. I will check into it.

DR. JAFFERY: So we maybe have some quality of life, and I don't know how long it would have been administered.

Just to the home dialysis question, I agree this is a bit of a moving target in a couple ways. There's the technology that's just been advancing, including places like CVS really digging into it.

You know, PD has been around a long time, and there's lots of cultural reasons why it hasn't -- it used to be more popular. It's not. There's a lot of training issues in terms of nephrology fellows learning about how to do the technology, in terms of a caregiver. PD, really you can do it yourself. Home dialysis, you need somebody. So there's differences there.

And I guess the final contextual point would be that administration has come up with a whole bunch of CKD

and ESRD initiatives, including some things to try and incent additional use of home dialysis. So we're starting to see people get prepared for that, including financial incentives. It's hard to imagine that we won't see some movement based on that, so just a couple other thoughts.

DR. CROSSON: Okay. Let's see.

DR. CASALINO: If I may just on this topic?

DR. CROSSON: Yeah.

DR. CASALINO: It's tricky because, on average, I think one wants to incent more, incentivize more home hemodialysis, but it really isn't for everybody. It's kind of like giving all physicians incentive to get every patient's blood pressure down to below X when that really might not be the right thing for some patients, and certainly for home dialysis, that's true as well.

I think a lot of dialysis -- this is a smaller point, but I think a lot of dialysis patients are actually fairly socially isolated, and the opportunity to actually go somewhere three times a week is not trivial. So this is, again, a reason why patients' experience measures could be important. The lesson we want is physicians or dialysis centers really pushing people into home dialysis who it

might not really be appropriate for. On the other hand, probably it's underused now, I agree.

DR. CROSSON: Okay. Bruce and then Warner.

MR. PYENSON: Nancy, on the reading materials, on the bottom of page 37, you report that administrative costs from the Medicare cost report are, I think, 24 percent of the total cost of running the dialysis program, and that strikes me as high, though I don't have much of a context for that. And I think that probably is a relevant issue as we think of smaller-scale operations, like Amol's example of moving to smaller-scale programs or smaller-scale operations.

I wonder if you could give a sense of the context for the 24 percent. Of course, I think of administrative costs from the standpoint of a payer, 24 percent would be very high for a payer, but how do you think of that?

MS. RAY: So the cost reports don't allow me to dig into that category any deeper than administrative costs. I'm thinking based on discussions with providers, it could range from insurance to the home office cost, to their corporate -- you know, if it's a large organization, their home office.

Back in 2014, the Commission recommended that CMS audit dialysis cost reports, and Congress took up our recommendation, appropriated money to CMS. And one of the reasons why we recommended that back in the day was to find out these kinds of questions, and CMS has said that the audit results are completed. But they have not announced them yet.

MR. PYENSON: Just a question on 24 percent, was that allocated to Medicare beneficiaries, or is that across the entire organization?

MS. RAY: That's an across-the-entire-organization number.

DR. CROSSON: Warner?

MR. THOMAS: I had a different question. In the reading, it's mentioned that there's basically two large dialysis organizations that account for about 75 percent of the care. Do you have any thoughts about any impact that has, one way or another, on the data or on the industry overall?

MS. RAY: Well, I mean, on the data, clearly the two large dialysis organizations have a large impact on -- well, they have a large impact on everything we see here,

ranging from access to care to quality to the providers' financial performance. Yeah.

DR. CROSSON: Warner, was your question how effective is the competition between the two? I'm not sure.

MR. THOMAS: I think it was really more just -- I mean, we've looked at consolidation and other facets, and this is one that's pretty consolidated. I just didn't know if there was any takeaways as you guys analyzed the data or looked at it, one way or the other. I mean, are there trends there? Do you see differences? I don't know. It's just a very unique situation, and as you mentioned, most of the centers that are closing are smaller, hospital-based. It was just more of a -- and, I guess, are you seeing any new entrants as well? Given that there's so much significance from these two entities, do you see new entrants trying to get back into this world? I mean, I don't know if you had any thoughts or takeaway from it.

MS. RAY: I mean, over the last 10 years, we have seen some new entrants, but by comparison to the two large dialysis organizations, I mean, they are relatively small.

I think the third biggest chain has facilities in

the hundreds by comparison to Fresenius and DaVita, which is each over a thousand.

DR. CROSSON: On this point?

DR. CASALINO: Yes.

I think on other sectors, we have spent a certain amount of time -- and the presentation sometimes included that information -- on what effect Medicare policies have had, if any effect, on consolidation. So this is an area I really don't know about, but it would be interesting in the future or if you have anything to say about it today to know more about whether there are Medicare policies that have fostered and/or continue to foster this kind of consolidation.

DR. JOHNSON: I think that's something we'll have to look into.

DR. CROSSON: Okay. Jonathan and David, I think you're both on this point, and then I think we have to move on.

DR. JAFFERY: Yes. This is related. I mean, I certainly agree with Warner. This is a unique situation where we've got this level, degree of consolidation.

There's also something else unique about it in

that these organizations are very vertically integrated. I don't know that we have other sectors. They make the machines. They make the filters and so forth. I think you mentioned some of that in the reading.

So my question is when we're looking at margins, does any of that factor into it for these organizations, or are we just looking at the dialysis book of business for them, the dialysis delivery?

MS. RAY: Oh. Well, the Medicare margin is just dialysis, and the total margin is just dialysis. The access to capital gives you the other factors going on.

In terms of the vertically integrated company selling equipment and supplies, so for their own cost report, I believe that they have to report a cost that's similar to the payment level that they're getting in the open market.

DR. JAFFERY: So for that part, they actually have better margins? Because they're not paying that much money for -- presumably.

MS. RAY: I mean, they have to charge themselves at the market rate for a dialyzer or a machine, for example. I can add that to the paper.

DR. GRABOWSKI: Okay. Yeah. Great.

I'm so happy, Warner, you raised this issue. This has bothered me about this sector, just how concentrated it is, and there is as fair amount of economic research focusing on just the implications of this concentration. So, to your point, Larry, we should really bring that in and think about that here.

I also wonder if there's anything we might analyze around entrance or exits and sort of market-to-market, are some more competitive than others, and what that might tell us about behavior here of the different centers.

MR. THOMAS: Great. One of the things I'm just sitting here wondering is that if we were -- I mean, we've had discussions on other sectors in the industry. If you look at whether it would be IRFs or hospitals or physicians and you said what consolidation would take place in order to get to providers that were 75 percent of the market, I think we'd go, "Wow. That's pretty significant."

[Laughter.]

MR. THOMAS: So, I mean, it's just something that we ought to just be mindful of, I guess, especially as we

look at other sectors as well.

MS. BUTO: The other thing is that this is a Medicare market almost entirely.

DR. CROSSON: Yes.

MS. BUTO: I mean, that's another aspect. So it's highly concentrated from a provider perspective and highly concentrated from a beneficiary.

DR. CROSSON: And it has a different level of pricing power than perhaps some other parts of the industry.

Okay. So let's see the recommendation, which has come current law. Any discussion, support, lack of support for the recommendation?

MS. BUTO: I am wondering whether we should try to address the drug issue in some way. I think we all were talking around -- you know, realizing that it's legislated and fairly recently, to be silent on it when it creates these distortions, I think we ought to -- I guess I would vote for bringing it back in January with an option to address the -- whatever we call it. TDAPA?

MS. RAY: TDAPA.

MS. BUTO: TDAPA issue.

Jim, I don't know what you think, but --

DR. MATHEWS: Can you say a little bit more about what --

MS. BUTO: What it would look like?

DR. MATHEWS: Yeah. Because in the past, we have, in comment letters, addressed concerns about the application of the TDAPA process, and we could contemplate a formal recommendation, but can you say a little bit more about the shape or form?

MS. BUTO: To me, the obvious one is something coming along in the same category that's already in the bundle, giving it a two-year, in a sense, pass-through. That strikes me as one we could recommend the bundle back in immediately or that it not be provided that kind of TDAPA. That just seems pretty obvious.

Anything really new, yeah, there might be an argument, but, anyway, I'd look at that because that seems -- I think several of us picked up on that.

DR. MATHEWS: Yeah. Well, when we head back, we'll see what we can do and consult with Jay and Paul, and we'll see if we can act on this for the January meeting.

DR. CROSSON: Yeah. Bruce?

MR. PYENSON: There's an issue that I probably should have raised in the first round, but it overlaps dialysis and Medicare Advantage, which we alluded to the higher reimbursement from commercial, which includes Medicare Advantage.

Starting in 2021, Medicare Advantage beneficiaries who have end-stage renal disease will be able to choose a Medicare Advantage plan, and it turns out like everything else in Medicare, the benchmarks are set on a fee-for-service basis. But the cost of the market domination of the LDOs -- reimbursement for Medicare Advantage is higher. The reimbursement rates from Medicare Advantage are higher. This gets involved with network adequacy rules and things of that sort.

So I don't know whether to raise this issue in the dialysis discussion or in the Medicare Advantage discussion, but I suspect the impact is pretty significant in both areas.

As with Kathy's comment on TDAPA, I think this is something to note. I know we don't have time to do a lot of work in it. What would you suggest?

DR. CROSSON: Well, I'd probably say, "What would

you suggest?"

I think if we're going to -- why don't we do this. I think we are going to talk about Medicare Advantage a little bit later, but one of the things I was going to say when we start that is that this is not our only bite of the apple, that we're going to come back on a range of Medicare Advantage issues in the spring, and so I think what I'm going to suggest is we leave this to Jim and the staff to determine whether or not we add this in to the discussion that we're going to have in January or we pick it up later, if that's okay.

DR. PAUL GINSBURG: Can I give a follow-up?

DR. CROSSON: Yeah.

DR. PAUL GINSBURG: Yeah, I think while Jim and the staff are thinking about this, the question I should have followed up with in Round 1 is, you know, with the sometimes higher payment rates than fee-for-service Medicare, to what degree is there a different regulatory structure for dialysis than we find in physicians and hospitals that might be the cause of this, or is it strictly the consolidation that creates a very different situation than we encounter elsewhere? Because I'm not

aware of any other service where Medicare Advantage is paying more, in any appreciable way.

DR. CROSSON: That sort of gets back to the question of, you know, whether with two dominant plays you are adequate competition or not.

Okay, so --

MR. THOMAS: Perhaps one of the things we could think about is, especially with ACOs growing or whatnot, could there be some incentive that ACOs, you know, get into this world? You know, and it's just an idea that I'm throwing out there, but, you know, most of them, whether it be physician owned, or probably are more significant and maybe could, you know, they're controlling populations of patients and maybe they should -- we could try to figure out a way, is there a way we could, through payment policy, help incent folks to get back into this world in a bigger way?

DR. CROSSON: Okay. Pat.

MS. WANG: Just my totally non-empirical response to Paul's question -- which one is it? It's the latter. It's market power. It's unusual but it's absolutely out there.

And I think Warner's question, I'm intrigued by any results from the ESCO demonstrations, the pilots, and whether -- it's a bundled payment for ESRD patients, whether there's any promising sort of lessons to be learned there that might lead to, you know, future payment policy.

DR. CROSSON: So it strikes me -- this has been a good conversation. It strikes me that some of the issues that have been brought up we'll be able to address in January. Others, once again, may require some further work and enter into the workflow a little bit later on.

DR. MATHEWS: And just a reminder on that point. We do have additional work on the dialysis facility PPS on top for our spring meetings, so there will be ample opportunity to come back to questions that we aren't able to address by January.

DR. CROSSON: Okay. Good. So seeing no further comments we will come back to this issue in January. Presumably we will have the same update recommendation perhaps? But the question of additional recommendations is on the table.

Okay, Nancy, thank you. Andy, thank you very much. We will move on.

[Pause.]

DR. CROSSON: Okay. Our final update discussion for the December meeting is going to be on hospice, adequacy of payment and recommended update. Kim is here, and you're on.

MS. NEUMAN: Good morning. So today we are going to talk about the hospice payment update for fiscal year 2021 and a policy option to modify the hospice aggregate cap. First I'll discuss some background on hospice, and then we'll go through the payment adequacy analysis. And then we'll switch gears a bit and talk about the hospice aggregate cap, and then finally we'll conclude with the Chairman's draft recommendation.

So, first a reminder about the hospice benefit. Hospice provides palliative care to terminally ill Medicare beneficiaries who have a life expectancy of six months of less, and who choose to enroll in the benefit. There is no limit on how long a beneficiary can be in hospice as long as a physician certifies that the beneficiary meets the life expectancy criteria.

So now some background on the hospice payment system. Medicare pays hospice providers a daily rate, and

this daily rate structure, as we've discussed before, has made long stays in hospice quite profitable.

Medicare's payments to hospital providers are wage adjusted, and then there is also an aggregate cap that limits the total payments a provider can receive in a year, and we will discuss that cap more later.

There are four levels of hospice care. Routine home care is the most common level, accounting for 98 percent of days. There are three other levels of care that offer more intensive services to manage a crisis or special situations.

In recent years, CMS has made changes to the hospice payment system to try to better align payments and costs. First in 2016, CMS modified the routine home care payment rates so that instead of a flat daily rate, Medicare pays a higher daily rate for the first 60 days and a lower rate for days 61 and beyond. One motivation of this change was to address the high profitability of longer stays, and this change did have some effect but it was modest.

Second, in fiscal year 2020, CMS rebased the payment rates by level of care. Payment rates for the

three more intensive levels of care have increased substantially to better match their costs. To make that payment change budget neutral, CMS decreased the routine home care payment rates slightly.

So a few key facts on hospice in 2018. In 2018, over 1.5 million Medicare beneficiaries used hospice services, including more than half of decedents. Medicare paid $19.2 billion to over 4,600 hospice providers.

And so we will now walk through our payment adequacy analysis using the same framework that you've seen in the other sectors.

First, we have provider supply. The total number of hospice providers has been increasing for many years, as you can see by the orange line in the chart. In 2018, the total number of providers continued to grow, up 3.4 percent from the prior year.

The other three lines show the number of providers by type of ownership, and growth in for-profit providers account almost entirely for the growth in provider supply.

Hospice use continues to grow. Both the share of beneficiaries who use hospice before death and their

average length of stay grew in 2018. The share of decedents using hospice reached 50.7 percent in 2018, increasing by a little less than 1 percentage point from the prior year. Average length of stay among decedents increased about 1.5 days between 2017 and 2018, reaching nearly 90 days.

Underneath the average length of stay is substantial variation across beneficiaries. Many beneficiaries have short stays, and some beneficiaries have very long stays, and beneficiaries with long stays account for the majority of hospice spending.

Long stays in hospice likely reflect several factors. It's partly a reflection of the uncertainty in predicting life expectancy, particularly for some conditions. It is also likely, in some cases, a reflection of the profitability associated with very long hospice stays.

Another indicator of access to care is marginal profit, and different from other sectors, we have marginal profit data through 2017, because the 2018 margin data is incomplete. In 2017, marginal profit, the rate at which Medicare payments exceed providers' marginal cost, was 16

percent, and this is a positive indicator of access.

Next we have a little bit more detail on how length of stay varies by beneficiary and provider characteristics. Because longer stays are more profitable, this information helps to explain some of the margins that you are going to see later in the presentation.

Length of stay varies by observable patient characteristics like diagnosis. So, for example, neurological patients have an average length of stay that's about triple cancer patients. And the difference in length of stay by diagnosis means that providers that wish to do so can focus on patients with longer more profitable stays. And we do see that for-profits have a longer stays than nonprofits, on average 110 days versus 68 days in 2018.

Two things explain this difference. For-profits enroll more patients with diagnoses that are more likely to have long stays, and for any given diagnosis for-profits have longer stays than nonprofits.

Next, quality. Hospice has a limited set of quality measures. There are seven process measures that gauge whether hospices appropriately performed certain activities at admission. So this is things like

documenting treatment preferences, screening and assessing patients for pain. Performance on those measures is very high and improved slightly in the most recent year. But there is concern these measures are mostly topped out.

A new process measure about whether a patient received at least one visit from a physician, nurse, nurse practitioner, or a physician assistant in the last three days of life has also recently become available.

And the hospice CAHPS survey, which surveys bereaved family members about the care that their family member received in hospice, showed stable performance in the most recent data.

So next, access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall access to capital appears strong. We continue to see growth in the number of for-profit providers, which increased about 4 percent in 2018, suggesting that 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 have more limited access. Provider-based hospices have access to capital through their parent providers.

Next we have margins, and as I said earlier, in the hospice sector we have margins through 2018.

The aggregate Medicare margin in 2017 was 12.6 percent, up from 10.9 percent in 2016. Margins vary by type of hospice. Freestanding hospices had a strong margin, at 15 percent. Home health-based hospices had 8 percent margin, and hospital-based hospices had a -14 percent margin.

Margins also vary by ownership. For-profits had about a 20 percent margin, and nonprofits had a margin of about 2.5 percent. Both urban and rural providers had strong margins at about 13 percent and 9 percent, respectively.

And then looking at hospices by whether or not they exceed the aggregate cap, we see that the margins of above-cap hospices would have been about 21 percent without the cap, and were about 13 percent after the cap. That margin is slightly higher than the margin of below-cap hospices, which was 12.5 percent in 2017.

Next we have a chart that shows margins by length of stay, and what we see in this chart is sort of the confirmation of the relationship that as length of stay increases, as you go from left to right on this chart, providers' margins increase.

This brings us to our 2020 margin projection, and we start with the 2017 margin, and then we take into account the payment updates that are occurring in 2018, 2019, and 2020. And then we make assumptions about increases in cost at rates similar to historic trends, and with those assumptions we have a margin estimate or margin projection for 2020 that is 12.6 percent, about the same as the 2017 margin.

So to summarize, indicators of payment adequacy are favorable. In terms of access to care, the supply of providers continues to grow. Hospice use rates and average length of stay increased. Quality data are generally favorable, although the measures are limited. Access to capital appears strong. The 2017 aggregate margin and the 2020 projected margin are 12.6 percent.

Overall, this analysis suggests that the hospice payment rates may be higher than needed to ensure

appropriate access to care.

Before we move to the Chairman's draft recommendation, we are going to shift gears for a moment and talk about a policy option related to the hospice aggregate cap. This policy option could be paired with the Commission's update recommendation as a way to address concerns about excess payments.

When the hospice benefit was first established, Congress included an aggregate cap to ensure that the legislation creating the new benefit saved money. The cap limits total payments a hospice provider can receive in year. The cap is an aggregate limit, not a patient-level limit.

If a provider's total payments exceed the number of patients served, multiplied by the cap amount, the provider must repay the excess to the Medicare program.

Currently, as of fiscal year 2020, the cap is about $29,965, and it is not wage adjusted.

When we look at experience with the hospice aggregate cap, what we see is that the cap essentially functions as a mechanism that reduces payments to hospices with long stays and high margins. In 2017, we estimate

that about 14 percent of hospices exceeded the cap, and as we've discussed, above-cap hospices would have had high margins without the cap, but the cap lowers there margin somewhat.

Patients treated by above-cap hospices high average lengths of stay, 276 days thru the end of 2017.

In terms of other characteristics, these hospices were disproportionately for-profit, freestanding, urban, small, and newer entrants into the Medicare program. They also had higher live discharge rates than other hospices.

Because the cap is not wage adjusted, the cap is stricter in high-wage index areas than low-wage index areas. This results in hospices treating patients in high-wage index areas being more likely to exceed the cap than in low-wage index areas, 25 percent versus 9 percent in 2017.

So the Commission could consider a policy option to wage-adjust the cap and reduce it by 20 percent. Wage adjustment would improve the equity of the cap across providers. Reducing the cap would generate savings for taxpayers and the Part A trust fund. And reducing the cap and wage-adjusting the cap would improve payment accuracy

by focusing payment reductions on providers with disproportionately long stays and high margins.

To illustrate potential effects of this policy option, we have done a simulation using 2017 historical data, and assuming no utilization changes. Since CMS' fiscal year 2020 rebasing is not reflected in the 2017 data, we simulated the effect of the rebasing before simulating the cap policy option.

Under the policy option, the share of hospices exceeding the cap would increase from about 14 percent currently to 26 percent under the policy option, and we can see this in the chart.

The green bars on the far right are hospices that are already over the existing cap, and the yellow bar, in the middle, are the additional hospices that would be over the cap under the policy option in our simulation. These new above-cap hospices have similar characteristics to existing above-cap hospices. They are largely freestanding and for-profit providers, with an average length of stay of 254 days and an aggregate margin of 22 percent in 2017.

Although more hospices would exceed the cap under the policy option, many would remain substantially below

the cap, and that is shown in the blue bars on the left.

So, we have also simulated the effect of the cap policy option on payments to providers in 2017, and as I noted before, and I'm going to stress again, the simulation is based on historical data only.

Overall, our simulation estimates that total payments would be 2.8 percent less in 2017 under the policy option. And as you can see in this chart, the reduction to payments occurs among hospices with the longest stays, the last two lines in the chart.

So to talk a little bit more about the effects of the policy option, most hospices would not be affected by the cap policy option. Those hospices that would be affected are those with long stays and high margins, mostly freestanding and for-profit providers. We find little effect on nonprofits and hospital-based hospices, provider categories with the lowest margins.

The policy option would improve the equity of the cap across providers in geographic areas, with the share of hospices exceeding the cap in high-wage index and low-wage index areas being much more similar.

Under the policy option, we expect that

beneficiaries would continue to have good access to hospice care, as many providers would remain substantially below the cap. Nonetheless, CMS should monitor utilization patterns, and in particular live discharge rates. CMS has experience monitoring utilization patterns, with payment changes in the hospice sector and other sectors.

So now turning to the Chairman's draft recommendation.

Given the strong indicators of payment adequacy in the hospice sector that we reviewed earlier in the presentation, the Chairman has the following draft recommendation on the hospice payment update and the hospice cap.

It reads: For fiscal year 2021, eliminate the update to the fiscal year 2020 Medicare base payment rates for hospice, and wage-adjust and reduce the hospice aggregate cap by 20 percent.

This two-part draft recommendation would keep payment rates unchanged in 2021 at their same 2020 levels, while modifying the aggregate cap to focus payment reductions on providers with longer stays and higher margins.

In terms of implications, the recommendation would decrease spending relative to the statutory update, and in terms of beneficiaries and providers, we expect that beneficiaries would continue to have good access to hospice care and that providers would continue to be willing and able to provide appropriate care to Medicare beneficiaries.

And that concludes my presentation and I turn it back to the chair.

DR. PAUL GINSBURG: Thank you very much, Kim. Very clear, excellent presentation.

Open for clarifying questions. Actually, let me go on this end. Larry, Karen, Bruce, Marge, Dana, Brian, Jonathan, and Jaewon.

DR. CASALINO: I agree, Kim. It was a very clear presentation. Thank you. It was very interesting about the cap.

I have a couple of questions. Do you have a sense of why there's no wage adjustment at the moment?

MS. NEUMAN: The cap was written into statute, and the statute does not have any mention of wage adjustment of the cap.

DR. CASALINO: But you're not aware of a

rationale for not having a wage adjustment?

MS. NEUMAN: No, I'm not aware of a rationale.

DR. CASALINO: Okay.

And the second is kind of a broad question and a comment. We see on Slide 11 about at least an eight-fold difference in profit margin between for-profit and non-profit facilities. This is bigger than we often see, but we see this kind of thing fairly frequently that one type of provider has much higher margins than others.

I would love it if the staff, which is so familiar in qualitative, not just in the numbers, but in qualitative ways with the sector, could try to give us more information on why some sectors are more profitable than others for this area, but I'm making it as more of a general comment.

This is a question, but just to finish off the frame of the question, I think that one can look at the report and say, "Oh, they're more profitable because they have a longer length of stay or they're more profitable because they select for neurologic diseases rather than cancers or whatever," but that's not really an explanation on how do they get a longer length of stay, how do they

select patients.

I would really love to see that in general in presentations, a little bit more information on when we see large differences, where they seem to come from. I realize that staff does not want to speculate too much, but if you do have specific knowledge, it would be nice for the Commission to benefit from that.

So, in this case, how do they get longer length of stay with the for-profit facilities? How do they select by diagnosis?

MS. NEUMAN: That's a difficult question to answer. I think right now what I can sort of point to is the data that we have, and the data that we have show that for-profits have a higher proportion of patients with certain non-cancer diagnoses. And then when we look at those particular diagnoses and compare similar patients, for-profit, non-profit, they have longer stays as well.

It's hard for me to speculate the sort of dynamics that are going on there at this point, and we can think about if there's things we can add. But I sort of fall back to the data.

DR. PAUL GINSBURG: Put the mic on, Jim.

DR. MATHEWS: In some instances, we can point to more direct factors that influence length of stay. So, for example, a patient who is referred to hospice during an acute care hospital stay at the end of life is likely going to have a shorter stay relative to someone who is referred from the community. I think in those instances, the proximal cause is a little clearer.

In other instances, as Kim said, it is -- "speculative" may be too strong a word, but less definitive, and you start getting into questions about how patients are referred to hospices and the role of hospices going out into the communities and soliciting those referrals. So it's much less definitive in terms of being able to say here is this patient, here are the factors that resulted in a longer or shorter length of stay.

DR. CASALINO: I guess I would just add that it's not, I think, simply an idle question or a political question. It may not be so relevant to the recommendations for payment updates, but if I were paying the gas company or electric -- if I had a choice of paying one eight times more than another, I would want to know -- or giving one eight times higher margins than another, I should say, is

it really eight times more efficient, or what is their reason?

So I think the Commission's more broad role of making recommendations about policy, I think we do need that kind of information about how margins can differ so much.

Just the last thing I'll have to say, because I've been at it long enough, this is -- I said this yesterday, and I'll say it again. The fact that things are stable to me are not necessarily an indication that things are okay. So when you see for hospice that only 75 percent, for example, report that they got care in a timely way -- I think this is on Slide 4 or whatever -- 72 percent had adequate pain measures, something like those numbers, I mean, this is hospice. They're supposed to be relieving pain. They're supposed to be there when people need them. So, although those numbers are stable, I'm not sure that I would think those numbers are good.

So I would, again, just appreciate more comments from staff. If things are stable, is your assessment that they're stable and good enough or stable and still not good enough?

MS. NEUMAN: I think on the CAHPS survey, it's hard to know what the right benchmark is. Clearly, a family member's perception of the care that their loved one received will not be 100 percent for all patients. The question is how close it should be to 100 percent, and we at this point don't have a good way to gage that. But it's something we could think about what others in the environment think the right number should be, to provide more context, longer.

DR. PAUL GINSBURG: Actually, before we go on to Karen, your first point about the fact that the statute does not have a wage adjustment, I think it's pretty normal in policy process that someone comes up with an idea, an aggregate per-patient cap, and it's enacted. And then people start realizing there are some inequities, and they refine the policy. I guess that's the stage we're in now.

DR. DeSALVO: So, Kim, thank you very much for all this great work. I'm going to pick up on the CAHPS line of questioning because, as you note in the chapter, there is a lot of opportunity to improve the way we're measuring quality in this space.

I first want to -- I was going to ask some

similar questions about what's the right number and are we really topped out, but I wanted to get a little bit better sense from you about the response rate for the CAHPS survey and how much of a voice of family we're actually getting.

MS. NEUMAN: So I think CAHPS response rates are on the lower side, and I'm looking for Ledia here. We could get back to you on what the rate is for hospice.

In hospice, it's going to be sort of an extra challenge in the sense that there is a waiting period between the time when a patient passes and when they survey the family.

DR. DeSALVO: Correct.

MS. NEUMAN: So there are even extra dynamics that go on in hospice that makes these kinds of surveys hard but important.

DR. DeSALVO: Yeah. I mean, there's as much psychology involved in the recall of the experience and the grieving at the same time, so worthy of at least understanding of how much a voice there is and if there's a way to improve that, but also what are the other opportunities for understanding quality?

As I understand it -- and maybe I missed this in

the chapter -- the Office of Inspector General last year did some work looking at hospices, following up on complaints, so sort of the negative view of where there may be problems. So, clearly, there's some opportunity.

I had just one more question about the discharge from hospice that you mentioned in the slides and that you have this table. I have to say, clinically, I was really struck by it, by the high rate of live discharge in that top decile, and just a clarifying question. You give it a nice treatment in the paper, but I don't remember if you said whether or not we can track fi those people were readmitted to hospice.

So say the reason for discharge was they relocated or they chose to disenroll. Can we track whether those individuals actually reenrolled in hospice?

MS. NEUMAN: We can, and we have done that in prior years. So we could bring back some of the prior-year analysis, and longer run, it's possible to do that kind of analysis more currently.

DR. DeSALVO: Thanks. It begs the question about program integrity, and it would be helpful to know if this is just really truly people making changes or if it's

something else going on in terms of a benefit need that we're not meeting.

DR. CROSSON: Yeah. Amol?

DR. NAVATHE: Just to add to that, I really like that idea, Karen, and I would say you did, in the mailings, highlight the reasons for live discharge, and to look at that by reason for live discharge would actually be really meaningful, particularly from a program integrity kind of perspective, individuals who effectively go on to switch hospices, even if they didn't move, for example.

DR. CROSSON: I have one. Kim, in terms of the CAHPS survey, is that generally administered as part of the mandatory bereavement services?

MS. NEUMAN: It's part of the Hospice Quality Reporting Program, and if the hospice -- there's like small providers are exempted, but everyone else in order to get their regular update needs to send the Bereaved Family Member Survey to their patient populations, families, who have passed.

DR. CROSSON: Okay. Bruce?

MR. PYENSON: Thank you very much, Kim. This is a terrific chapter, as others have said.

I've got two questions. One is on the recommendation. I think the existing law is at 2.8 percent increase, and the recommendation is zero percent combined with the cap, reducing the cap by 20 percent and wage adjusting. Do you have a secret slide that --

[Laughter.]

MR. PYENSON: That shows perhaps some scenarios, what if the cap were reduced by 30 percent or 40 percent, sort of the tradeoff of cap and savings from the cap? The 20 percent sounds like a great number, but it seemed like, if anything, we could be more aggressive about the cap.

MS. NEUMAN: So I don't have a secret slide.

[Laughter.]

MS. NEUMAN: What you're saying, I mean, that kind of math is possible.

What I would also say, however, is that what I have done here with the 20 percent is a simulation based on historical data, assuming no utilization changes. That's a very different thing from what an organization like CBO would do to say what the budget effect would be, and so we ourselves can't tell you that second bucket.

DR. MATHEWS: If I could also just augment Kim's

response, as Kim mentioned in the presentation, financial performance in 2018 has improved relative to what we reported out last year. Last year, we made a recommendation of a minus 2 percent update, and this year, given the improvement in financial performance and the stability of other measures, we might have been in consultation with the Chairman, talking about a minus 3 percent across-the-board update this year.

But, as it happens -- and here, I am going to say things that may or may not be correct, and Kim will correct me, as Warren did, but the effect of a zero update and reducing the hospice cap by 20 percent is a net reduction in revenues of about 2.8 percent, thereabouts.

Kim is nodding, for the audience there.

And so it has the same aggregate effect on hospice revenues as a 3 percent across the board, which we might otherwise have contemplated, but has the benefit of targeting that reduction on those providers that have the longest length of stay and are more profitable. So, in that sense, from my perspective at least, there is a greater attraction to using this approach rather than an across-the-board update.

MS. BUTO: Jim, just to follow on that, my impression was, Kim, that you picked up a lot of the long-stay live discharge, highly profitable providers by moving to the 20 percent. If you went further down to say 40 percent, I think it's possible you'd start getting into, I guess, what we would think of as providers who are less profitable and serving a higher acuity or a population that doesn't survive the hospice stay. So I don't know where that cut point is, but it struck me that you picked up a lot of those patients.

MS. NEUMAN: Right. I mean, that yellow bar that we're picking up with this policy option, those folks look pretty similar to the above-cap hospice folks. If we walked that reduction up further, you're moving more to the left, and I don't have the data right here, but you would incrementally be making the pool look more similar to the average. Yeah.

MR. PYENSON: Thank you. I had another --

DR. CROSSON: Are you still on --

MR. PYENSON: I had a different question, if I could, on the wage index, and I'm very glad that you raised the wage index. I think my question is going to be applied

to a lot of other areas where reimbursement is tied to wage index.

When I look at the wage indexes that are out there, for example, for hospitals, there's perhaps 3,000 or so wage indexes, and perhaps a quarter of them have been adjusted for the purpose of hospital reimbursement. But it seems as though that's not the case for hospice or others, and I'm wondering if you -- so I'm assuming you used the unadjusted wage index in your work.

MS. NEUMAN: So Medicare payments are wage-adjusted using the pre-reclass wage index for hospitals, as you're pointing out, and so when we did the cap work, we just followed suit to be consistent. It's sort of a different animal of question about what's the right wage index to use in hospice, and that's something we haven't in hospice particularly thought about. But I know that the Commission in general has thought about wage index and what's the right way to go more broadly.

MR. PYENSON: I would certainly welcome more about that. I think it's been a while since we've seen any material, the Commissioners have seen material on that, so I'm not sure if this is a stage one or stage two question,

Round 1 or Round 2. But I'd certainly welcome learning more about that.

DR. MATHEWS: Yeah. So I think -- and here, I'm looking for some historical memory -- we made a recommendation to do a comprehensive overhaul of the Medicare wage index or Medicare's approach to wage indexing in 2007 or thereabouts, and we did some modeling that showed a number of improvements to the approach we recommended relative to what's currently used in terms of discontinuities between contiguous geographic areas, circularity. Our approach would remedy a number of things, and we've continued to maintain that work since. And I think we can contemplate bringing it back and giving it the current status.

I'm not sure we can do it this cycle, given our schedule, but this is something we can easily do next year.

DR. CROSSON: I wonder if the complexity in this particular case is that we've got both institutional and non-institutional providers, hospital-based hospice care and then non-hospital-based hospice care.

MS. NEUMAN: Right. In hospice, we have that dynamic going on, they although for hospice purposes get

the pre-reclass wage index.

DR. PAUL GINSBURG: Yeah. I would think that whether hospice care is delivered by a hospital or freestanding, probably the types of labor used are pretty similar.

DR. CROSSON: Okay. Marge?

MS. MARJORIE GINSBURG: I'm also interested in knowing more about the live discharges.

I think you showed that they predominantly happen in for-profit institutions. They're not evenly divided between for-profit and non-profit.

Are surveys done in particular with those groups, particularly with the family members or the patients themselves about why they were discharged and their feelings about being discharged? I don't know whether they're volunteering to exit or whether they're being booted because the hospice doesn't want to take it on the head, you know, when they go too many days. So anything more about that?

MS. NEUMAN: So it's a really good question, and the CAHPS survey focuses on family members of decedents. So we don't have a tool right now, the Medicare program at

large, to understand the experiences of folks who have been discharged alive. So that is an area where there could be room for improvement.

DR. CROSSON: Okay. David. Oh, I'm sorry. Dana.

DR. SAFRAN: Thank you. So a few questions that will help me understand my point of view, or frame my point of view about the cap. No question about the wage adjustment part, but I'm just wondering where to set the right level.

So the first question is, the increased use of hospice among Medicare decedents is pretty remarkable. Years ago we were bemoaning the fact that it was so rarely used, and to see it's over 50 percent is pretty remarkable. I wonder if there are data on what that has done to Medicare spending for the relevant conditions where hospice is being used, end-of-life spending. What do we know about that?

MS. NEUMAN: So it's a complicated question, because it's hard to say what would have happened if someone didn't enter hospice. And so there's literature that looks at this question in different ways and comes to

different conclusions.

The Commission sponsored a study trying to look at the divergent findings in the literature and try different methodologies and see if we could figure out what we think, based on various different methodologies, what the effect of hospice is on aggregate Medicare spending. And what that study found was that we think in aggregate, the increased hospice use has not led to program savings overall. It may have increased costs slightly. That's what the study suggests.

But what underlies that is that hospice seems to save for patients in the last month or two of life -- you know, acute care that's avoided, and so forth. But when patients are in hospice for a long time, then the costs outweigh the savings.

And so what the study showed was that in aggregate, even though we see savings, and particularly for non-cancer patients, on the whole, it appears that we don't see savings, and that is because the costs for the long-stay patients outweigh or offset savings for shorter-stay patients.

DR. SAFRAN: Yeah. Okay. And that actually

points to what my second question was. So it was clear from the materials that cancer patients, you know, the stays are much shorter than neurological patients. And just trying to understand, number one, do neurological patients sort of make up -- are those the two principal areas of diagnoses for which hospice is being used? And with the neurological conditions -- maybe I should ask some of my clinician colleagues to weigh in on, you know, is the point of end-of-life just so much harder to predict with those conditions? So I just want to understand that a little bit.

MS. NEUMAN: So there are a couple of sort of larger-sized populations that hospice treats, and in some ways it reflects the decedent population overall. So there is cancer patients, as we talked about. Another big group is neurological patients, and another big group is patients with heart and circulatory conditions. So those are probably the three big groups.

On the point about neurological patients, and clinicians will have more information on this but I wanted to just point to, we have a footnote in the paper which sort of looks at length of stay for neurological patients

for for-profits and nonprofits, and we see that at the 75th and 90th percentiles, for-profits have much higher lengths of stay than nonprofits.

So there seems to be, among providers, differences in length of stay, even for difficult-to-predict conditions.

DR. SAFRAN: Interesting.

DR. DeSALVO: On this question, is neurological, does that bucket include stroke, or is that in circulatory?

MS. NEUMAN: Let me get back to you.

DR. CROSSON: Kim, the mic is off.

MS. NEUMAN: I will get back to you on that. I don't want to misspeak.

DR. CASALINO: Just a clinical response, Dana. I think that with something like -- I think Karen's question was a really good one because it's slightly different for that. But for things like amyotrophic lateral sclerosis, there is really no treatment and the patient is just going to decline. You don't know exactly at what rate but you're getting them some help early on.

You know, with cancer it's different because people want to be treated with whatever modalities they're

being treated with, until it's clear that there is no hope, and that can be pretty close to the time of death, rightly or wrongly.

So I think that's the reason for the difference in the two types of diseases.

DR. DeSALVO: Potentially, dementias are included in the neurological bucket, and it is extremely difficult.

DR. SAFRAN: Right. That's what I was imagining. So it's for another conversation, but I think it's worth our thinking more broadly about hospice policy, and, you know, how we try to consider the likely duration of some of these conditions and what that should mean for hospice care.

But my last question goes to the information that you had on Slide -- my notes have covered up the slide number -- 19.

DR. CASALINO: Karen and I were just talking. It could be that for patients with dementia or a slowly progressing neurological disease, essentially the long-stay hospice is being used as a substitute for home health care. And so that's a policy issue to be talked about, and what are the comparative costs and benefits and so on.

DR. SAFRAN: Right. Yeah, that's what I was thinking. Okay.

So on Slide 19, do we have information on, like if there was another column here on margins, can you tell us to what extent, you know, margin tracks with length of stay here, because I didn't see that information in the materials. Sorry of I missed it.

DR. CROSSON: Kim, the microphone keeps going out.

MS. NEUMAN: Sorry. I'm going to flip back a couple of slides. So right here, these bars track to those rows in the table.

DR. SAFRAN: Okay. Got it. Thanks.

DR. CROSSON: Brian.

DR. DeBUSK: First of all, thank you. Great report. Really good read.

I want to tie into something Bruce was comment on, on the wage index, and also express a little bit of the same question that Dana had around, you know, for example, a dementia patient versus, say, a cancer patient. I'm not sure that all long stays are bad actors, and I would appreciate some information on that.

But first I want to go to Chart 11 in the presentation, where it looks at the urban versus the rural Medicare margins. Could you speak to, you know, what could be causing those differences, and what adjusters are in place to account for, say, differences in metropolitan and rural care?

MS. NEUMAN: So hospice does not have any rural or urban adjusters, so those are the raw margins. There are differences in size. Some rural providers are smaller, and smaller providers have, you know, not as much economies of scale, so that's one factor that might influence it.

You know, we can think more about what other factors might drive that. It looks like it's about a, what, four-point spread? So we could look and see if we can add any more detail there.

DR. DeBUSK: Okay. I would just be curious about that.

The other thing, and this gets back into the wage index thing, my first question was going to be what percentage of the labor portion is applied, of the hospice wage index, is applied to the overall payment, but thanks to the excellent Medicare payment basics document that I

googled, yeah, found, it's 70 percent. Thank you. Really nice.

Could you speak to, one more time, the difference, though, in the hospice wage index and the hospital? I think I understand it but I'd like to hear one more time.

MS. NEUMAN: So hospice uses the pre-reclassification, wage index. So the hospital folks can do more justice to this than I can, but there are adjustments that are made to the hospital wage index. People are reclassified to various areas, and so forth. Those changes that get made in the hospital sector, to the wage index, that does not apply to hospice. They use the straight, initial wage index.

DR. DeBUSK: So they skip that step, the reclassification, the frontier states, all that, and then they apply budget neutrality, though, to hospice, just like they do to hospital wage index.

MS. NEUMAN: They are now applying budget neutrality. There was a time they didn't, but they do.

DR. DeBUSK: Okay. Okay. So the end product of both calculations is budget neutral. I was just curious to

see if there was any upward or downward bias there.

So my final question, and I could use help with the math, $30,000 cap effectively. We want to knock it down 20 percent. But then we also want to apply the wage index to it. Could you speak to, knowing that it's applied to, say, 70 percent of the total, you know, I'm used to swings in the wage index of 2.8 on the high side, 0.7 on the low side. Can you speak to what impact would it have on the cap? Like what's the high and what's the low that we would experience here?

MS. NEUMAN: So there's that text box at the very end of the paper that gives you the percentile distribution of something that we call sort of like the ratio of the wage-adjusted payments to the not-wage-adjusted payments. So we calculate here's what you actually got paid, and here's what you would have gotten paid if the wage index didn't exist. It's on page 64.

And so what we see is at the 10th percentile, the wage adjustment reduces your payments by about 14 percent, and at the 90th percentile, it increases your payments by about 16 percent. And those numbers take into account the fact that the wage index only applies to, you know, 68, 70

percent of the payment, as you said.

DR. DeBUSK: Okay. Help me with this. This is the ratio of wage-adjusted payments to payments without. Oh, this is looking at who would be the most affected. There we go.

MS. NEUMAN: That shows you sort of, right now what the wage adjustment is doing to various people's payments.

DR. DeBUSK: Okay. So, for example, it would be, in this lowest percentile, then, it would be 20 percent, which is the reduction, plus an additional 14 percent on top of that.

MS. NEUMAN: Right.

DR. DeBUSK: And then the people that were basically in the highest percentile, they would get a 20 percent cut, but then they would get 16 percent of that back.

MS. NEUMAN: Right.

DR. DeBUSK: So basically they wouldn't get a cut at all.

MS. NEUMAN: There are some people who wouldn't get a cut at all, yeah.

DR. DeBUSK: So we'd effectively be transferring money out of rural areas and intro metropolitan areas, to attempting the cap.

MS. NEUMAN: I think -- if you look on -- there's another chart that sort of addresses that, on page 60, which shows you the rural and urban effects of the policy, and it shows it to you by length of stay. And what you can see there is that, point number one, whether you're rural or urban, if you have long stays you have high margins. Rural and urban doesn't matter. And then the second point is that this chart shows you that the policy option, which includes wage adjustment and reducing the cap, together, that policy option is really just focusing on the long-stay providers in both rural and urban areas, and the shorter-stay providers in both areas are largely unaffected.

DR. DeBUSK: Okay. And then you can get back to us with sort of the dementia versus cancer, and, you know, good guy but long stay versus bad guy, long stay.

MS. NEUMAN: So we can try to bring you more information on that. The good guy/bad guy --

[Laughter.]

DR. DeBUSK: Was I oversimplifying?

MS. NEUMAN: -- is not in my skill set.

DR. DeBUSK: Okay. Thank you.

DR. CROSSON: Okay. So we've got Jonathan, Jaewon, and Jon, and we have run out of time.

DR. JAFFERY: Great. Thanks. I'll try to be quick. So first I just want to add one other clinical point to Dana's question. I totally agree with what Larry and Karen had said and how that impacts maybe length of stay on some of these conditions that -- neurologic conditions that may have a longer time frame than the cancer patient. But there are also some other categories, like congestive heart failure, which there may be patients who then make some improved clinical steps. The reason I bring it up is that a policy perspective might contribute to some life discharges, more than some of these other conditions.

And then my question, on Slide 6 you show the supply of hospices increasing and how this is virtually all for-profit, and in thinking about our previous conversation about dialysis consolidation. And it's interesting. We've got these two sectors that, in some ways, primarily exist because of Medicare payment policies. I think hospice is

probably the only thing I can think of that's even got a higher percentage of Medicare payment as part of most of their book of business.

Do you have any sense about, with these increases, how many of them are totally new entrants into the field, or are we seeing any trends towards larger groups consolidating, getting market share across either regions or the country at large?

MS. NEUMAN: So I think we can bring you back some more granular information on that. In general, we are seeing both new entrants, so we are seeing new hospices coming in, especially as we've talked about in certain state, right? So we've seen, you know, some big, new entrants in certain states. And then we also do see providers leave. And then, in addition, there are mergers going on. So there are all three dynamics at play, and we haven't sort of disaggregate it. But, you know, that kind of thing is possible.

DR. GRABOWSKI: On this?

DR. CROSSON: Yes.

DR. GRABOWSKI: The other phenomenon, right, is there's some vertical integration, not just horizontal but

some nursing homes owning hospice. And those relationships have always struck me as being fraught with potential issues. I don't know if that's something. It may be a smaller part of this but it's certainly something to flag around kind of consolidation.

DR. CROSSON: Jaewon.

DR. RYU: Yeah. I have a couple of questions, one I think we've talked about already, but just the long length of stay and the cap dynamic and the clinical dynamic. You know, is the Dana and Larry and Karen and Jonathan discussion.

I guess my question is just, is there any way to tease apart? Is it because of the referral or is it because of who the hospice chooses to accept that drives the long length of stay? You had referenced earlier, on Slide 8, that under the nonprofit/for-profit and the difference in average length of stay, you know, there are two dynamics at play. One is for the same diagnosis there tends to be a longer length of stay in the for-profit, but then the other is they tend to enroll folks who tend to have a longer length of stay, and on that dynamic, is it possible to tease apart, is that happening because they're

seeking and getting referrals that are of a different patient mix or is it that they're accepting, or choosing to admit or accept a different mix of patients?

The reason why I ask that is I think understanding that dynamic is important to understanding the clinical one around will there be a disproportionate impact on specifically, you know, we've used the neuro example or the circulatory example. But I guess I'm still kind of hung up on how are they getting in and how are they selecting?

So that was question one. On the life discharges, I think it's similar to where Marge was going. It would be interesting to know, is it because the prognosis changes and improves, or is it because they quit the program? Do we have any insight into that?

MS. NEUMAN: We have a chart where we look at the reason for life discharge as reported on the claims. And so we can see that the two biggest groups are because they're either not terminally -- determined not to be terminally ill any longer, and then the other big group is because the beneficiary chooses not to enroll.

Underneath this data, there are, though,

questions about sort of, you know, is the beneficiary choosing not to enroll? Is the beneficiary being encouraged to leave hospice? So there is some -- underneath the data, we don't know entirely sort of the dynamics that are going on.

DR. RYU: And do we know how much longer they live, the live discharges?

MS. NEUMAN: So we do have some very detailed work that we've done on older data that we can bring to you, and look at that, and that is something that we could dig into longer term as well.

DR. RYU: Thank you.

DR. CROSSON: Jon? Sorry.

DR. MATHEWS: Sorry. Just to go back to your first question, I think it is length of stay is a function of both activities that you mentioned. It's both seeking out referrals as well as choosing who to admit, and some of the larger hospice organizations, it's my understanding, are reasonably sophisticated in tracking how close to the cap they are getting almost in real time, tracking their aggregate length of stay, and they are able to change their referral sources, again, almost in real time. If they

start to see they're having cap issues, they might seek referrals from hospitals who are more likely to have shorter lengths of stay.

So there's degrees of sophistication in how hospices manage this process.

DR. CASALINO: Kim, on those point, is there any data on percentage of referrals that hospices decide that the patient is not eligible?

MS. NEUMAN: You mean referrals. So refused referrals?

DR. CASALINO: Yeah.

MS. NEUMAN: I don't believe that we have that kind of data.

DR. CROSSON: Jon?

DR. PERLIN: Thanks. Given, Jay, as you said we're out of time with this, on this topic, I'm going to take the prerogative going to Round 2 because Dana really started the question of what I was asking, but there are, I believe, a set of implications, which may be broader than what we can tackle this year but I believe really come forward.

In isolation, we've been looking. We're asking

the question: Do we have the right patient selection? We've noted the differences systematically between neurologic, end-stage neurologic disease and the length of stay and other patients with more acute deterioration. That's a good question within this context.

But more broadly, in the materials this year, the rate of -- this past year, the rate of hospice use was 50.7 percent, and the truth is I don't know whether that's actually high or low. What I know is that there's an implication that there is an expanding group of individuals with dementing diseases who likely need a policy approach to support as their conditions deteriorate.

Simultaneously, as explored, what is the right number of patients who should go to hospice? Is this not a moment where we have to consider not just in isolation but in terms of the broader context of the Medicare program?

With that in mind, it strikes me, one of the current features of the Medicare hospice benefit is that the patients have to forego conventional care for terminal conditions and related conditions.

In 2005, for example, Aetna released an approach which actually allowed patients to include elements of

curative care, and this was a substantially progressive approach because it increased the uptake of hospice in particular.

So I think we have a set of questions to really ask about the changing demography of end-stage disease with an aging and increasingly chronic disease-burdened society, and associated with that, what are the policy implications not only for how those individuals are supported, but also in terms of whether the benefit is appropriately structured compared to when it was first framed?

So thanks.

DR. CROSSON: Okay. So Jon initiated the discussion period, and the discussion period is now open and soon to close.

Brian?

DR. DeBUSK: Super fast, Round 2.

My one comment -- and you could tell from my questions -- what I would do before we really finalize this thing, I would take the cap. I would back the 20 percent out. I would apply the 70 percent. I would pick a low wage index, like the .7, the .75s, apply it to 70 percent of the payment schedule, take a new look at the cap. And I

think you get about $19,000. Take that $19,000 and then look at that against some of these longer neurological-type patients in the rural areas, where they're already 4 percent, 4 margin points behind their urban counterparts.

I would just make sure that we aren't stacking things up so much that when you get a rural patient, so you're down 4 points, then you take 20 percent off the cap, and then you apply a .7 wage index to 70 percent of their fee schedule, and then you get that neurological patient, I think you may have -- it may not just be feasible anymore. So what you may be effectively doing is eliminating hospice care for these longer neurological cases in rural areas.

I would just do a gut check before --

DR. MATHEWS: Yeah. So, Brian, just one thing to keep in mind is the cap is applied on an aggregate basis for each hospice, and I think there is material in the paper that provides an illustration along the lines that a hospice can have, in this example, half of their patients with average length of stay of 300 days and half with 30 days and still be comfortably below current cap and I believe even a cap reduced by 20 percent.

MS. NEUMAN: With a cap reduced by 20 percent,

it's a bit below 300, but it's in here.

DR. MATHEWS: Yeah.

MS. NEUMAN: It's in the mid-200s.

DR. MATHEWS: And so reducing the cap does not mean that every single neurological patient is going to be looked at negatively by a hospice, but it's more in the aggregate, is the hospital complying with the applicable eligibility requirements and not admitting large numbers of patients who are going to have stays of 300 days?

DR. DeBUSK: Okay. So the thinking is even with the compounding of the setbacks in the cap that they can manage to that. That was to your earlier point. You think the behavioral response will be "Oh, we'll just take in more short-term patients, and it will balance"?

DR. MATHEWS: That's one potential response, or they might be more judicious about the timing of admission for patients with longer-term end-of-life degenerative diseases.

DR. DeBUSK: And say no from time to time.

DR. MATHEWS: Pardon?

DR. DeBUSK: Which means to say no from time to time.

DR. MATHEWS: Or not yet.

DR. CROSSON: Less active recruiting.

DR. DeBUSK: Okay.

DR. CROSSON: Kathy?

MS. BUTO: So I do think your question is back to Jon's question about we really need to look at the basic nature of the hospice benefit as it was originally designed, which was as an end-of-life option really aimed at cancer patients. I mean, that was the original idea.

Obviously, it's migrated to something else. We need to look at that because I think what everybody is talking about is, in a sense, creating or expanding the benefit and making it something different. So I think that's fair, but I don't think it's the update recommendation fair.

My one really quick question to you, Kim, is whether the wage index part of this, not the reduction in the cap and not the update recommendation, could be done by CMS, because I don't believe the legislation prohibits them from wage adjusting. But is it your view that we would have to get legislation to wage adjust the cap?

MS. NEUMAN: I'm not a lawyer, so I hesitate to

give an opinion.

I think perhaps we could go to CMS and ask them what their opinion is on this topic.

MS. BUTO: I just bring that up because I think it's helpful to us generally to know what things CMS might have within its own authority, given how difficult it is to get some of these things legislated, and that seems to be something that at least in my view, I would want to take a look at it if I was at CMS to see if you could do it anyway because it seems like a move in the direction of greater equity.

DR. PAUL GINSBURG: Kathy, on an issue like this, you need to keep in mind that if it's really unclear whether CMS has the authority and they go ahead and do it, they're likely to be sued, which in a sense would postpone the policy change for a long time.

MS. BUTO: Right. But I think that wouldn't stop us from looking at it and pointing out whether we think they have the authority, but you're right.

MS. NEUMAN: I would just add that there were a number of lawsuits about various ways that the cap was calculated in the past. So this is an area where they

might want clarity.

DR. CROSSON: Okay. Seeing no further comments, I'm going to try to parse this. So keep your eyes on me here.

This has been a good discussion, and I think it has drawn out what I think is becoming increasingly clear, as Kathy pointed out, and that is the hospice benefit has and is in the process of materially changing. And it's different now, and it's becoming more different than what was intended. This is a policy issue for the Commission, and I think we will absolutely have to take this up.

I'm not certain that that issue or some of the other requests for additional information that Kim could put into the material for January suggests that we cannot take a straw poll here in terms of -- I haven't heard any -- other than Kathy -- and I'm going to ask you in a sense -- I haven't heard anything that makes me think we don't want these recommendations.

Now, Kathy, we could change the second part of the recommendation to say something like "Congress should wage adjust and reduce the hospice aggregate cap by 20 percent unless CMS is able to do this."

MS. BUTO: No, I wouldn't do that.

DR. CROSSON: You don't want to do that. Okay.

MS. BUTO: I think Kim is right. It's a lot cleaner to get Congress to direct in this area, and Paul's point too about litigation.

DR. CROSSON: Okay.

MS. BUTO: And since we want the rest of it, just doing the wage adjustment is not really enough.

DR. CROSSON: All right. So my assumption is that we have a broad support for these. Seeing no objection, we'll bring this forward in the expedited voting process in January.

Thank you, Kim.

[Pause.]

DR. CROSSON: Okay. Our final presentation and discussion for the December meeting is our annual update on the Medicare Advantage program.

I would note for the Commissioners that as you may remember from the November meeting, we did have a discussion about some options for impacting the relative payment rate for the MA program compared to the fee-for-service. We are going to be coming back to that issue or a

set of issues related to Medicare Advantage payment in the spring, and so we will not necessarily resolve or even try to substantially address that set of issues in this presentation.

With that, Luis and Andy, you have the floor.

MR. SERNA: Good morning. I am going to present our analysis of the Medicare Advantage enrollment, plan availability, and bids for 2020. Then Andy will give you an update on MA risk coding intensity and the current state of MA quality measurement.

As Jay said, we will not present any recommendations today, but there may be recommendations in the spring related to work that includes improving MA quality incentives.

Thirty-four percent of Medicare beneficiaries are now enrolled in MA plans, up from 24 percent in 2011.

The Affordable Care Act of 2010 established changes to MA payment rates, essentially phasing in a reduction of MA payment rates by 10 percentage points between 2011 and 2017. Despite some initial projections that the decrease in MA payment rates would coincide with enrollment declines, MA enrollment has continued to grow

rapidly.

In 2019, MA enrollment grew 10 percent to 22.5 million enrollees. The 10 percent growth exceeds the growth of the prior year by 2 percentage points, coinciding with an increase in the number of plans bidding.

Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries. For 2020, 99 percent of Medicare beneficiaries have at least one plan available; 93 percent have a zero-premium option that includes the Part D drug benefit, up from 90 percent in 2019. The average Medicare beneficiary can choose from 27 plans in 2020, up from 23 choices in 2019.

I'll now briefly go over the MA payment system. Plans submit bids each year for the amount they think it will cost them to provide Part A and B benefits. Prior to risk adjustment, this is known as the base rate.

Each plan's bid is compared to a benchmark, which ranges from 115 percent of fee-for-service spending to 95 percent of fee-for-service n the highest-spending counties.

Quality bonuses can increase plan benchmarks by as much as 10 percent.

For nearly all plans, 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 to 70 percent, depending on quality scores.

Plan rebates may go toward lower beneficiary cost sharing for A and B services, supplemental benefits, or enhanced Part D benefits.

However, Marge, as you alluded to in November, rebate dollars are paid for by the Medicare program. Moreover, not all rebate dollars go directly to beneficiaries. Plan rebates include administrative expenses and profit related to reducing A&B cost sharing and providing supplemental benefits.

The average rebate that plans have available for extra benefits in 2020 has increased to $122 per member per month, a record high. The level of rebates, now at 13 percent of total payment, reflects MA plans' ability to increase the efficiency of their bids relative to payment benchmarks.

However, because benchmarks have been much higher than fee-for-service spending, lower plan bids have not

translated to Medicare savings. In 2020, before accounting for coding differences between MA and fee-for-service, we estimate that benchmarks, represented by the blue line, will average 107 percent of fee-for-service spending. Payments, represented by the solid red line, will average 100 percent of fee-for-services pending. Quality bonuses will add about 4 percentage points to MA benchmarks and 2 to 3 percentage points in payments.

As Andy will discuss later, overall payments to MA plans will be about 2 percent higher than fee-for-service after accounting for our most recent estimate of coding practices by MA plans that result in higher risk scores. This is represented by the dotted line in light red.

When we look at overall bids relative to fee-for-service, represented by the green line, we see a slight decline from 89 percent in 2019 to 88 percent in 2020.

Next, we show how the level of fee-for-service spending in a plan's service area impacts its bid relative to fee-for-service.

As expected, plans bid high relative to fee-for-service in areas with low fee-for-service spending, and

plans bid low relative to fee-for-service where fee-for-service spending is high. However, even in the low spending areas, most plans bid below their local fee-for-service spending.

Let's look at the left-most column, circled in yellow, which shows the bids for plans concentrated in counties in the lowest spending quartile. We see that the median bid is 97 percent of fee-for-service. This means that for the second consecutive year, most plans in the highest benchmark counties are bidding below local fee-for-service spending.

However, the relative reduction of plan bids in these areas has not produced Medicare savings. For 2020, Medicare is still paying an average of 110 percent of fee-for-service spending in these areas. This is due to the benchmarks in those areas averaging 117 percent of fee-for-service spending with quality bonuses.

Now I turn it over to Andy.

DR. JOHNSON: We now turn to a discussion of risk adjustment and coding intensity in MA.

Medicare payments to MA plans are unique to each enrollee and are the product of two factors. The first is

a base rate that Luis described, and the second is a risk score, which is the ratio of a beneficiary's expected spending to average fee-for-service spending.

The risk model includes demographic information and certain medical conditions that are identified by diagnosis codes and grouped into hierarchical condition categories, or HCCs. The more HCCs indicated for a beneficiary, the larger the risk score and the larger the Medicare payment for that enrollee.

A risk score increases payment for beneficiaries who are more sick and are expected to have greater health care expenditures, and vice versa.

The risk model is estimated using fee-for-service data and therefore reflects the diagnostic coding practices in fee-for-service Medicare, where payments are more often based on procedure codes and there is little incentive to code all possible diagnoses.

In MA, there is a significant financial incentive to document all diagnoses, as more HCCs increase payments to the plan. The difference in fee-for-service and MA coding intensity causes beneficiaries of equivalent health status to have higher risk scores when enrolled in MA.

Our analysis of 2018 data found that MA risk scores were about 8 percent higher than fee-for-service beneficiaries with comparable health status. Each year, the Secretary reduces MA risk scores by a minimum amount mandated by law to account for the impact of coding differences. The adjustment was 5.91 percent in 2018.

The amount of coding intensity impact above the adjustment between 2 and 3 percent of MA risk scores generated about $6 billion in payments to MA plans in excess of what fee-for-service Medicare would have spent for the same enrollees.

This bar chart shows the overall impact of coding intensity on MA risk scores, with the green portion of each bar representing the coding adjustment and the gray portion representing excess payment to MA plans. Our analysis of MA coding since 2007, has consistently found that greater coding intensity inflates MA risk scores by about one percentage point per year, relative to fee-for-service. This trend increases the overall divergence of fee-for-service and MA risk scores.

Two temporary factors have limited this divergence in certain years. The yellow arrows represent

the implementation of new risk score model versions that were less susceptible to coding differences. The red arrows represent two years of faster fee-for-service risk score growth following the implementation of ICD-10 diagnosis codes. However, fee-for-service and MA growth rates have since returned to their prior norm, where MA and fee-for-service risk scores continue to diverge.

In the coming years, additional model changes are likely to exacerbate the difference in coding. The minimum coding adjustment, however, will remain a 5.9 percent. Therefore, we expect excess payments to MA plans to increase.

Apart from not adjusting for the full effect of coding intensity, the coding adjustment policy generates inequity across MA contracts. The coding adjustment is shown by the red line. Each gray column in this graph shows one MA contract's coding intensity relative to fee-for-service. As you can see, coding intensity varies significantly across MA contracts. Because the coding adjustment reduces all MA risk scores by the same amount, contracts on the left of the dashed line are penalized by the adjustment and contracts to the right are overpaid,

despite the adjustment.

In 2016, the Commission recommended a three-part approach that would make the coding adjustment more equitable across MA contracts and would account for the full effect of coding differences.

Now turning to a summary of quality. Through Carlos' work over several years, the Commission has concluded that MA quality cannot be meaningfully assessed through the current system and it should not be used as the basis for distributing bonus payments. Using the MA contract as the reporting unit is the source of many flaws in the current program. Quality assessment is masked across large and geographically dispersed contracts, and contract consolidation has exacerbated the issue, having moved nearly five million enrollees into bonus status over the past five years.

In addition, MA quality bonus program uses a large number of measures, including administrative measures, to judge quality. Some have sample sizes that are too small to provide a valid representation of quality in MA. Furthermore, the current system prevents beneficiaries from assessing quality in their local market

and comparing MA plan quality with the fee-for-service program.

Despite these issues, the MA quality bonus program provides highly-rated plans a bonus, in the form of a 5 percent increase in their benchmark, or in some geographic areas, a 10 percent increase. Eighty-two percent of MA enrollees are currently enrolled in contracts receiving a bonus, which would generate about $6 billion in bonus payments.

We continue to address these issues through our work on the MA value incentive program.

To summarize, the MA program is extremely robust. Enrollment continues to grow, plan offerings continue to increase, and extra benefits are now valued at $1,500 annually per enrollee, a historical high for the fourth year.

Over the past decade, concerns about significant MA payment reductions, instituted through the Affordable Care Act, have not borne out. Instead, bids have come down in relation to fee-for-service, even in areas where sponsors might have found it challenging to operate successful plans, such as in low fee-for-service spending

areas where MA benchmarks are 115 percent of fee-for-service spending.

Despite the health of the program, we have identified some policy areas of concern in recent years. We will continue to track issues stemming from MA coding intensity and incompleteness in the encounter data. Staff will present an update on our work to improve the MA quality bonus program in future meetings this cycle.

DR. CROSSON: Okay. Thank you, Andy and Luis. And we are now open for clarifying questions. Let's see, Brian, Jonathan, Bruce, Pat.

DR. DeBUSK: Thank you. Great report. It was a really good read. I had a couple of questions. Let's go to Chart 10 where you talk about the coding difference. You know, if I remember correctly we have historically said that the coding differential is about 3 to 5 percent was sort of the working number when I first joined the Commission. I was a little surprised. Can you speak to, since 2016, it doesn't look like it's even cleared 2.5 percent. Is that correct?

DR. JOHNSON: These are -- we're talking about the gray --

DR. DeBUSK: The net. The net coding differential.

DR. JOHNSON: Yes. Yes. And so it did decrease between 2015 and 2017, and in both of those years there was two things going on. One was the introduction of a risk model that tended to reduce the differences in coding between MA and fee-for-service. There was some attempt to identify diagnoses where the MA and fee-for-service coding differential was greatest and exclude those from the model, was part of CMS' reforms. And then the second effect was the fee-for-service coding rate increased for two years, but that has since subsided.

DR. DeBUSK: Can you speak to what's driving the fee-for-service coding increases?

DR. JOHNSON: It's hard to say for sure. I tend to think it is mostly due to the ICD-10 diagnosis code implementation, because the trend in fee-for-service relative to MA coding rates has been the same for many years, but it dramatically changed in 2015, when ICD-10 codes were introduced. It slightly changed again in 2016, almost stating to return to the normal pattern of MA rates increasing faster than fee-for-service rates. And then in

2017 to 2018, we are now back to what we saw prior to that period, in terms of relative growth rates.

DR. DeBUSK: So it's sort of mixed results on whether or not they're going to continue to diverge or converge. Do we have to wait and see or could you speak to -- where do you think it's going?

DR. JOHNSON: It seems likely that they will continue to diverge, that the relative rates are back on track, and in the next couple of years a few risk model changes we think are likely to exacerbate the difference in MA and fee-for-service rates.

DR. DeBUSK: Okay. And then I also had a -- thank you -- I also had a question on Chart 7. You talk about, you know, the bid, or the benchmark at 107 percent, the bid is at 88 percent, and the payments at 100 percent, you know, net of the coding adjustment. How do we account for -- and this is a genuine question; this is not a Round 2 -- how do you account for the fact that sort of the first thing the MA plans have to do is buy a Medigap light plan. I think on the reading material, on page 16, you talk about that.

It looks like about, what, 80 percent of their

rebate, of their $122, goes into cost-sharing reductions. How do we account for that, because in one world the beneficiary pays for a Medigap plan and in the other world it's the private insurer that pays for essentially a Medigap light plan. Actuarially, can you help me there? I mean, what does an MA-equivalent Medigap plan, what would a beneficiary pay for something like that?

DR. JOHNSON: I'm not sure that we can compare the relative cost-sharing that's offered through the extra benefit in MA plans to what Medigap would be. Is that what you would say?

MR. SERNA: Right. So given current data sources we're not able to do that. So we estimate these prospectively, using CMS' projected fee-for-service spending in each county, standardized by risk. So it doesn't take into account any comparisons or any comparability with Medigap plans.

DR. DeBUSK: Okay. Is the nominal Medigap plan, though, a little more generous than, say, the nominal MA cost-sharing reductions?

MR. SERNA: I don't think we're able to say that.

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

DR. DeBUSK: Bruce, please.

MR. PYENSON: So the MA, the bid is based on the actuarial equivalent of the fee-for-service benefits. Medigap fills in, essentially, all of the cost-sharing. And, you know, you could argue that it's not 100 percent but it's fairly substantial. The MA has an out-of-pocket limit set at the ACA limit, so there is substantial cost-sharing, almost always, in Medicare Advantage plans. It gets filled in but that's -- you know, you could look at some of the surveys of what's out there to create actuarial values for that.

But a fee-for-service plus a Medigap is more complete coverage than you're going to get from MA, even with the fill-in of use of rebate for extra benefits.

DR. DeBUSK: So if we were sitting at $900, and one beneficiary in fee-for-service, say, spends $150 a month to buy a good Medigap plan, that same $900, we're using some of that $122 rebate to cushion cost-sharing, but then the beneficiary may have to throw in, is it $60? Is it $90? Is it $30?

MR. PYENSON: Something like that. Of course, it varies a lot because MA plans vary a lot and have different

strategies for attracting members.

DR. DeBUSK: Okay. I'll save everything else for Round 2. I'm just trying to get to the bottom of apples to apples.

MR. PYENSON: One way of looking at it, and Pat has another answer, if you look at how MA plans, where the cost-sharing is filled in by Medicaid for the dual eligibles, that gives you the feel for how important cost-sharing is.

DR. CROSSON: Pat, on this point.

MS. WANG: I was just -- I don't know the precise answer to your question. I just wanted to note that the apples-to-apples, the majority of MA plans today still are HMOs, and that is not an apple-to-apple with Medigap, which is open access. So, you know, your question would be more relevant for folks who are buying PPO products. Maybe you could kind of look at that and I think there's been some growth in that, because some of the Medigap, you know, letters or plan options are phasing out.

But it's not an apples-to-apples when you're looking at HMO versus Medigap, because they're two completely different benefit designs.

DR. CROSSON: Pat, let me just be clear I understand. So are you talking just then about the out-of-pocket burden or are you talking about something larger, in terms of --

MS. WANG: No. It's product design. It's network PPO, dissimilar to Medigap because it's open access to any provider. There's no network.

DR. CROSSON: That's what I thought you meant.

MS. WANG: Yeah. So I'm just saying it's hard to kind of -- I don't think that there's a precise answer. There's not one answer to it.

DR. DeBUSK: Well, I'm oversimplifying, but what I was trying to get to is, oh, what MA is. You made a great point, by the way. All MA is, is you enter into enrollment, you give up the any willing provider aspect. They essentially buy you a Medigap policy plus you throw in an extra, you know, 40 or whatever Bruce tells me, dollars per month.

I'm just trying to figure out, sort of conceptually, what --

MS. WANG: Yeah.

DR. DeBUSK: Okay.

DR. CROSSON: Okay. Marge on this as well?

MS. MARJORIE GINSBURG: Yes. And you know I'm a Medicare counselor in California so I can only speak to California. But the main difference is, if you're on original Medicare you can buy a supplemental plan, which right now coverage virtually all the cost-sharing a patient is going to have. That changes a little bit next month. If you get a Medicare Advantage plan, you cannot buy a supplemental plan. You are not allowed to buy. But in exchange they do have lower cost-sharing than if you were in original Medicare only, which is 80 percent A, 80 percent B. But the cost-sharing is there, but it's not as big as 20 percent.

So that's clearly the tradeoff. Original Medicare, you pay a lot more up front, because you're buying the Part D plan premium, and you're paying for supplemental. In Medicare Advantage, much lower up-front costs but you're seeing it as a patient. You're seeing higher costs than you would otherwise. Is that clear?

DR. DeBUSK: That's great. Thank you. And the rest is Round 2, so thanks.

MS. MARJORIE GINSBURG: Now that may be different

in other states. That's California.

DR. CROSSON: Okay. Jonathan.

DR. JAFFERY: Thanks. I want to go back to some of the coding intensity stuff and actually just start with, Brian had brought up the question about why we were maybe seeing more fee-for-service. And so one thing is I wonder if -- the thing that came to my mind had to do with ACOs and people starting to get into risk adjustment on the fee-for-service side, so I wondered if you thought about that and if you're seen an impact on that.

And then the other thing is just this, thinking about this in reading the chapter, which was excellent, by the way, it's hard not to just see this as sort of an accelerating game. And now we've got some differences in how the risk adjustment works in MA versus ACOs. In some of these things we've seen really a cottage industry. It's a lot of time and work for physicians and other providers.

And so I wonder if you are aware of anyone working on trying to come up with completely different methodologies away from just patient-by-patient coding and documentation to get at a better risk adjustment methodology, whether it's CMS or anyone else. I'm looking

at you, Karen. Not really, Karen.

DR. JOHNSON: Not that I'm aware of for purposes of use in the Medicare Advantage program. I think there are ideas about them in academic literature, but to implement, you know, would require a different basis of data, likelier than claims, and there are a lot of complexities and concerns about whether or not utilization information is included or not, and if you're paying more for more utilization. So not that I'm aware of.

And on your first point about the ACO coding, I think that is certainly something I will continue to track over the years, or in the coming years. From my understanding, the ACOs that have the most incentive to put effort into coding, the next-gen ACOs, and the share of fee-for-service in those has been very slow. It doesn't necessary explain the shift in fee-for-service coding rates over the last couple of years, but I think you're right that in the coming years it's going to be something to watch.

DR. CROSSON: Jaewon, are you on this point?

DR. RYU: Sort of, yeah.

DR. CROSSON: Sort of? Go ahead.

DR. RYU: On page 42 of the readings it gets to this. You mentioned some of the things that plans use in order to capture the diagnoses, but how much visibility -- it's your data comment -- how much visibility do we have into, you know, health risk assessments? Obviously that's been the focus of a lot of discussion in recent years, but around how much of the coding intensity comes from something like that versus some of the other levers there?

DR. JOHNSON: As part of our work leading to the 2016 recommendation, I think we estimated that health risk assessments accounted for about 1 to 2 percent of the overall difference, of the 8 percent. That would be between 6 and 7 percent if you got rid of health risk assessment diagnoses.

As far as what the rest is made up of, and tying it to the strategies described in the chapter, I'm not sure that we're able to disentangle what strategies account for what share. One thing we could look into, now that we are having more years of the encounter data, is the share of diagnoses that come from chart review, which are commonly not done in the fee-for-service world but are often done in MA.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you for a terrific chapter. There's a couple of questions I have, more along the lines of puzzles. You've outlined very well here the issues with Medicare Advantage encounter data, but for five years many of the same organizations have been submitting data for risk adjustment and other purposes for their marketplace ACA blocks of business, some organizations, to CMS, through what they call an EDGE server process. And that seems to work okay, well enough for tens of millions of lives and risk adjustment and other purposes.

And I'm not sure sort of who to point the finger at, you know, or what's going on with why that system that seems very functional for concurrent data is -- somehow we can't seem to even get retrospective data on very good measures. And this affects, you know, of course the risk adjustment but also many of the quality metrics, which could be generated likewise. So that's one question I have. I have another one.

DR. JOHNSON: I'll answer that one first, so I remember. So I think through discussions with many of the plans there's been reports that submitting the encounter

records was a big issue early on, and there were a lot of changes to the algorithms that CMS uses to review encounters, and there's a lot of effort done and a lot of back-and-forth that plans had to work with CMS on in order to submit their encounter data.

Based on our conversations, it seems like many of the transmission issues have mostly subsided, and, you know, through our encounter data work in the June chapter of last year we did compare the encounter data to several sources of other MA utilization information. And to my knowledge I don't think the EDGE server would necessarily solve the issues that remain, because I think that speaks more to the method of transmission of encounter data, which seems to be more smooth now than it was in the beginning.

MR. PYENSON: So this time next year, we'll have a different story?

DR. JOHNSON: I wouldn't say that.

MR. PYENSON: My second question is on the construction of the benchmark, and this gets, I think, to some of Brian's question. There's been some publication recently that looked at the induced utilization of Medigap, and I think the vast majority of Medicare beneficiaries

have some form of supplemental insurance, either through Medicaid or through employer, retiree, or Medigap. And some of the estimates -- one of the published estimates was close to 20 percent of additional Medicare cost.

I'm not saying that's right or wrong, but there's certainly something. And my understanding is that gets built into the benchmark, provided to MA plans. So the extra cost to Medicare from beneficiaries who have bought Medigap is already part of the benchmark for MA.

If that's the case, what does that mean about the ability of MA plans to generate a rebate, to provide extra benefits?

DR. JOHNSON: I think any inducement from Medigap policies is included in the fee-for-service benchmarks. I'm not sure we can say specifically about what it provides to plans about their ability to generate rebates, except that higher benchmarks would give greater leeway for a plan to have a larger spread between their bid and benchmark.

MR. SERNA: And just to be clear, the supplemental coverage isn't directly in the benchmark. The inducement of utilization would be but not the supplemental coverage.

DR. CROSSON: Nicely made point, couched as a question. Very skillful.

[Laughter.]

DR. CROSSON: Okay. Pat?

MS. WANG: I just to make sure that I understand table, chart 7 and how to make sure to read it.

So what this is saying is that in 2020, the average benchmark was 107 percent. The plans bid 88 percent, and they got paid 100 percent, right? So the 100 percent represents the amount after CMS, whatever the rebate was? CMS took its share, so they got paid.

As between the 88 percent of the A/B bid and the 100 percent payment, is it possible to translate into what percentage of that went into beneficiary supplemental benefits or cost sharing or all the rest? Because, Luis, as you said, you know, it can be used for a lot of different purposes. Do you know how much were sort of beneficiary-specific? And I would include in that reduction in cost sharing as well as true supplemental.

MR. SERNA: So for the rebate amount for non-SNPs, about 49 percent of the rebate is cost sharing. About 18 percent is for supplemental benefits, and the rest

is a split, as Part D benefits, and a small sliver for reduced Part B premium.

MS. WANG: Oh, interesting. Thank you.

Going back to Slide 11, which a lot of people had great questions about -- I also had a similar question to Jonathan about possible impacts or changes within fee-for-service coding behavior, but would you just confirm for me? Because I just don't know. Do ACOs use the HCC risk adjustment model? Is it the same, same exact thing?

MR. SERNA: Yeah.

MS. WANG: Interesting.

MR. SERNA: It's the same exact thing, but there are limits to coding increases in both MSSP and next-gen that don't apply to MA plans.

MS. WANG: Okay. But the underlying coding happens, and then there's some sort of limitation placed on top of it?

MR. SERNA: For ACOs, yes.

MS. WANG: Yeah, okay. But to the extent that ACOs are improving documentation and coding and fee-for-service because now they are paying attention, that would affect the MA risk scores, right, or the comparison of fee-

for-service --

MR. SERNA: Yeah, correct.

MS. WANG: Okay. Can you go through a little bit more what -- and somebody asked the question. Jonathan. Is there a better way to do risk adjustment if there were 100 percent encounter submission? Would that enable a different, better process?

DR. JOHNSON: It would remove the issue of using fee-for-service data as the basis, and so it would essentially take the Medicare payment to the MA plan out of the issue, and that it's not going to be based on a fee-for-service basis. So we wouldn't have to track that set of gray bars.

However, if you turn to the next slide, Luis, there would still be differences across plans, but that competition for coding -- so competition for coding at the MA contract level would still be there, but it would just be among the plans instead of having an effect on the total payments that Medicare makes to MA plans.

MS. WANG: Interesting. So if it was 100 percent based on encounter submission, would there be a need for a coding intensity adjustment, or would you still need to --

DR. JOHNSON: Not for a separate adjustment like the Secretary makes now. So the 5.9 percent adjustment could go away.

MS. WANG: I see. Okay, okay.

The only other thing that I would say in terms of the EDGE server, what you said is what I understand also to be differences between the MA and the encounter data and the EDGE server process. It's just always been described to me, EDGE server as a lot simpler. The benefit package is a lot smaller. Their work has shown that the match between like sort of the acute care stuff is -- that's the other thing. In the ACA world, there is no fee-for-service comparator. So you don't actually know how accurate the information is that's being submitted through the EDGE server, which is sort of interesting, but the complexity of some of the like post-acute and other sectors seems to still be really a problem with encounter data submission and accuracy, so just that point.

DR. CROSSON: Great. Thank you, Pat.

So David and Amol?

DR. GRABOWSKI: Yeah. Pat twice said if we had complete encounter data, and I think that's a big if. I

think your report does a great job of tracking sort of the validation, you know, just what's happening over time with your validation efforts with the different datasets. It looks really flat right now. It's not improving.

I know we made a recommendation around encounter data. What's the status of that? Is CMS actually implementing some of this, such that we can achieve that complete encounter data? This would be so beneficial on so many different fronts.

DR. JOHNSON: I'm not aware of any changes that CMS has made to either track or report back to plans on additional completeness metrics.

I think your assessment that it seems like the completeness had a period of improving and is not roughly flat is correct. I think I would just caution again that there is a significant portion of services that we don't have a comparator for.

DR. JOHNSON: Just as a follow-up, I can't remember, Jim, when we made that recommendation about encounter data, but is there any way to kind of go back to that? We had a year in there where we wanted to see complete data. I can't remember if it was 2023. Is there

any way to get them on a faster pace here?

DR. MATHEWS: We can check in with the agency and get a little more detail if they are increasing their efforts and report back out.

DR. CROSSON: Amol?

DR. NAVATHE: So thank you for a lot of explanation of the coding differences, and the work is, I think, really very helpful and quite revealing.

A couple of questions. One thing, on this chart itself, I am wondering if you could just clarify exactly the methodology of what we're looking at. I'm not sure I totally understood it. It seemed like perhaps to some extent, we're normalizing by looking at people who enroll in a certain year and then looking at growth based on that timing of enrollment and using their historic kind of pre-enrollment factors as the way to sort of compare like to like. Is that what we're doing here, or is there something different that we're doing here? I'm not sure I totally understood.

DR. JOHNSON: So, in this chart, we assign each enrollee to either fee-for-service or a specific MA contract based on their enrollment in 2018, so the most

recent year of risk scores we have. We follow all of the enrollees back as far as they were continuously enrolled in A and B Medicare. So it includes if an enrollee is in an MA plan in 2018 but maybe switched back and forth a couple times. It would capture those differences. And if we go back as far as 2007, if people were enrolled continuously for that long.

The other comparison, I think, is we exclude PACE contracts and special needs plans, just because the comparison to a general fee-for-service population wouldn't be fair for those specific populations of enrollee.

And I believe in this analysis, we compared contracts with their local fee-for-service market area, not the fee-for-service national average.

DR. NAVATHE: So, to some extent, if I'm understanding correctly, there's two pieces of information that are commingled in this, which is to the extent that there were plans who truly had bigger changes or smaller changes, that variation would also be reflected in here. It's not exclusively, quote/unquote, "differences" in coding practices?

DR. JOHNSON: The part I didn't mention is we

also control for differences in the age and gender distribution between the fee-for-service and Medicare Advantage. So, to the extent that there are differences outside of those controls, that would be included in there.

DR. NAVATHE: Okay. Thank you for explaining that.

The second question is a clarifying question or kind of related to this ACO piece, because I think a number of Commissioners have brought it up.

My understanding is that yes, to some extent, at a very aggregate level, coding under ACOs is beneficial for ACOs, but if you actually look at a contract-by-contract basis, the risk adjustment is essentially frozen at the time from the benchmark basically from performance. So once you have a member who is going to be attributed to you coding more actively in performance year one or performance year two doesn't create a benefit, and so I was wondering if that is accurate and if that might influence our interpretation of what's happening in the kind of fee-for-service baseline increase in coding.

MR. SERNA: So for ACOs, coding more actively or more completely would benefit them when they rebase. So

that's one thing. There is always an incentive to code more completely.

Secondly, the new MSSP rules, you can increase your coding 3 percent for each performance year. So that is somewhat flat the more you code, but again, when you rebase --

DR. NAVATHE: I see. So you can't get some incremental benefit. It's capped, but the real true benefit or largest benefit would come at rebase time frame. But there is some marginal incentive in the performance year.

MR. SERNA: Right.

DR. DeBUSK: And on that, I think, even with the older ACO design, you can go down. So, for example, if you brought in a bunch of new healthier beneficiaries and your score went down, they did take your benchmark down accordingly. So you would have to code a little bit up just to hedge, just in case you got some healthy people attributed to you.

DR. NAVATHE: Okay. Thank you.

My last question --

MR. SERNA: I'll also add one more thing.

There's also regional adjustment. So to the extent if you're an ACO, if your coding is relatively more complete than your region, that also benefits to you there.

DR. NAVATHE: Thank you. That's super helpful.

I have one last question. I commend you on your sort of articulation of the details of the HCO program. I think that's really helpful.

The last question is I totally agree with the comments that getting to full encounter data would be a major boon. I think my question is sort of the thoughts of how we use that. Is the idea then that we would be able to risk-adjust within the MA program very effectively, or is the thought also -- and this is the place where my question is. Would it really help in the fee-for-service to MA translation to some extent? If we know that there is some selection that happens in people who join MA relative to fee-for-service, if there's any difference in the likeness of those populations, then that won't help us do that crossover as accurately. It certainly will help within the MA adjustment.

So can you clarify? When we've made recommendations in the past and how we're thinking about

using that, what is the thought process there?

DR. JOHNSON: One aspect of our recommendation and the related work was to continue to use the encounter data for the basis of HCCs to try and boost the incentive to submit more encounter data.

I think the coding adjustment law says that the adjustment will be in effect until the Secretary uses Medicare Advantage diagnostic cost and use data in order to calibrate the risk adjustment model, and it does seem like there is some contemplation of going to an encounter data-based risk adjustment model for MA.

I think whether or not the improvements in the accuracy of being able to predict MA costs because the basis of the risk adjustment is MA data, I think there are some pros and cons. There was a discussion in April about the relative benefits, but the Commission has not come down on either side of whether or not that is a good thing or a bad thing.

DR. NAVATHE: Thank you.

DR. GRABOWSKI: I thought we wanted to make -- maybe you said this and I missed it, but utilization-based comparisons of readmissions, hospitalizations across fee-

for-service and MA with the encounter data. I think that would be a huge --

DR. JOHNSON: Yes, absolutely. I only meant to speak to incentive for greater encounter data for risk adjustment purposes, but that would be one of the biggest.

DR. CROSSON: Okay. We will now move on to the discussion period, having used up all the time for the morning. But I do think it's important to make sure that we have provided Andy and Luis with thoughts for improvements what is already a very well-constructed report and update on Medicare Advantage.

So if there are any issues of that sort, like we would like to see this added to the report, let's do that.

I saw Brian and then Karen.

DR. DeBUSK: As you can tell from my Round 1 question, I would urge you, as we're looking at benchmarks, bids, rebates, all that, to incorporate some of the Medigap. I mean, I hate to see when they say, "Well, program spending is at 100 percent of fee-for-service spending," knowing of that $122, a certain portion -- and I don't know exactly how much of that it should be -- has to be spent on some cost-sharing reductions, or basically, you

have a non-viable MA plan. I mean, you'd have to spend something there.

I hate to walk into this thinking, "Oh, it's program spending-neutral, and shouldn't the program be generating some cost savings?" I mean, it is generating beneficiary savings right now, probably to the tune of 10 to 12 percent of the benchmark, because again, I think page 16, you talked about 49 percent of the entire benchmark goes just to the A and B cost sharing.

So, again, when we look at the program and overall, is it saving Medicare money, there's a beneficiary aspect to this that I hope we keep in mind.

DR. PAUL GINSBURG: Yeah, actually, Brian, I thought it was all there, in a sense, where the rebates is what the beneficiary is coming out with and the payments, you know, in relation to 100, is the degree of overpayments, when you put in the quality bonuses and risk adjustment. So, in a sense, I think it's all there, other than saying, maybe going into it a little bit more, what the rebate is going for, which we've heard that there is data on that.

DR. DeBUSK: Well, I'm just thinking in the OM

side you've got $900 you're going to spend. On the MA side you've got $900 you're going to spend. It's just that in the OM side the first thing we do is go to --

DR. PAUL GINSBURG: What's the OM side?

DR. DeBUSK: -- original Medicare. In OM, you take that $900 and then go to the beneficiary and say, "I need another $150, $160 a month" for you to buy your Medigap plan, whereas in the MA side, we go to the MA plan and say, "Hey, here's your $122 rebate. Now go buy a Medigap light plan with the first tranche of your savings." And I think those are just fundamentally different when we try to compare the two programs, in terms of taxpayers and in terms of beneficiaries. I think it's just slight -- it's apples and oranges.

DR. PAUL GINSBURG: I just thought the 34 percent of beneficiaries enrolling in MA, many of them have figured out that they're getting a free Medigap plan in the process.

DR. CROSSON: Okay. I've got Karen and then Dana and Amol and Bruce.

DR. DeSALVO: Oh boy. Thank you, guys. I wanted to ask for you to consider putting a nod to the social

determinants of health work in the chapter, given how the MA plans have been pioneers in this space. They were given latitude by Congress a couple of years ago and there's been ongoing guidance from the Administration. There seems to be a lot of interesting benefits, supplemental benefits being provide in a broad array of areas, and it's yet to be seen if those are of interest to the beneficiaries.

But given the significant change to addressing whole health, it would be important for us, I think, to at least acknowledge that and watch it to see if that's something that seems of interest and benefit to the beneficiaries.

DR. CROSSON: Thank you. Paul.

DR. PAUL GINSBURG: Yeah, I was just going to say, actually, two things. One is, as far as give consideration to whether there is a recommendation about encounter data that would be useful to put in the March reports. And the other point I wanted to make is that I wasn't sure that if there are any places, when you're comparing, you adjusted for both quality bonuses and risk adjustment at the same time. It always seemed to be one or the other. So I found myself being a little bit confused.

DR. CROSSON: Dana.

DR. SAFRAN: Just two quick, small comments about the risk adjustment divergence issue. One is, I shared Jonathan's hypothesis that it could have something to do with ACOs, and I take your point that, you know, a small number of ACOs, but I would suspect that those organizations are changing coding -- once they change coding they're changing coding. So I just think it's worth a look there to see what role that could play and what the implications are going forward, given the direction CMS is taking around the ACO program.

And the other comment is, you know, it's long struck me that the changes we see at the population level in risk scores tell a totally different story from the story we see when we look at changes in patients' functional health status scores over time. And the Medicare program does have that latter information from the HOS survey.

And so I think it could be worth just something in the chapter about that and about the importance -- somebody brought up and I forget who; apologies -- of considering whether there is just a whole new approach we

could be taking to risk adjustment. Thanks.

MR. PYENSON: Dana, could you clarify which way do those go?

DR. SAFRAN: So in functional status, self-reported functional status, you know, changes like watching the grass grow or paint dry, like it's very, very slow, even in the Medicare population, a year, I think if I remember the numbers right. So it suggests much slower, less dramatic changes in how people are feeling and functioning than what we see with changes in risk scores, which suggests every year our populations getting 3, 4 percent sicker.

DR. CROSSON: Okay. So I've got Bruce and then Pat.

MR. PYENSON: Thank you very much for the chapter. I know, in past years before my term as a Commissioner, the Commission did address the role of Medigap and induced utilization. And I agree with Brian that it would be helpful to have that, perhaps that work looked at again in the context of Medicare Advantage and the creation of the benchmarks. I don't know if that belongs in this chapter, or perhaps this chapter next year,

but to at least recognize the importance of that issue, because we have choices for beneficiaries and two substantial and different programs going on. So understanding the interplay there I think would be really helpful for our understanding.

DR. CROSSON: Thank you, Bruce. Amol.

DR. NAVATHE: So one very discrete suggestion and one very general suggestion. So the discrete suggestion -- well, let me start with the general suggestion, actually, because the discrete fits under it.

So the general suggestion is, when I read the mailing materials, I think there is a lot of, obviously, clear focus on the coding piece. I think one part that -- I guess this may be as an economist and I'm sort of obsessed with, is this idea that there's still a selection effect here, in terms of who gets into MA. This relates to Karen's point, which is that there are other factors that are also at play here that may be very important.

So I think it would be helpful to see a little bit of discussion of that, which I think is related to the coding piece as well, to provide context for what might be happening. And, over time, I think this is not necessarily

for the next version of this, but over time it might be nice to see more work trying to understand exactly what's happening with the selection and how the populations outside of the specific coding pieces here may actually be different or similar, and how that may be changing over time.

So I think we talked a little bit about using something the health and retirement study or something like that as a way to get at that, and so I just wanted to put a plug in for that for the future.

The subpoint that I think is more of a discrete suggestion is, when we do analysis like this I think an alternative way to view it is instead of looking at enrollment into 2018 and then going backwards and looking at changes in risk scores, maybe to actually look at individuals who were enrolled in fee-for-service and then switch in a given enrollment year, say 2012, 2013, whatever it is, and then follow those populations prospectively from there, using the common fee-for-service time, 2012 or 2011, whatever it is, as a way to say, okay, we knew these patients looked quite similar up to this point, and as a cohort then follow them forward.

That would, I think, give us, at least me, greater confidence that what we're seeing is perhaps netting out more of some of the other endogenous differences and could be much more related to the coding intensity piece. And especially when you're comparing across MA plans but probably controlling for some of those selection effects as well. And I think it would give me a little bit more confidence when we look at the variation here.

DR. JOHNSON: I should say we did do some of that analysis in the past, that has since fallen out of the chapter, but we can bring it back. And I think the main finding was over several different cohorts the first year of switching from fee-for-service to MA was about a 6 percent increase in risk scores relative to the change in the otherwise fee-for-service group, and then it leveled off to 1 or 1.5 percent over time. But we can bring that discussion back.

DR. NAVATHE: Great. Thank you.

DR. CASALINO: On this point, I think, I'm not sure, but it could be that people switched from Medicare Advantage to fee-for-service when they get sicker. And so

if we were to look at what happened to the risk score and actual cost of care for people in the year or two after they switch from Medicare Advantage to fee-for-service, and try to get a group that looks matched on risk score, or even on diagnosis, that stays in Medicare Advantage, and looks at what happens with their risk scores and looks at what happens with their costs, I bet you we find that the people who switched to Medicare Advantage, although they look the same in risk score, wind up having a higher cost because they're sicker in ways that the diagnoses are not necessarily going to get it.

DR. CROSSON: Okay. Pat, I think you have the last word.

MS. WANG: Okay. This is quick. I just was curious whether, in the discussion of sort of the percentage of the rebate dollars that are going to sort of alleviate cost-sharing or what have you, Part B premiums, in the bids, whether you have ever looked at not just the dollars that are spent but changes in the way that plans design cost-sharing. Because you know, the point is they have total flexibility on where they're going to apply cost-sharing as long as it meets the bid submission rules,

so eliminating copays for primary care, for example, you know, using copays for certain things, cost-sharing for others, redoing the inpatient deductible.

And the only reason I mention it is that it might be interesting information to the extent that there is a point that, you know, we've talked about supplemental benefits and buying down cost-sharing, but that plans actually change the benefit structure from traditional Medicare in ways that might be interesting for traditional Medicare to know about.

DR. JOHNSON: I like that idea a lot. I think we might be limited by what's available in the bid data and that we can parse out the rebates into five categories. But what's within the cost-sharing might not be difficult, but we'll see if we can --

DR. DeSALVO: Just to add onto that, that's one of the areas where understanding the social determinants of health benefits will be very helpful, because the fee schedule may want to begin covering the delivery service or transportation.

DR. CROSSON: Okay. Very good discussion. Good presentation. And you've got some richness here to add to

your report. We look forward to reading it. Thank you, Andy and Luis.

DR. CROSSON: We now have time for a public comment period. If there are any of our guests who wish to make a public comment, step to the microphone. I will point out -- just let the table clear -- I will make a point that this is an opportunity. It is not the only opportunity that is available to communicate with the MedPAC staff. But I would ask you to come forward now, and if you would like to introduce yourself and include any organization that you may represent, or are speaking for in some way, do that. And we would ask you to limit your comments to two minutes, and when this light returns, that two minutes will have expired. Thanks.

MS. ACS: Good morning. My name is Annie Acs, and I am the Director of Health Policy and Innovation at NHPCO, the National Hospice and Palliative Care Organization. On behalf of our President and CEO, Edo Banach, I respectively submit comments on MedPAC's staff recommendations.

NHPCO is the largest membership organization representing the entire spectrum of not-for-profit and for-

profit hospice and palliative care programs and professionals in the United States. MedPAC is tasked with analyzing access to care, quality of care, and cost containment of care spending. We are deeply concerned that the proposed recommendations to modify the aggregate cap will undermine all three of these tenets: access, quality, and cost containment.

I offer this perspective for the following reasons. We are concerned about creating a new barrier to beneficiary access to high-quality hospice care that would result by implementing the proposed changes to the aggregate cap, as we hear from providers that urban providers that serve rural areas may reduce their service areas to mitigate cap risk, or rural providers with a small census may be forced to go out of business because the aggregate cap has been reduced so dramatically.

We agree that changes in the aggregate cap may result in delays to accessing hospice care. Medium length of stay is already less than three weeks. These changes will lead to shorter lengths of stay and more expensive, acute, inpatient care. These are seriously ill patients with high needs for services, many living in rural and

underserved areas. We should be providing more care earlier.

We strongly believe that a reformed hospice benefit and a pre-hospice community palliative care benefit is essential to addressing these needs. We wish we were discussing these needs instead of debating an outdated cap mechanism that already deprives people of needed interdisciplinary care and drives people to a care system that does not meet their needs.

We would like to work with MedPAC to determine current savings to the system when hospice is chosen as an alternative to costlier services, as this analysis is necessary in informing any proposals to the change to the aggregate cap.

On behalf of NHPCO I thank you for your service. We will continue to offer our assistance to MedPAC in your important role in advising Congress. Thank you.

DR. CROSSON: Thank you for your comments.

Seeing no further individuals at any of the microphones, we are adjourned until January 2020.

[Whereupon, at 11:49 a.m., the meeting was adjourned.]