MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 12, 2013
9:05 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
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GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [9:05 a.m.]

MR. HACKBARTH: Okay. We have a long day ahead of us, so it's time for us to get started. Welcome to people in the audience.

Herb suggested that I need to make an announcement like they make on the airplane. This is the Medicare Payment Advisory Commission. If you are not doing Medicare, you're in the wrong room. The Medicaid and CHIP Commission is also meeting today in the same building, and hopefully people will get to the right place.

So this is the meeting at which we begin our consideration of update recommendations for the Congress. Today we will discuss a series of draft update recommendations that I have put together in consultation with Mike and Mark. There will be no votes today. The votes on these recommendations will come in January. We will discuss the draft recommendations today. There may be changes in the drafts based on that discussion in advance of the final vote in January.

In making our recommendations on updates, we use what we refer to as a payment adequacy framework, and I think that's going to be described a little bit in our

initial presentation, so I won't go into detail, but we take into consideration a number of factors, including most importantly patient access to care and quality of care, access to capital for providers to provide that care, and financial margins where that data is available.

In making our recommendations, MedPAC focuses on the base rate for each of the relevant payment systems, and we're recommending whether the prevailing base rate should change for the year in question.

We start with the assumption of no change in the base rate, that the current base rate should be carried over to the following year. We're making recommendations in this case for fiscal year 2015. If we recommend a change in the base rate, whether the rate goes up or down, it's because we think that there is evidence to support that proposed movement in the base rate.

We don't start with an assumption about, oh, there should be an automatic increase of market basket minus productivity or any other particular number. We start with zero, i.e., the current base rate, and recommend whether that number ought to change.

This highlights a difference between what we do

and what Congress sometimes does in setting long-term baselines for spending. Our process is a year-by-year process. We look at what the change in the base rate should be for the year in question, fiscal year 2015 in this case. We are not trying to make a recommendation about what the rate of increase should be ten years from now. And one way to think about this is that Congress, as part of its budget process, must set these long-term baselines, and they look to MedPAC as one source of information about whether that baseline that they may have set years before continues to be appropriate for the year in question. And so our task in that respect is different than what sometimes Congress does.

When we consider the recommended change in the base rate, we do not take into account the sequester. The sequester was initially enacted as a temporary measure, and for that reason we have elected to focus on the base rate. In our presentations we will note from time to time that the sequester, of course, would change projected margins, for example, but we are recommending what should happen to the base rate, not taking into account the sequester.

So what that means is if we recommend a base rate of X for hospitals, say, and the sequester produces a rate

of payment for hospitals that is X minus 2 percent, MedPAC is going on record as saying the sequester produces rates that are too low for hospitals. It's Congress' prerogative, of course, to decide to go ahead with lower rates. We are strictly an advisory body. But we would be going on record as saying the sequester is producing rates that we think are inadequate for hospitals in the example I've cited.

Now, we will look at for next year whether this approach dealing with the sequester is the proper one. As I said, we started with this method based on the assumption that the sequester was going to be a short-term thing. Members of Congress in both parties had gone on record saying that they didn't think the sequester was a good approach and they wanted to do a more targeted approach to controlling spending. But the sequester has now been in effect for several years, and the pending budget agreement on the Hill that was reached this week includes the sequester being extended to 2023. So in light of the seeming durability of the sequester, we will take a look at how we should include it in our process for the updates next year.

The last thing I would say about the challenge of

making update recommendations is there is no clear analytic right answer to this question. It cannot be reduced to a formula that says plug in these factors and the appropriate update is X. Almost by definition what we're talking about is a range of reasonableness. Congress has asked us as one group to put together our knowledge, our experience, our judgment, and choose a single number, and we do that to the best of our ability. We have no illusions that our number is the only right number.

So with that preface, let me turn to our first presentation. There will be some further discussion of the update framework and then a focus on physicians and other health professionals. Kate?

MS. BLONIARZ: Good morning. Kevin and I are going to go through the Physician and Other Health Professional Payment Adequacy Assessment and the Commission's approach to the sustainable growth rate. Then we'll turn it over to Ariel and Dan to talk about ambulatory surgical centers.

The Commission's framework for assessing adequacy of Medicare payment to physicians and other health professionals is as follows. First, we look at access to

care using beneficiary surveys and other measures of access. We review measures of financial performance, quality measures, and volume growth. Unlike some sectors you'll hear about today and tomorrow, such as hospitals, we do not have indicators of access to capital, and because clinicians do not report their costs to Medicare, we cannot calculate a Medicare margin. So, fundamentally, we rely on measures of access and volume.

In your draft chapter, there are a few places where we don't yet have updated information, so we'll send you a cover memo with that detail, but generally, we don't expect the story to change too much.

And then, finally, we'll go over MedPAC's prior recommendation on the sustainable growth rate, as Kevin and Julie discussed in November.

Physicians and other health professionals bill Medicare using a fee schedule. In total, fee schedule spending was around $70 billion in 2012, 12 percent of Medicare fee-for-service spending. There are about 850,000 practitioners billing Medicare, 500,000 physicians and 350,000 nurse practitioners, physician assistants, therapists, and other providers. Nearly every beneficiary

receives at least one fee schedule service.

So, the first part of the payment adequacy framework is access and the Commission conducts a telephone survey of 4,000 Medicare beneficiaries and 4,000 privately insured individuals age 50 to 64 every summer to ask respondents about their access to physician and other health professionals. Here's the top line story.

We find that Medicare beneficiaries are pretty satisfied with their care. Eighty-eight percent report that they are very or somewhat satisfied, and this is higher than the 83 percent of the privately insured that report that they are very or somewhat satisfied.

So, in the survey, one set of questions tries to assess how long beneficiaries must wait when they want to see a doctor. Seventy-three percent reported they never had to wait longer than they wanted for a routine appointment and 82 percent reported that they never had to wait longer for an illness or injury appointment, and these rates are about four to five percentage points higher than the insured individuals we surveyed. There's remarkable consistency over time with this question, and the rates are always -- nearly always a few percentage points higher for Medicare

than for the privately insured.

There are some differences by race with respect to this question. Minority beneficiaries are more likely to report always waiting longer than they wanted for both routine and illness and injury appointments, and this is one of the few places in the survey where we do see a statistically different finding between white and minority beneficiaries.

We also ask a series of questions on whether people face difficulties finding new doctors when they are looking for one. Only about ten percent of beneficiaries are even looking for a primary care or specialist, and so these numbers are very small.

We find that beneficiaries, when they are looking for a new doctor, don't have much trouble finding one. One-point-three percentage points face a big problem when finding a primary care doctor, and 0.7 percent face a big problem when finding a specialist. And it's similar to what we find in prior years. When looking, a larger share of beneficiaries report a big problem finding a primary care physician than those reporting a big problem finding a specialist.

There's a lot more detail on the survey in your mailing material, so I can address other issues on question, but I do want to mention that, in general, we don't see any statistically significant differences in responses between urban and rural beneficiaries, and most questions have shown remarkable stability over time.

We've looked at some other surveys of beneficiaries and providers that generally show similar results to our survey, that access for Medicare beneficiaries is equal to or better than access among privately insured individuals.

And I want to give a little advertisement. Sometime this cycle, Joan will discuss in more detail the focus groups she runs with beneficiaries and providers, which also gives us a lot of information on access.

The ratio of Medicare payment rates to private PPO rates is around 80 percent, similar to the prior few years, and we also look at a set of quality measures assessing ambulatory care for the elderly. We don't see many changes this year. Among the 38 measures, 33 were stable or improved slightly. And most of these measures assess under-use, and we're cognizant of the interest among the

Commissioners in assessing overuse and inappropriate use of services, and so we have some work going on in that area.

So, to sum up before I turn to Kevin, there's a few other measures that I wanted to put in front of you. The share of providers who are participating in Medicare hasn't changed. It's up over 95 percent. And these participating providers accept Medicare payment as payment in full, or, in other words, they are paid on assignment.

One new piece of information that CMS has released is the share of providers who opt out of Medicare. There's been some press around this, as well. And the numbers are a small share of all clinicians billing Medicare. It's only around 6,600 clinicians, and this is less than one percent of all billing Medicare, and over half are dentists or psychiatrists.

So, turning over to Kevin to talk about volume and the sustainable growth rate.

DR. HAYES: All right. So, for our next indicator, we use -- the volume indicator, we use Medicare claims data to analyze changes in the volume of services per beneficiary. Across all services, the volume of fee schedule services per beneficiary remained essentially

unchanged from 2011 to 2012, with a growth rate of minus-0.2 percent. Among broad categories of service, growth rates were 0.1 percent for evaluation and management, 0.2 percent for major procedures, 0.4 percent for other procedures, and minus-0.5 percent for tests. Use of imaging services declined by 3.2 percent.

On the decrease in use of imaging, it's unlikely that the decrease is a sign that payments are inadequate. First, the Commission and others have paid particular attention to these services. Cumulative growth in the volume of imaging from 2000 to 2009 was about 85 percent. The decrease that followed totaled about seven percent.

Second, the decrease occurred amid concerns about appropriateness. These concerns have been expressed in the medical literature, and specialty societies have drawn attention to appropriateness through, for example, the Choosing Wisely campaign.

The decrease in imaging was also influenced by shifts in the site of care. To illustrate the effect that shifts in the site of care can have on volume growth, we examined cardiac imaging. From 2011 to 2012, echocardiograms per beneficiary furnished in hospital

outpatient departments went up by 13.5 percent, but the number furnished in professional offices went down by nine percent. Over the same time frame, cardiac nuclear medicine studies per beneficiary as furnished in hospital outpatient departments went up by 9.4 percent, while the number furnished in professional offices went down by 15.9 percent. Much of the decrease in imaging volume is due to this shift in setting for cardiac imaging. If cardiac imaging is excluded from the calculations, the imaging decrease from 2011 to 2012 would be 1.9 percent instead of 3.2 percent. You will hear more about the shift in setting during this meeting's next session on hospital services.

Returning now to the general issue of volume growth as an indicator of payment adequacy, it is worth remembering that spending on the services of physicians and other health professionals is a function of both payment rates and the volume of services. While it's true that updates for this sector have been modest in recent years, shown here as the yellow line, the volume of services has increased. That volume growth, in turn, has contributed to an increase in spending, represented here as the red line, and, therefore, has raised the revenues of those who bill

Medicare.

Before we get to the update recommendation, let me summarize the assessment of payment adequacy. Our payment adequacy indicators show that access and quality are stable. The volume of services is essentially unchanged. With findings such as these, the Commission in recent March reports has stated its recommendations on repeal of the SGR and payment reform. We note also that the Congress is currently pursuing repeal of the SGR.

The Commission's position is the repeal of the SGR is urgent. Temporary overrides of the SGR update formula have created uncertainty for beneficiaries and the practitioners who bill Medicare. Those overrides have also been an administrative burden for CMS. And the focus on the overrides has been a barrier to broad-based reform. One further reason for the sense of urgency is that while the cost of repeal has decreased, the cost could rise again.

The Commission has articulated certain principles that should guide repeal. One, preserve beneficiary access to care. Two, rebalance payments, with higher payments for primary care relative to other services. Three, encourage movement toward reform delivery systems through new payment

models, such as Accountable Care Organizations. And, four, recognize the budget implications of repeal.

Given what the indicators of payment adequacy are telling us, given that the Commission has chosen in recent reports to reiterate its SGR recommendations, and given the principles just listed, the Chairman's proposal is to maintain the Commission's SGR recommendations. Repeal the SGR and replace it with a ten-year path of legislated updates with higher updates for primary care than for other services. Collect data to improve the relative valuation of services. Identify overpriced services and rebalance payments. And, encourage ACOs by creating greater opportunities for shared savings.

That concludes the portion of the presentation on services furnished by physicians and other health professionals. Dan and Ariel will now address payment adequacy and the update for ambulatory surgical centers.

DR. ZABINSKI: All right. Important facts about ASCs in 2012 include that Medicare payments to ASCs were about $3.6 billion. The number of fee-for-service beneficiaries served was about 3.4 million. And, the number of Medicare-certified ASCs was up 5,357. In addition, most

ASCs have some degree of physician ownership.

An important factor to consider in regard to the payment adequacy of ASCs are the benefits and concerns of ASCs relative to OPDs, outpatient departments. Supporters of ASCs argue that ASCs offer efficiencies relative to OPDs for both patients and physicians. In addition, ASCs have lower Medicare payment rates than OPDs, which can result in lower aggregate payments for Medicare and lower aggregate cost sharing for patients.

But most ASCs also have some degree of physician ownership and the ownership status may give those providers an incentive to furnish more surgical services than they would if they had to provide those services in OPDs. Evidence from recent studies indicate that physicians who own ASCs do perform more procedures and that markets that had ASC entry had higher growth in colonoscopies and upper-GI endoscopies than did markets that didn't have any ASC entry.

An additional concern about ASCs is that, relative to OPDs, ASC patients are less likely to be dual eligible, minority, under age 65, or age 85 or older.

In our assessment of payment adequacy, we use the

following measures: Beneficiaries' access to ASCs and the overall supply of ASCs, ASCs' access to capital, and aggregate Medicare payments to ASCs. We're not able to use margins or other cost-dependent measures because ASCs do not submit cost data to CMS. In addition, we can't assess quality of care because the quality data that ASCs have submitted is not yet available.

The measures of payment adequacy were generally positive in 2012, as the number of fee-for-service beneficiaries served, the volume of services per fee-for-service beneficiary, the number of Medicare-certified ASCs, and Medicare payments per fee-for-service beneficiary all increased. Indeed, the increase in beneficiaries served and Medicare payments are at least as high in 2012 as in recent years. But, the growth in the volume per fee-for-service beneficiary and the number of ASCs are lower in 2012 than in previous years.

The factors that may have contributed to this relatively slow growth include increasingly higher Medicare payments when a service is provided in an OPD than in an ASC, and as the OPD rates increase relative to the ASC rates, providers are more likely to sell their practices to

OPDs. Also, more physicians are becoming hospital employees, and as this occurs, physicians may be more inclined to provide surgical services in hospitals than in ASCs.

But, despite the slowdown in the growth of some of the measures, all of the measures on this table are positive and these results do inform our access and use framework.

And to evaluate ASCs' access to capital, we examine the growth in the number of ASCs as capital is needed for new facilities. The positive growth of 1.2 percent in the number of ASCs in 2012 indicates that access to capital has been adequate. But, as we saw in the previous slide, the relatively slow growth rate in the number of ASCs may be due perhaps to the factors that we discuss there.

And now, Ariel will discuss quality and a draft recommendation for ASCs.

MR. WINTER: The Commission has recommended that CMS collect quality data from ASCs, and we've also recommended that the Congress direct CMS to use the quality data to develop a value-based purchasing program that would reward high performing facilities and penalize low

performing ones.

CMS began collecting data on five measures through a quality reporting program in October of 2012, and ASCs that do not report quality measures will have the lower annual update beginning next year. However, CMS has not yet released the data that they have collected, so we can't use it in our analysis. In addition, CMS does not have the statutory authority to establish a value-based purchasing program for ASCs.

So, to sum things up, we find that access to ASC services continues to increase, as shown by a growth in the number of beneficiaries treated, volume per beneficiary, and the number of ASCs. Also, growth in the number of ASCs suggests that access to capital has been adequate.

However, as we have noted, our analysis is limited because we lack cost and quality data. The Commission has recommended several times that ASCs be required to submit cost information. Cost data would allow us to determine the relationship between Medicare payments and the costs of efficient providers, which would help inform decisions about the ASC update.

In addition, CMS uses the Consumer Price Index to

update ASC payments and the Commission has raised concerns that this index may not reflect the cost structure of ASCs. So, cost data are also needed to identify an appropriate input price index for ASCs. But CMS does not collect cost data and has not announced plans to do so.

This brings us to the Chairman's draft recommendation. The Congress should eliminate the update to the payment rates for ASCs for calendar year 2015. The Congress should also require ASCs to submit cost data.

With regards to the implications, under current law, ASCs are projected to receive an update in 2015 of 1.3 percent. Therefore, relative to this statutory update, the draft recommendation would produce small savings.

Because of growth in the number of ASCs and the volume of ASC services, we do not anticipate that this draft recommendation would diminish beneficiaries' access to care or providers' willingness or ability to furnish services.

And, finally, ASCs would incur some administrative costs to submit cost data.

This concludes our presentation and we would be happy to take any questions.

MR. HACKBARTH: Okay. Thank you. Great job.

Would you put up Slide 16 for a second? So for the audience, I want to make it clear that we will not be voting on a new recommendation on payments for physicians. We've made a multi-year recommendation that includes the elements described on Slide 16, and we will reiterate in the text of our report our support for those principles to guide payment reform, but there will not be a separate vote on a physician update.

Now, put up Slide 6, please. I just wanted to make an observation about these data. The data presented in this year's report are very similar to what we've had the last three or four or five years. And whenever I have testified in Congress on this issue and presented these data, one reaction that I often get is: "I don't believe your data. My experience is very different from these data. I'm a Member of Congress from," you know, place X, Y, Z, "and I get hundreds of calls from Medicare beneficiaries about how they're having difficulty finding a primary care physician in particular."

I want to make a couple points about the data. First of all, these are national averages, so the experience of any individual community or market may be better or worse

than the national average, and we've got anecdotal evidence to suggest that, in fact, there is that variation. In fact, I think my home State of Oregon, many markets within Oregon are places where it's relatively more difficult than the national average to find a new primary care physician. So we acknowledge that there is variability in this. It simply isn't feasible for us to collect enough survey information to be able to report detailed results at a lower level. We already survey 4,000 Medicare beneficiaries and 4,000 people who are in the age group just before Medicare. That's costly in its own right. Given our budget resources, we simply can't do market-by-market surveys. We provide national information.

Even if you focus on the national average, say you're a congressional district that is at the national average, so we say 1.3 percent of Medicare beneficiaries report a big problem in finding a new primary care physician. That's a lot of people. You know, multiply 1.3 percent times 50 million Medicare beneficiaries, and you're talking about 650,000 people nationwide. There are 435 congressional districts. That means on average, if the district is right at the national average, we're talking

about 1,500 Medicare beneficiaries in that district who are having a big problem finding a primary care physician. That can produce a lot of calls to the congressional office and a lot of local newspaper stories. That doesn't mean these data are wrong. That's entirely consistent with these data.

So, you know, how you feel about the numbers in part depends on the lens through which you look at them. These are the best available information, I believe, on the national picture for Medicare beneficiaries.

Okay. So let's go to Round 1 clarifying questions. Any clarifying questions?

MR. GEORGE MILLER: Thank you. I appreciate the information. Very well done.

If you could put up Slide 5, please. Kate, as you were going through the slide, you mentioned the percentage of minorities that you said statistically had a difference. Do you know where those patients are and where they're served, what area of the country?

MS. BLONIARZ: No. As Glenn described, we only have --

MR. GEORGE MILLER: The national average, okay.

MS. BLONIARZ: -- 4,000, and we're not able to

really drill down other than just saying things like urban versus rural. But that's basically it.

MR. GEORGE MILLER: Okay. All right. Thank you.

MR. GRADISON: Slide 12, please. In the discussion, in the presentation of Slide 12, my understanding was that the comment included a staff comment that the volume had gone up even though the updates were modest and so forth.

I wanted to call attention in that to a sentence at the top of page 25 in the briefing materials which seemed to be opposite and try to understand what is going on. This sentence reads as follows: "They" -- referring to a study done by others, Chapin and Ginsburg. "They maintain that physicians and other health professionals have responded to the slow growth in payment rates by reducing the amount of services they provide," and so forth.

That sounds backwards to me, and it also sounds contrary to our experience of many years with the SGR. Frankly, I didn't go back to the original study. I just thought I'd ask you. Is this a misprint or is this a different view of the data? And if so, why would they -- how would you square your observation that volume seems to

be going up with relatively flat payment rates and theirs that volume actually is going down because of the slow growth in payment rates?

DR. HAYES: I'd want to go back and look at that study and see. That's the most important thing I can say. I think I know what the answer is, but I'd want to look at the study and see.

MR. GRADISON: Thank you.

DR. MARK MILLER: Just to be clear, there's a couple things going on. There's the general trend over the decades that are shown in this, which has generally been up. There has been a slowdown in volume, aggregate volume as well in the last year or so. And so that may not be as inconsistent as your comments would imply. And I also thought the Ginsburg and White piece, or White-Ginsburg piece, whichever way it's supposed to be, was talking about slowdown in rates of growth. And, again, I couldn't tell whether your comments were absolute levels or growth. So I'm not sure there's a lot of inconsistency between what we're saying and what that article's saying, although I haven't read it recently.

MR. HACKBARTH: We'll come back in January with a

response.

DR. REDBERG: On Slide 3, can you give us any idea of the breakdown of spending between the different groups? So the 850,000 practitioners but some are physicians, some are nurse practitioners, physician assistants, therapists?

DR. HAYES: At the April Commission meeting, we talked about payments to advance practice nurses and PAs relative to other practitioners, and my recollection is that at least for the first two types of professionals shown here -- nurse practitioners and PAs -- the percentage was somewhere in the area of 4 percent of the total.

DR. REDBERG: Thank you. One other question. CMS has been collecting quality data on ASCs since October of a year ago. Is there any -- when are we going to see it?

MR. WINTER: They have not said. They have said there will be a process where ASCs can review their data before they are publicly released, but they have not laid out a time frame for ASCs to review the data or for public release of the data. In our comment letter on the proposed rule for 2014, the most recent proposed rule, we urged them to make this data publicly available as soon as possible, and also as part of the recommendation we made in 2012 and

2011. So stay tuned. We are trying hard to find out when that will be available.

DR. HALL: On Slide 4, going back to Slide 4 and the comparisons of satisfaction between Medicare and privately insured, apropos of Glenn's comment that even though the percentage is small of people who are dissatisfied, it reflects a very different population than privately insured. I've often thought that when we compare Medicare to privately insured, there's kind of an unintended regression to the mean. It's kind of like the airlines that say, "Our on-time performance is X compared to the industry." But if you go to small towns or somewhere, you find out that certain airlines, almost everybody is dissatisfied with the service. So maybe it's less relevant for airlines than for health care.

But at least one discriminator, I wonder, can you look or have you looked in the survey at just one simple question: Do you have Medicare Advantage or not?

MS. BLONIARZ: So this has been an issue for a long time. We generally try to keep the survey to the same length so that there's consistency over years. And in the past, we've tried to ask what type of coverage people have,

whether they have Medicaid, employer supplement, Medigap, Medicare Advantage. We have not gotten any real good results on that that we can, you know, determine in a kind of short period of time. People often don't know exactly what they have, and the amount of back-and-forth that would be needed to kind of really clarify just doesn't work in terms of how this telephone survey -- how long the telephone survey takes.

MR. HACKBARTH: So a beneficiary might not distinguish between the private insurance company that they have for a supplemental plan and the Medicare Advantage plan.

MS. BLONIARZ: That's right.

MR. HACKBARTH: It's just not a distinction that's familiar to them.

MS. BLONIARZ: And especially because a lot of companies will have multiple -- may be involved in the Medicaid market as well as Medicare Advantage or Medigap.

MR. HACKBARTH: Right.

DR. HALL: So a common question that I get is: "We're going to spend winter in Florida. Can you recommend a doctor?" And I've long since realized that unless they

can get into an MA program, they're not going to find a doctor. So part of this is perhaps related to Medicare recipient literacy in terms of plans and what to get. That's beyond -- we'll save that for a different round.

MR. HACKBARTH: Clarifying questions?

DR. CHERNEW: You note in the chapter that volume per beneficiary went down by about 0.2 percent points. But on the chart, spending is going up more than prices. So what accounts for that difference between the -- you have spending going up, but volume being basically flat. Is it a mix issue? Is that what's basically going on, that when they move to higher levels of services that doesn't count as volume or price, that's a third category? I'm confused about how spending can go up per beneficiary at the rates you showed and volume can be flat.

DR. BAICKER: And prices.

DR. CHERNEW: Right.

DR. HAYES: Right. There are some other payment changes that are included in the spending numbers, things like a floor on a work GIPC, PQRS-related bonuses, things of that sort. So they could be increasing spending in addition to any volume increases and conversion factor changes that

occur.

MR. HACKBARTH: In this period for these data -- I don't know what time period it is.

DR. CHERNEW: 11 to 12 is [off microphone].

MR. HACKBARTH: There was a conversion factor increase I think in one of those years as part of the SGR patch.

DR. HAYES: Sure. There have been some increases over that period, and you can see them in that yellow line. That represents small increases in the range of half a percent to 1 percent.

MR. HACKBARTH: Yeah, so even the conversion factor is not constant. It went up a little bit.

DR. CHERNEW: I think I understand that. There's something else in there I haven't fully figured out, but we can go around and sort of -- if you have volume flat and spending going up more than prices, something's --

DR. HAYES: Right.

DR. MARK MILLER: And that's probably bonus payments and the like.

MR. HACKBARTH: So I have Peter and Jack. Anybody else with a clarifying question?

MR. BUTLER: Slide 11. So we know that the cardiologists have seen rapid employment and this kind of shift going on. And I think I know the answer to my question, though. This leaves the impression that patients are physically now going to a hospital outpatient department for their services instead of their physician office when, in fact, they're probably going to the same physician office they've always been going to, it is just being paid in a different way.

We don't have any way to distinguish between the actual setting where they're actually getting the treatment, right?

DR. HAYES: That's correct. The billing data identify whether the billing location is classified as an office versus a facility setting, but it doesn't classify the physical location of the site. And the reason for that would be that the payments, as you know, are different depending upon how the billing location is identified.

MR. BUTLER: So just as an editorial, when we use the word "shift" to outpatient, we should be careful about the -- you know, it's not really a physical shifting in most cases. It's a shift of the payment methodology.

Page 17, we note in the recommendation that the -- okay, so there's 3.6 billion in payments. I'm one that likes to keep score on how we do collectively by the time we end with our recommendations against current law. So you just said, well, it's a little bit different than current law. Did you cite 1.3 percent as the current law increase for ASCs?

DR. ZABINSKI: For 2014?

MR. BUTLER: For 2014.

DR. ZABINSKI: 1.2.

MR. BUTLER: So my calculation is on 3.6 billion, it's still over $40 million of savings compared to current law, I think.

DR. ZABINSKI: Sure, yeah.

MR. BUTLER: Is that about right?

DR. ZABINSKI: Yeah.

MR. BUTLER: Okay.

DR. NAYLOR: Can you remind me how long the bonus or primary care incentive program will continue?

MS. BLONIARZ: Through 2015.

DR. HOADLEY: Back on Slide 11, the percentages in the two columns are obviously, I think obviously, off of

different bases. So I just want to make sure we can't compare sort of the magnitude. Do we have a sense of the size of the volume in the two columns so that we know sort of -- as opposed to just rates of increase what's the actual --

DR. ZABINSKI: I mean, are you getting at, you know, what -- is there a net effect of going up and going down?

DR. HOADLEY: Yeah, net effect.

DR. ZABINSKI: Echocardiography is about level. The volume really hasn't changed. The nuclear cardiology is going down on net, if you add the two together.

DR. HOADLEY: Okay.

DR. ZABINSKI: By, I don't know, a fair amount, 10 percent.

DR. HOADLEY: Okay.

MR. HACKBARTH: Okay. So as I said earlier, we don't have a separate draft update recommendation on which we will then vote in January for physicians. We do have one for ASCs. So in Round 2, what I want is for people in particular to say their tentative view on ASCs. Are you for the recommendation? Do you have concerns about it? If you

have concerns, what could be done to address your concerns? And then if you also wish to make any additional comment about physician payment, you can do that as well.

Jack, do you want to begin Round 2?

DR. HOADLEY: Sure. On the draft recommendation, I'm fine with the direction that the Chairman has recommended. I think that makes good sense.

The one thing I wanted to comment on, I really like a lot of the material in the chapters, and what I particularly think is useful in the physician side is our ability to look directly at access measures. You know, so often in these sectors we have to look at access through indirect kinds of criteria. And I think it's kind of really pointed out by the whole discussion of imaging where, you know, we're reporting on a decline in imaging, the use of imaging services, and in some ways that can say, well, is that an access problem? And obviously you talk about that. But when we look at the direct measures of access through the surveys and other kinds of things, we're able to speak more directly to access. And I do think that's something we maybe over time need to think about. Are there other ways in some of the other sectors to get at access in the more

direct kind of approach that we're able to use in this sector. I know we can't do surveys to look at ASCs or something that people aren't going to be able to comment on, but be able to think about how to sharpen our look at access measures. So that's the comment I wanted to make.

MR. ARMSTRONG: Other than to say I support the direction that the recommendations are heading in, I don't have anything to add.

DR. NAYLOR: I also support the recommendation, the direction that the recommendation related to ASCs is moving. In terms of the physicians and other health professionals, I think if there's any opportunity to probe the 1.3 percent who report a big problem in accessing primary care, I don't know -- I know you can't do that via survey, but if we can get any understanding about why that exists, I think that would be very helpful. I have only a couple more years on the Commission, but I would love to see that the survey work that you do really recognizes the changes in who's delivering primary care, and the survey continues to ask about physician and satisfaction and access. With nurse practitioners and PAs and others delivering or solely responsible for about 10 percent of

primary care and 34 percent -- more than a third -- I think it's really important that we begin to have our surveys help us to uncover how issues of access can be addressed by other health professionals. So that would be my recommendation again.

MS. UCCELLO: I support the ASC recommendation, and I really like how the chapter also kind of points out or clarifies that although growth has slowed, it's partly due to this migration to the higher-paying HOPD, so it further highlights our need to pursue this as a policy option.

In terms of physicians, I just think it will be interesting in the coming years when we look at the survey to see -- to monitor whether, you know, as more people obtain coverage through the Affordable Care Act, how that may change, or not, access overall and also the differences between the pre-Medicare and the Medicare population. It will be interesting to look at.

MR. HACKBARTH: Just to pick up on something that Mary and Cori said here, I believe -- and this is just my personal view; people are welcome to disagree with it -- that although we've shown steady access numbers for Medicare beneficiaries, numbers that compare favorably to private

sector patients, we shouldn't be lulled into complacency by that. I do think that there are trends afoot that could, particularly in the case of primary care, result in access getting worse and maybe in some markets relatively quickly. And you just touched on some of those, Cori. I think a growing number of Medicare beneficiaries, the fact that many more Americans may get insurance coverage under the Affordable Care Act, the fact that there's a pretty large cohort of primary care clinicians that is also nearing retirement age, you know, in some individual markets the supply and demand is in fine balance, and relatively small shifts in those things could result in a fairly significant quick deterioration in access for Medicare beneficiaries, and in particular with regard to primary care.

You know, Mary, on your point about what's going on with the 1.3 percent, the fact that seemed significant to me there is that the comparable number for private patients is -- what is it, Kate? It's similar or worse, which suggests to me -- and this has been supported by other studies that have been done -- that where there are problems, they're not Medicare-specific problems so much as community problems and an imbalance between supply and

demand.

MS. BLONIARZ: Yeah, so for primary care it's a little worse in the privately insured. It's 1.4 percent.

MR. HACKBARTH: So it's very similar. As I say, I do think there's some evidence from some other research that where problems exist, it's not Medicare-specific; it's a more general problem.

MR. KUHN: I support the recommendation and have no changes to it and would just also like to lend my voice to this conversation that we've been having about access issues. I think Glenn did a very good job of setting up earlier the notion of hot spots out there that can be in different parts of the country. How we capture that in the future is uncertain.

But the other point that he just made and something I've been thinking pretty hard about is the fact that I know in our State of Missouri, we did some research not long ago where we looked at the age of primary care physicians practicing both in urban and rural areas, and those in the rural areas are significantly older. It's statistically different. And I think in the next four to seven years, as that group begins to retire, then I think

you begin to see some access issues if you're unable to backfill. So somehow to continue to refine this kind of information and continue to monitor it very closely is going to be pretty important for us.

DR. SAMITT: So I, too, support both recommendations. I want to tag on to the discussions about the 1.3 percent, and I think my vantage point may be a little bit different in that I think there is significant value in studying that further. What I would be most interested in knowing is do we see a distinction in beneficiary satisfaction or access between fee-for-service, ACO, and Medicare Advantage. We've long talked about the desire to get MA encounter data so that we can distinguish performance within Medicare Advantage. This is an opportunity for us to say do we see differences in quality, service, access between these alternative models. And so I would encourage us commissioning a separate study to really look at this 1.3 percent to understand whether beyond geographic differences we see differences in the manner, in the products essentially that these beneficiaries are purchasing.

MR. BUTLER: So I suppose another way of saying it

is that you can drown in a lake that's an average of five feet deep, but I suppose we should, you know, celebrate in some ways the fact is that no matter how big and important that small population is, the vast majority of people can have pretty good access. And I think that that is true. I don't think we should escape the fact that physicians are participating in Medicare in almost universal -- almost 100 percent rates, and it seems to not be diminishing that quickly.

So with respect to the ASC recommendation, I am supportive of it. I also would draw attention to the chapter having a lot of good data that really starts to even better identify the differences in the patients between the HOPD and the ASCs. They're different types of cases. They're different types of demographics. Minorities are underrepresented. They're different payer mixes, and physician ownership I think is one of the factors that kind of drives all this, and I think we need to still be quite sensitive to shining the light on that, even though we're not really changing the differences -- in fact, we might be increasing the differences by the time we're done between that HOPD payment for surgery versus the ASCs. But I think

the content of that chapter and the data is an important part of what we're doing.

DR. CHERNEW: So, I know we're not voting on it, but I'm supportive of our previous SGR recommendation, just to get the pleasure of saying that.

I'm supportive of the recommendation here, as well. I just wanted to note three quick things.

The first thing is, in most industries, volume moves from the high-cost to the low-cost provider. Here, it seems to move from the low-cost to the high-cost provider, and that's a worthy thing of note as we have a future discussion about the provision of products in multiple sectors, and this is a month when we do things in silos in ways that are sometimes problematic.

The second thing I'll say is there are clearly important workforce issues going on with the provision of care, and I think it's not just issues that they're retiring, but there's going to be an issue about the type of person that people see for certain types of providers, the role of technology, a whole range of things that are going to go on. So, I think that's both worth monitoring and important, and I do think maintaining access is important.

I agree with all that was said about hotspots. I like that term, Herb. I will just say, the solution, if you found there were places where there wasn't access, would simply not to be, well, we just have to pay everybody more, and we've had discussions in other contexts that our goal would be to find targeted solutions where there's targeted problems. So, I think the idea of identifying where there are targeted problems and thinking about targeted solutions is important, but I wouldn't want to leave the impression that if we found an access problem in a certain number of places or for a certain number of people that the solution would be some across-the-board payment increase overall.

DR. BAICKER: I'm supportive of the recommendation. I echo Craig's thoughts about the value of data on these things, particularly the cost data for the ASCs. And in addition to having more data available to CMS, it would be good. I'm glad that we're highlighting the importance of being able to analyze that data in a timely way and for us to get access to some of the data that is in existence but not available right now.

DR. HALL: I'm also in favor of the recommendation and I just have two provisions that have been sort of

touched on. One is the unintended consequence of moving volume from the ambulatory setting into hospital settings, whether it's high-price, low-price, or whatever, maybe it's the death knell of ambulatory centers, which we point out in the center do serve a very good purpose, particularly in terms of access to certain key parts of the population. So, what I hope is going to happen is that this is going to incentive people who run ASCs to become more efficient, to be able to adapt to a -- the end of an unending stream of increased updates. So, I hope that that's going to be the outcome of that.

Just because I don't think it's coming up anywhere else in our discussion, I'll just be very brief. We mentioned the Choose Wisely initiative that has been going on in the country, where various specialty societies in medicine are, rather than telling people how to practice, telling them how not to practice, that is to say, what things need to be eliminated. So, it's an interesting phenomenon that's going on here. If you talk to anybody who's in a specialty society and the people who have contributed to the "don't" lists in their own specialty, what you find out is that there's no news there for them.

They already knew this and it was easy for them to write these recommendations.

But the flip side of that is that I truly believe that as now there's 24 societies that have gotten involved in this, that it's starting to have a more general impact on the overall physician community writ large. This became very obvious to me when we started rolling out the education of these Choose Wisely to a group of sort of undifferentiated stem cells, our residents who are generalized at the present time. It's always good to get them at that point, if you can, because you can't transplant it later.

[Laughter.]

DR. HALL: And what we're finding is that they're saying, well, this is great for all aspects of my practice. And so I think the next application of this is going to be to -- is not to set this up for us to self-congratulate ourselves in the specialties, that we know what we shouldn't do, but to make sure the medical community writ large is doing it, and I see that happening now.

DR. REDBERG: I support the recommendation on eliminating the update and submitting cost data.

I also wanted to comment, because last year, I think, we recommended some value-based purchasing with regard to ambulatory surgical centers, and I was just struck looking at the list on Table 5 on page 17 in our mailing materials that a lot of the procedures that have been increasing in the ASCs are -- it's important to add appropriateness measures perhaps kind of related to Choosing Wisely because a lot of these are measures that are now clearly in our beneficiaries' best interests.

I mean, colonoscopies, which, yes, we should be doing as part of colorectal cancer screening, but the frequency is recommended every ten years and we know that a lot of beneficiaries are getting colonoscopies paid for by Medicare more frequently than the recommended, and that is not in their best interest because it subjects them to the risk of the procedure without the benefits of too frequent.

A lot are injections for a paravertebral, a lot of back things that are of questionable value. And, again, with the imaging, I mean, we know that a lot of imaging is being done, particularly advanced imaging, CT and MR, for back pain is still being done within the first six weeks of onset of back pain symptoms when it is recommended in all

the guidelines not to do imaging, because most back pain gets better on its own without imaging.

The same with cardiac imaging. I mean, I think the concern is not really access so much as is the imaging appropriate, and we have, certainly, as Kevin noted, seen a huge increase in volume in cardiac imaging in the last decade, and I just think that when we go forward, it's important to include appropriateness in our value measures as well as access.

MR. WINTER: Just on that note, Rita, the CMS adopted two measures of appropriate use of colonoscopy for the ASC quality reporting program and the outpatient department quality reporting program. They'll start to report on those measures, I think, in 2015, but the data will be based on 2014.

DR. NERENZ: Okay. I'm going to be generally comfortable with the recommendation as judged through the lens of the adequacy criteria that we talked about.

I did have an additional question that I think echoes the question that Bill raised during phase one, just about what are the behavioral responses that we might expect based on whatever it is that we choose to do. In this case,

the absence of an update makes work in the ASC just marginally less attractive than a positive update.

And then the question is, well, what happens, and we tend to have a mix of things that we talk about or that we actually see data about. ASC providers could do more services in order to meet fixed revenue targets and cover practice expenses. There's some evidence of that. But also, in almost the same breath discussion, we talk about them doing fewer things because each one is marginally less attractive financially than it would have been with an update. But those two things are sort of opposite. They could become more efficient, maybe. We'd probably like that to happen. Or, in this case, there could be a shift to doing the same thing in HOPD, where the payment rate is higher.

The text in the chapter, pages 16 to 18, I think was very nice about what some of these trends have been. If I read correctly, there has been a trend from HOPD to ASC in a number of these areas. But then we have the question of, you know, any decision we make about an update is going to have some effect, probably, on that trend. The trouble is, it's uncertain. It's small, hard to know.

So, I guess all I can say is I wonder about these things, but it doesn't rise to the level of saying I would not somehow be comfortable with the recommendation.

And, lastly, I just want to speak strongly in support of what Rita just said. I also looked at Table 5 and was looking at things that we probably would wish to see more of. Appropriate colonoscopies, we work hard to try to get more of. Other things, perhaps not.

Now, the general update decision is a blunt instrument. It sort of moves the whole thing up or down. But there may be opportunities at some other point in our discussion to talk about how payment policy may be more tailored to focus on the desirable and try to push that up and opposite for the others. But I thought that was an excellent point and had my book open to the same thing already.

DR. COOMBS: So, I'll start with the last recommendation first and then talk a little bit about Slide 16.

One of the things I'm interested in is the whole piece on quality and what happens at ambulatory surgical centers. One of the things that we have to appreciate --

Mike said it good in terms of -- very well in terms of moving less costly to a more costly environment, is if ambulatory surgical centers want to prevail in a given community, they will have more higher-paying, or more, let's see, reimbursement to cost ratio patients that will actually come there. Their efficiency may be, when we look at the quality data, may actually say that this is a place that you might want Medicare patients to go to, but because of maybe the impact of this negative update, it may not incentivize that driving into ambulatory surgical centers.

And so that what would happen in a given community might be that all the Medicare patients would go to the hospital to have their procedures and all the privates would go to the ambulatory surgical center. By decision making, that's what a provider would -- thinking from a provider's hat, that's what would happen in reality so that the ASCs would actually select the situation whereby there would be selection within a given community as to where you'd have a given procedure, even though we know already that hospitals, OPDs, tend to have more vulnerable populations there for which there should be compensation for taking care of sicker patients. So, that would be the impact of a continued flat

update over the next ensuing years.

As for the physician update, I want to focus on a couple of things with the survey. The Mass Medical Society did a survey where the individual called not the patient, but the person conducting the survey would actually call the doctor's office and ask the doctor, "I'm a Medicare patient. When can I get in to see you?" That's basic. It gives you an objective number. And you can do this in a pilot fashion and actually find out, what is that wait period?

The problem with this survey instrument is a perception study. It depends on the educational background, the total environment that you ask the patient, do you have a problem, yes or no, maybe so. It doesn't get at what you really want to know, is that if that extended wait period is three months or two weeks or whatever it is, does it result in that patient having an escalation of care? That's what you really want to know, because if your wait period is long enough and you wind up in the emergency room or with exacerbation of disease, then that's really, really important. A perception answer on was it good or bad, yes, no, maybe so, without the other part in the survey, doesn't help us as much. And so I think that objective data, even

in a smaller group, might be more beneficial.

And, I agree with Craig. You know, knowing the difference between the other person on the phone, if you're going to do that kind of survey, whether or not they're Medicare Advantage versus fee-for-service versus a robust ACO, it's going to make a huge difference because that patient will feel a lot different, even if there's physician navigators and a vulnerable population such, you know, someone who's linguistically confident on the other end of the phone. So, I think that's a really important part of the survey that would make things different, even if we were to go ahead and redo that survey.

In terms of the spending projection and the graph that was portrayed, a lot of things that I think you mentioned were added into the beneficiary spending that are maybe attributed to practitioners, physicians or nurse practitioners, that, indeed, may not be the result of the nurse practitioner in terms of all the other things that are mitigating factors. So, it might be good to tease out what that beneficiary spending increase is, and I know you could probably draw a curve that says, okay, if we didn't include this, this is where this would wind up, because it doesn't

make sense. If volume is down, then the beneficiary spending being up speaks to some other things which might invoke some things such as coding and things of that nature, as well. So, I think that's important.

And, workforce, I think people have alluded to this whole notion of two things intersecting at the same time. We have a seismic shift in terms of the ACA and this infusion of all these patients and you have a fixed workforce. Your workforce is fixed. It's not going to change that quick.

The recommendations in terms of a ten-year path to legislative updates, I feel uncomfortable with anything that's fixed over ten years with this new change in terms of ACA and the transition into the health care reform track of physicians and providers trying to migrate into Accountable Care Organizations. So, I think that's a piece of it that I think if you were to have a ten-year solution to a changing environment that's so rapidly changing, I think we make a mistake with that, and that's partly because I know that this part over here with the number of providers, you're not going to turn out a lot of doctors and nurse practitioners in the next three years. It's going to be relatively

constant. But you're going to turn up a lot of patients in the office when they have an ATM card they then go to the bank with, you know, they can get their care. So, I think that's a really important piece of it.

And then the notion of what we do for primary care versus specialists. Primary care is really important. I think going forward, with some of the circles that I've been in, primary care will progressively be cared for by non-physician practitioners as we go forward. It might be a year or ten years down the line will we see a mix of a one-to-one ratio with physicians and nurse practitioners. It may change quicker than that, but I'm thinking that that progression will probably continue to occur over the next ensuing years.

In terms of the specialists, though, there are some specialties that are really at critical levels in given communities, and I dare say that those are the specialties that the physician extenders are less present in, and those are nephrology, general surgery, and urology. And in general surgery, the turnout is somewhere a little over a thousand doctors a year turn out. And so the general surgery has been in a deficit, a critical deficit, over

years, and what happens to the general surgeons who retire and the steady state of the workforce, I think, is really important going forward for Medicare beneficiaries.

So, you wouldn't want to have a ten-year fix on one side, the primary care or the specialty side, without knowing what's going to be happening with the workforce, and I think that I would be more comfortable with something that was more on a short-term basis because of the many things that are changing on the health care landscape.

MR. HACKBARTH: Let me just pick up on that point, Alice. Could you put up Slide 16 for a second. And let me -- the point you're raising about the ten years is a good one and I will think about is there maybe a way to address this for January.

I did want to explain, though, the context of a ten-year path of legislative updates. This was part of a package that was designed to not only recommend repeal of SGR, but also suggest options for the Congress on how to finance repeal of SGR, which we have been told repeatedly by Congress was the principal barrier to their acting on repeal. They couldn't figure out how to finance it. So, what we did in October 2011 is try to say, here is a way

that you might approach that, including some options to offset the cost, and so it was in that context that we talked about a ten-year path of legislative updates.

We took pains, however, to emphasize that what this would do is simply reset the baseline. We would get away from the baseline based on the SGR calculation, which produces big cuts in rates, say, substitute the ten-year path as a new baseline. However, each year, you would need to revisit the adequacy of those rates to determine whether they continued to be appropriate.

So, again, your point is a good one. We will work to clarify this. But we were not saying, we'll fix it for ten years and then walk away from it. Far from it. We said, you'd need to analyze it each year. This was just about resetting the baseline, okay.

MR. GRADISON: I support the recommendations.

I want to comment briefly about the question of primary care which so many others have quite properly called attention to. The data, so far as I understand them, with regard to the division of the extra ten percent, which is to go through 2015, roughly 50 percent to internal medicine physicians, about 40 percent to family doctors, and the

other ten percent to PAs and nurse practitioners. I am not suggesting a change in our survey. I do wonder whether any data may be available through CMS that would give us greater insight into that ten percent, and in particular, to how that may vary, if it does, among the States, and how that might relate to the scope of practice laws in those States. While I think I know what the answer would be, it may be possible through actual data from payments already being made to get a sense of what that is, what's happening out there, and coming back to the comment that Alice just made, there may be States that are slowly, to be sure, moving in the -- faster over this ten-year time period than others.

Having said that, I just want to be very clear. Certainly from my contact with, now and then with medical students and so forth, this ten percent is really piddling in terms of, in my opinion, in terms of influencing career choices or specialty decisions for medical students because the gap is still so great between the, on average, between some of the higher-paid specialties and primary care even with the ten percent. Not arguing against the ten percent, but it's hardly a solution to the problem, in my opinion.

MR. GEORGE MILLER: Yes. On the recommendations

for the ASC, I agree in principle with the Chairman's draft recommendation, but I'm having a little bit of a heartache, particularly because of Slide 18, dealing with the concerns raised by the staff, and I want to illuminate on those concerns, particularly at the top of page 18 and we say the great benefits of efficiencies for patients and physicians, but below, the concerns -- and I want to illuminate those concerns -- dual eligibles, minorities, don't seem to benefit from those great benefits at the same degree, and I am troubled by that. As Peter illuminated, those who have funds can go to the ASC and those who are poor and vulnerable seem to go to HOPDs. I think that's a problem for me, and I'm wondering if that can't be addressed in the draft recommendation that's probably a little more aggressive than the current.

MR. HACKBARTH: So, say a little bit more. How would you address it in the recommendation?

MR. GEORGE MILLER: That's -- well, unfortunately, we use the blunt instruments of payment updates, and that's what this is recommending, that no payment updates. I think, if I remember correctly, the margin is still pretty substantial with ASC --

MR. HACKBARTH: Actually, we don't have any margin based on ASCs because they don't file cost reports.

MR. GEORGE MILLER: That's right. The data is not there. Well, again, I think, since we represent all Medicare beneficiaries, all Medicare beneficiaries should be treated exactly the same, and if there's a great benefit, all of the benefits should benefit all Medicare beneficiaries and there's clear evidence it does not, and I have a problem with that. I'm not sure how to quantify the solution or the amount to recommend, but I think we should be more aggressive than your recommendation until -- if it's good for some Medicare beneficiaries, it should be for all. It should not be any difference in utilization for dual eligibles and minorities.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: And one further, to add to Craig's point of his new Commission study, I would like to add to his Commission study, if he doesn't mind, to the fee-for-service, MA and ACOs, also, the notion of where minorities fall in the scheme of things and segment to find out where they are, where their locations. My concern would be the difference of not having accessibility to physicians

are in urban areas and safety net areas. That may make a different statement if they're generally dispersed throughout the population. So, I'd like to add that to your recommendation.

MR. HACKBARTH: Jon.

DR. CHRISTIANSON: So, as long as we're talking about -- we seem to be talking about Craig a lot, so I'll continue to do that. That was also on my list, and I fully understand the problems of asking people what their insurance coverage is. I've tried to do that. It doesn't work very well with Medicare. And I also understand the benefits of having a consistent survey over time so you can have trends. But, I do think it's time for us to consider, and I know this costs money, consider using other information we have to identify people who are in MA plans and possibly in ACOs and beginning a parallel set of surveys, not a one-off survey.

I think the information we have from the existing survey becomes less useful to policy over time if we continue it without having similar information available for people that are in MA plans. Particularly, that's becoming a more important part of -- you know, the percentage of

people in those plans is growing in Medicare, but also the policy proposals relating to reform of Medicare have -- many of them focus on putting more people in MA plans.

So, it's just something we need to do, and I feel pretty strongly about this, actually. We need to try to find the money to do that. So, that's my thoughts about the physician presentation that haven't already been covered.

I agree with the Chairman's recommendation. I do wonder, there is a statement on your Slide 23 that says that CMS doesn't have the authority to do value-based purchasing. I'm wondering whether we shouldn't consider that as part of a recommendation. I'm not sure what the appropriateness in this context is for adding that, but I say that for a couple of reasons. One is it certainly would be consistent with value-based purchasing strategies that are being pursued in other parts of CMS, but also, I think it would jump-start the collection of cost data. Particularly if you're doing shared savings as part of the value-based purchasing arrangement, you're going to have to have a cost basis, so it provides a reason to collect cost data and maybe some experimentation there, and it also will focus more attention on developing additional quality measures in this area.

So, I'm wondering if the Commission wouldn't want to, assuming that statement is correct on page 23, if the Commission wouldn't want to extend the Chairman's recommendation and recommend that CMS be given the authority to do those sorts of things.

MR. HACKBARTH: So, remind me, Ariel, we recommended in a previous year that the data, the quality data be collected, but stopped short of recommending that there be a value-based purchasing program for ASCs, is that right?

MR. WINTER: In 2011, that was our recommendation. In 2012, we recommended that CMS develop a value-based purchasing program for ASCs by 2016. And then last year, we repeated that recommendation without voting on it again in the chapter and we were planning to do so again for the 2014 chapter. Obviously, it's your call whether to vote on it again, but we have been reiterating that recommendation, at least in the text.

MR. HACKBARTH: Okay. So, that is part of our historical recommendation, and let me just think about re-voting on that, but we are on record in favor of value-based purchasing for ASCs.

Okay. Thank you very much. Good job. We now need to move ahead to hospital.

[Pause.]

MR. HACKBARTH: Okay. Who is leading in this illustrious panel?

MR. LISK: I'll lead off. Good morning. This session will address issues regarding Medicare payments to hospitals.

First we will review the adequacy of Medicare payments through 2014. Then we will discuss changes in policy that are in current law and additional changes proposed by the Chairman as part of our draft recommendation. These changes will improve incentives of the health care system.

To evaluate the adequacy of Medicare payments, we use a common framework across all sectors. When data is available, we examine provider capacity, service volume, access to capital, quality of care, as well as providers' costs and payments for Medicare services.

Also, when we discuss profit margins, we will present Medicare margins for the average hospital and for relatively efficient hospitals.

The hospital team has a lot to cover today, so we will move fairly quickly through it all. More detailed information is contained in your mailing materials.

As we discussed in November, access to capital [sic] is strong, and we do not see any near-term issues that would affect beneficiaries' access to care. We will not review all of that information again.

In most markets we find an excess supply --

DR. MARK MILLER: Craig?

MR. LISK: Yes?

DR. MARK MILLER: You meant "access to care."

MR. LISK: Access to care.

DR. MARK MILLER: Yeah, your first statement was "access to capital."

MR. LISK: Sorry. I misspoke.

DR. MARK MILLER: No problem.

MR. LISK: We will not review that information again. In most markets, we find an excess supply of hospital beds with occupancy rates declining.

At the November meeting, a number of Commissioners expressed concerns about part of the excess capacity coming from hospitals that have low patient volumes and do not

provide high-quality care. Your paper includes a new analysis that examines these poor performing hospitals -- hospitals that have low occupancy rates, high readmissions, and low patient satisfaction -- and we find that some of these hospitals are undergone major structural changes through mergers or acquisitions by larger hospital chains, for example, and in some cases these hospitals have closed or curtailed selected services. In 2012, we found that the number of closures roughly equaled the number of new entrants.

One of the reasons for the excess capacity is due to declining inpatient admissions. Medicare inpatient admissions per beneficiary went down by 4.5 percent although outpatient volume went up by 4.3 percent. On a dollar-weighted basis, however, overall Medicare volume went down by 2 percent. The decline in volume is due to less demand for care rather than capacity constraints.

We find that access to capital is adequate. In the equity markets, hospital stocks have increased 30 to 70 percent so far in 2013, indicating the capital markets' faith in hospitals' prospects. Most hospitals have access to bond markets also, though some hospitals have faced

downgrades in part due to concerns about volume of services. Hospitals may also face some liquidity issues due to spending on practice acquisitions, hospital acquisitions, and health information technology.

While there is still room for improvement, quality-of-care indicators are generally improving. We see improvements in 30-day mortality for the conditions we monitor including AMI, congestive heart failure, stroke, hip fracture, and pneumonia. There has also been some improvement in patient safety.

Readmission rates also have shown some improvement as we enter the second year of the hospital readmission reduction program.

The declining volume of services per beneficiary allowed spending to remain roughly flat. In 2012, Medicare fee-for-service spending for inpatient and outpatient services totaled about $166 billion. This represents a 0.3 percent increase in spending per beneficiary.

Spending was essentially flat due to declines in volume offsetting increases in prices from 2011 to 2012.

In this next chart, we can see how growth in Medicare inpatient costs per case, the green line, has

steadily fallen over the past decade. The lower cost growth we observed since 2009 is a result of the combination of lower hospital input price inflation, which has remained well below 3 percent since 2009 -- the blue dotted lined -- and hospitals keeping their cost increases closer to this lower level of input price inflation. Although we do see a jump-up in cost growth in 2011 and 2012, we believe this is at least partly due to an increase in the average complexity of Medicare patients admitted to the hospital, as some easier cases have not been admitted.

So what does this all mean for Medicare margins? A margin is calculated as payments minus costs divided by payments and is based on Medicare allowable costs.

From 2011 to 2012, Medicare inpatient and outpatient margins both declined, but the overall Medicare margin remained steady at minus 5.4 percent due to increases in Medicare HIT payments hospitals received from 2011 to 2012.

Our next slide here shows how the overall Medicare margins differ by hospital groups.

The average overall margin for rural hospitals was minus 1.9 percent in 2012, which is almost four percentage

points above the margin for urban hospitals.

For-profit hospitals had the highest overall Medicare margin at a positive 1.5 percent in 2012. We think this higher margin is due to a combination of factors, with for-profit hospitals having lower cost structures and a tendency to provide more profitable outpatient services. And there's some discussion about that in your papers.

Next we are going to move on and discuss our forecast of the overall Medicare margin for fiscal year 2014, the current policy year. We estimate that the overall Medicare margin will decline slightly, going from minus 5.4 percent in 2012 to minus 6 percent in 2014.

So why do we expect margins to decline slightly?

First, payment rate updates will increase revenues by a little over 4 percent over the next two years along with some growth in case mix.

Second, we expect costs will go up more than payments, with costs continuing to go up close to 3 percent per year. This is similar to last year and what has been reported by for-profit hospitals through the first nine months of 2013.

Finally, increases in HIT payments will mostly

offset this difference between the payment increase and cost growth. And note, this does not account for any sequester effect for 2014.

While Medicare margins continue to be low, all-payer margins are at record highs, as you can see here, where they rose to a positive 6.5 percent in 2012.

Other total hospital financial indicators stayed strong in 2012 as well.

This slide highlights the divergence in margins we talked about last month. All-payer margins were at record highs in 2012. But Medicare margins are negative on average and expected to fall.

Now Jeff will move on.

DR. STENSLAND: Craig just discussed how quality is improving, but Medicare margins are negative. The academic literature also shows quality improving, but some of the literature suggests that quality could be even better if Medicare payments were higher. Some may interpret this literature as suggesting that Medicare rates are too low to allow hospitals to produce high-quality care.

To address this issue, we investigate whether there are a set of hospitals that perform relatively well on

quality-of-care measures while also doing relatively well on cost measures. We deem these hospitals our set of relatively efficient hospitals.

To determine who is relatively efficient, we used the same criteria as the last couple years. I will not go into them in detail. Hospitals are categorized as relatively efficient if they performed relatively well on either mortality or standardized costs, and did not perform poorly on mortality, standardized costs, or readmissions in any of three years, 2009, 2010, or 2011.

After identifying the group that's relatively efficient in historical year, then we look to see how well they did in 2012.

Here are the results. We ended up with a group of 302 hospitals that have historically been relatively efficient providers for three straight years prior to 2012. This group of 302 hospitals represents about 14 percent of all IPPS hospitals that had usable data.

If we look at the first column of numbers, we see that the historically efficient hospitals had 13 percent lower mortality while keeping costs 10 percent lower than the national median. The lower costs allowed most of these

hospitals to generate positive Medicare margins in 2011, with a median margin of 2 percent. It is important to remember that when we talk about efficiency, we are talking about quality and cost. Craig mentioned earlier that for-profit hospitals tend to have lower costs, but they actually are underrepresented in our efficient group due to being less likely to perform well on the mortality and readmission measures. So it's not just about cost.

Now to summarize our payment adequacy findings, first, access is strong; access to capital is adequate, although a few providers with financial problems have faced rating downgrades; quality is improving; margins are low for the average provider; but relatively efficient providers were able to make a slight profit serving Medicare beneficiaries in 2012.

However, as we discussed in November, there are payment policy changes scheduled to take place in 2015 that would reduce payments to hospitals. If current law holds, we would expect negative margins in 2015 even for the relatively efficient providers.

Now we are going to shift from talking about whether aggregate payments are adequate to talking about how

to improve incentives in the system.

One way to improve efficiency of the system is to equalize payment rates across sites of care for similar patients. Patient decisions regarding what site to use and physician decisions regarding what site to practice at can be made without the distortions of unequal payment rates. Today we discuss how to remove two specific distortions to Medicare pricing.

The first issue is equalizing payment rates between outpatient departments and physician offices. Two years ago, we recommended equalizing payments for evaluation and management visits. Today Dan will update you on your ongoing discussion about equalizing payments across sites of care for another 66 APCs. A problem is that the current system has a built-in incentive for hospitals to acquire physician practices and increase revenues by billing for the same services as outpatient services.

The second issue is LTCH payments. Earlier this year, Dana discussed some ideas for bringing LTCH and IPPS payments to a similar level for similar patients. This involves two changes:

First, for the less severely ill patients, LTCH

rates would be brought down toward the acute-care hospital rates. The savings from reducing payments for less severely ill LTCH patients would be transferred to acute-care hospitals in the form of higher outlier payments for the most costly ICU patients in acute-care hospitals. By bringing LTCH payments down and acute hospital payments up, we can eliminate some of the distortions that currently generate adverse incentives.

I will now turn it over to Dan.

DR. ZABINSKI: Payment differences across settings is becoming an increasingly larger concern because it appears that services are shifting from lower-cost office settings to higher-cost OPD settings.

In a previous presentation, we had this slide, or a similar one, anyway, that shows that volume of E&M office visits, echocardiograms, and nuclear cardiology services that are provided in free-standing offices all decreased in 2011 and 2012, while the volume increased in OPDs for the same services.

For example, the volume of echocardiograms in free-standing offices decreased by 7 percent in 2011 and 9 percent in 2012 while the volume of echocardiograms in OPDs

increased by 18 percent in 2011 and 13 percent in 2012.

This shift from offices to OPDs follows the financial incentives that we have discussed in prior meetings where Medicare pays substantially higher rates for services provided in OPDs rather than physician offices.

We estimate that Medicare and beneficiaries are paying over $2 billion more for E&M visits and other services than they would pay if the OPD rates were more closely aligned with lower physician office rates. If the shift in site of services continues, the cost to Medicare and beneficiaries will increase further.

In our March 2012 report, the Commission recommended equal payments for E&M office visits whether they are provided in free-standing offices or OPDs. Also, the Commission has had several discussions about eliminating or narrowing the differences in payment rates between freestanding offices and OPDs for other services, and we have a chapter in the June 2013 report reflecting those discussions.

We want to emphasize, though, that it's not appropriate to pay equally across these two settings for all services, but we have identified five criteria that services

should meet in order for payments to be equal in offices and OPDs.

And we have discussed these criteria in detail in previous meetings and the June 2013 report, so I won't cover them in detail here. But key points are that at least half the volume should occur in free-standing offices to assure that the service is safe to provide in offices. Also, the service should have at least a minimal level of packaging of ancillary items under the outpatient PPS because that payment system often packages ancillary items more than -- let me try again -- more ancillary items with primary services than does the physician fee schedule. And this additional packaging makes services appear more costly in OPDs.

We have identified 24 APCs in the outpatient PPS that meet the five criteria from the previous slide and are, therefore, viable candidates for equal payments across settings, and we call this Group 1.

We have also identified 42 APCs that meet four of the criteria, but they have greater packaging under the outpatient PPS than the physician fee schedule. For these 42 APCs, the payment rate differences between offices and

OPDs could be narrowed, but the rates should remain higher in OPDs than free-standing offices by the cost of the additional packaging in OPDs.

Making these payment adjustments for these 66 APCs in Groups 1 and 2 would reduce Medicare program spending and beneficiary cost sharing by $1.1 billion per year. This translates to lower overall Medicare revenue for hospitals of 0.6 percent.

Most hospital categories would be affected by about the same amount as the overall average of 0.6 percent, except that rural hospitals and hospitals that have 100 or fewer beds would be affected more.

A concern that many have expressed about these lower OPD rates is that access to ambulatory services for low-income patients may be adversely affected. In response, we have developed an illustrative example of how losses to hospitals that serve low-income patients could be mitigated.

But the effects of this stop-loss are quite small in this case because many of the hospitals that are most affected by this policy either don't serve low-income patients or are specialty hospitals.

Now Dana will talk about payment reform in long-

term care hospitals.

MS. KELLEY: As you know, we have been working for some time on ways to improve Medicare's payments to LTCHs. Our goal has been to improve the accuracy of Medicare's payments by better aligning them with the costs of patient care and thereby reduce incentives to admit patients who aren't appropriate candidates for LTCH services.

Last month, Commissioners expressed a preference for a payment reform proposal that would maintain a separate LTCH payment system. Under a reformed LTCH PPS, higher LTCH level payments would be made only for LTCH cases that were chronically critically ill, or CCI, and those patients would be defined as those who had had eight or more ICU days during an immediately preceding IPPS stay. All other LTCH cases, the non-CCI cases, would be paid IPPS comparable rates.

All LTCH cases, whether CCI or non-CCI, would be eligible for LTCH outlier payments. The outlier pool in the LTCH payment system would remain set at 8 percent of total LTCH payments.

Under this proposal, LTCHs would be required to maintain an average length of stay of more than 25 days only

for their CCI cases. Savings from this proposal would be transferred to the IPPS outlier pool an used to boost outlier payments for chronically critically ill cases in the IPPS.

Under this plan, 36 percent of current LTCH cases would meet our definition of CCI and continue to receive higher LTCH payment rates. Aggregate payments for these cases would remain unchanged. Payments for the remaining cases in LTCHs would be paid at IPPS comparable rates. Both CCI and non-CCI cases would be eligible for outlier payments, as I said.

The impact on any given LTCH would depend on the facility's mix of cases. Total Medicare payments would fall more for LTCHs with a high share of non-CCI cases. Bigger impacts will be seen in for-profit LTCHs and in markets that have a high ratio of LTCH beds to beneficiaries.

We would expect to see behavioral changes under this scenario. LTCHs would admit fewer non-CCI cases or would alter their patterns of care so as to reduce their cost for non-CCI cases. LTCH lengths of stay and cost per case likely would fall for non-CCI cases. LTCHs could continue to admit patients who had had longer ICU stays.

We're still in the process of finalizing our modeling of this proposal and will have detailed impacts at our next meeting.

Under this proposal there would be no reduction in payments for IPPS hospitals. Savings from the LTCH reform would be used to increase outlier payments for eligible IPPS cases that had had long ICU stays. Most IPPS hospitals would see some benefit, but gains would be greatest for IPPS hospitals that have a high share of CCI cases. These include hospitals in large urban areas, major teaching hospitals, larger hospitals in urban areas, and hospitals in areas with a more moderate LTCH supply.

Now Jeff will wrap things up for us.

DR. STENSLAND: All right. So Dan and Dana just outlined some ways to improve the incentives in the system. The most important effect of these proposals is to remove the incentive to provide care in higher-cost settings even when there's no evidence that it produces better outcomes. However, the secondary effect of these proposals is that they will affect acute-care hospital payments.

First, the 66 APC policy that Dan discussed would reduce payments to acute-care hospitals by roughly $1.1

billion per year.

Second, the new outlier payments associated with the LTCH reform that Dana discussed would increase acute-care hospital payments by about $2 billion per year.

I also want to remind you that the Commission passed a recommendation two years ago to equalize E&M payments in OPDs and physician offices. If Congress adopted this, it would reduce payments by another $1 billion. So those are the policy changes we're talking about.

Now, the other factor that would affect payments is the update recommendation, and this slide shows the status of current law.

Under current law, both the inpatient and outpatient updates are set to equal the projected increase in hospital input costs as measured by the hospital market basket minus two adjustments. One is the adjustment for multifactor productivity over ten years, and the other is an adjustment for a budgetary adjustment of 0.2 percent.

The bottom line is that, given current projections of inflation and productivity, the update under current law would be about 2.2 percent in 2015, and that's the year that we'll be discussing the update recommendation for.

Now I will turn to the Chairman's draft recommendation. The recommendation states as follows:

The Congress should direct the Secretary of HHS to:

Reduce or eliminate differences in payment rates between outpatient departments and physician offices for selected APCs.

Set LTCH payment rates for non-CCI cases equal to acute care hospital rates, and redistribute the savings to create additional inpatient outlier payments for CCI cases in IPPS hospitals.

Increase payment rates for the acute-care hospital inpatient and outpatient prospective payment systems in 2015 by 3.2 percent concurrent with implementing the above changes to the acute-care hospital and LTCH payment systems.

This slide just provides a side-by-side comparison of how current law compares to the Chairman's draft recommendation I just read. As you can see in the first column, 2015 policy changes in current law are expected to push rates down by 3.5 percent, and the update is expected to increase rates by 2.2 percent under current law. The net result is a 1.3 percent decline in payments from 2014 to

2015 under current law. And as I stated earlier, this is expected to bring the margins of even relatively efficient providers to a negative level in 2015 if current law holds.

In the second column you'll see the additional effects of the Chairman's draft recommendations. The first effect is the site-neutral recommendation with respect -- the first is the site-neutral recommendation with respect to LTCH reform, and that would increase hospital payments. The other reduction would be the site-neutral recommendation for APCs, the 66 APCs, and that would end up reducing payments. This means the Chairman's recommendation on net would increase payments to acute-care hospitals by about 1.6 percent above current law, and that 1.6 percent is the difference between the negative 1.3 percent in current law and the positive 0.3 percent we have in the Chairman's draft recommendation.

The last row shows the E&M site-neutral recommendation the Commission made two years ago. We present this because Congress may choose to adopt the E&M site-neutral recommendation along with the 66 APC site-neutral policy we are discussing today. We wanted you to see both impacts in the same table.

But the bottom line is the Chairman's draft recommendation, with or without the E&M recommendation, would result in payments being relatively flat, either a plus 3 percent without the old E&M recommendation or minus 3 with the old E&M recommendation.

Now I'll go to the recommendation rationale. The rationale is that there is a need to reduce incentives to shift care to higher-cost sites of care. The Chairman's draft recommendation would accomplish three specific goals along these lines:

First, it would align outpatient rates for 66 APCs with physician office rates. This would slow unnecessary shifts of cases to hospital outpatient department billing.

Second, it would equalize LTCH and acute-care hospital rates for non-CCI cases. This would eliminate the problem of LTCHs keeping low-severity patients for longer than truly needed in order to increase their payments.

Third, it would increase acute-care hospital CCI payments to bring them up closer to LTCH payments. This would bring greater equity between markets with and without LTCHs.

In addition, the Chairman's recommendation is

designed to provide adequate payments. After considering beneficiaries' strong access to care, the potential for declining margins given changes in current law, and the chairman's two draft policy changes, an update above current law is warranted.

And now for the implications. In 2015, this recommendation would increase Medicare spending on IPPS hospitals by roughly $2.5 billion over current law. It would decrease spending on LTCHs by roughly $2 billion relative to current law. The net Medicare spending effect would be an increase of roughly $0.5 billion over current law.

The impact for beneficiaries and providers is that it may slow or stop the shift of services from free-standing practices to OPDs. It would also end up reducing beneficiary OPD cost sharing because they face higher cost sharing when they go to the OPD. It will reduce payments to LTCHs, and it could assist IPPS hospitals providing care to the most difficult CCI cases.

Now we open it for questions.

MR. HACKBARTH: A clarifying question, I think for you, Jeff. The productivity adjustment in current law here

is estimated at 0.3 percent. What has been the productivity adjustment in the last several years? What's the trend on that?

DR. STENSLAND: It's generally been higher than that --

MR. HACKBARTH: Mm-hmm.

DR. STENSLAND: -- and it all depends on what's happened in the prior ten years. So, it's taken a dip now that some of the high-productivity boom years in the 1990s have gone away --

MR. HACKBARTH: Uh-huh.

DR. STENSLAND: -- and we have some of the really low-productivity years, like the 2008, 2009.

MR. HACKBARTH: Uh-huh.

DR. STENSLAND: So that's why we have this low adjustment of 0.3. Eventually, around 2018 or so, once those negative years of 2008 go away, it'll start going up again.

MR. HACKBARTH: Yeah. So, it is a ten-year average.

DR. STENSLAND: Correct.

MR. HACKBARTH: And what was it last year, do you

remember?

DR. STENSLAND: I think it was 0.4 or 0.5.

MR. HACKBARTH: Okay. And then the year before that, it was a little bit higher because we still had the high-productivity years, and so it's sort of been trending down the last few, is that right?

DR. STENSLAND: Yes.

MR. HACKBARTH: Okay. Other clarifying questions. Craig and Peter, Dave, Bill, George. Craig.

DR. SAMITT: So, on Slide 25, please, the distinction between the minus-1.3 percent and favorable 0.3 percent growth and the Chairman's recommendation, that does not take into account the reduction in payment to LTCHs on this slide, correct, or is that folded into and summed up in one of these other lines --

DR. STENSLAND: No. This slide just refers to the payments going to IPPS hospitals, and we left it this way because the update recommendation you're going to be talking about is just the IPPS hospital update recommendation now. We'll talk about LTCH after lunch.

DR. SAMITT: Great. Thank you.

MR. HACKBARTH: I'm sorry. Let me get Mary,

Peter, before --

DR. NAYLOR: I just wanted to clarify in terms of the differences in the margins that you reported. The effort -- as I understood it, earlier MedPAC's work showed that most of those differences are due to uncompensated care, the differences in payment, is that correct, what you're expecting in terms of what is happening in reductions in current law?

DR. STENSLAND: Right. So, that was in November, we talked about that first line.

DR. NAYLOR: Yes.

DR. STENSLAND: So, what's happening there is they've changed the DSH policy and the uncompensated care policy and so they basically took the money from DSH, stuck it in uncompensated care. And then every year that we have a reduction in the number of uninsured, that pool of uncompensated care dollars shrinks. So, basically, that two percent is saying, given the projected decline in the number of uninsured individuals due to either gaining insurance through the exchanges or expansion of Medicaid, we'll see those uncompensated care dollars shrink and that means less Medicare dollars going to the hospital.

DR. NAYLOR: So, help me to understand the earlier work of the Commission that said that about 25 percent of those dollars, uncompensated care, could be empirically justified.

DR. STENSLAND: Okay. So, before, the Commission had -- to start at the beginning of this, there was the DSH policy said, well, we think poor people just cost more to treat than wealthier people. Maybe they don't have the resources at home, so you have to keep them longer because they can't go home to somebody or they can't afford private nursing or whatever. So, poor people might be more difficult. And then we did some regression analysis to say, well, how much more expensive are they actually, and we came up to the conclusion that, at most, 25 percent of the current additional payments were justified due to the higher cost of treating poor folks.

So, the way the law said is, okay, we're going to keep the 25 percent of the old DSH payments as continuing to be traditional DSH payments directed toward hospitals that have more poor individuals under the assumption that their Medicare costs will be higher. And the other 75 percent will be directed purely to cover their uncompensated care

costs, their charity care costs or their cost with bad debts. So they took our 25 percent number and used it to take that pool of dollars and split it into two groups, and the rationale, then, is the hospitals will have that money at first to care for uncompensated care, but as people become insured, they're going to have less need for those uncompensated care dollars and that pool will shrink.

DR. NAYLOR: Thank you. I was trying to interpret how we should interpret what the contribution of DSH to the margin differences this year, and so thank you.

MR. BUTLER: So, keep in mind the 0.13 percent decrease here and then flip to Slide 12. I just want to be clear. Where there's a two percent margin now for relatively efficient hospitals, you made the statement, in fiscal year 2015, even the efficient hospitals would be losing money, and so I'm taking the two percent and subtracting 1.3 percent and still having a positive number. So, how should I --

DR. STENSLAND: They would have a positive number if they kept their cost growth to zero, but we think they probably can't keep their cost growth to zero in 2015 because we're saying their actual payments are going down to

1.3 percent --

MR. BUTLER: I got you. The Slide 25 is strictly the payment reduction. It doesn't take into account costs. Got it.

MR. HACKBARTH: Clarifying questions? Dave. No?

DR. NERENZ: Already answered.

MR. HACKBARTH: Already got it. Bill.

MR. GRADISON: Thank you. I have a question with regard to -- on page 22 of the briefing materials that were sent out ahead of time. This has to do with budgetary impact of our proposals for refining the hospital readmission reduction program. On page 22, there's a text box which includes a summary of some of the benefits and good things about this policy, a policy which I support, and then includes, and it says, "and will not increase Medicare spending relative to current law." I'd like for you to explain that to me, because my understanding is that under our proposal -- in fact, bullet one is there would be a fixed target so that there would be no penalty if you were below that rate. So if everybody, let's say, were below that rate, there would be no penalties imposed, whereas under current law, there is always going to be half the

hospitals or some proportion that are above the mean or the median, however it's actually defined in law. And so I'm not sure that -- I don't understand why Medicare spending would not be reduced by our proposal.

DR. STENSLAND: It wouldn't be reduced -- it would be reduced -- it wouldn't increase relative to current law given current rates of readmissions, and the basic idea is that under our proposal, we are saying we can generate our savings one of two ways, either through the penalty or through reduced readmissions. If readmissions go down, then we're saying, okay, we got our savings that way and we don't need to have the penalty.

MR. GRADISON: Thank you.

MR. LISK: I mean, in part, we think the incentive for having a target may be stronger for reducing readmissions on all hospitals versus the current policy, where you may not have as strong an incentive to reduce the readmissions, particularly hospitals that don't perform as well, and may give up because of how the current policy is structured, too.

MR. GRADISON: Thank you.

MR. HACKBARTH: George, and then Jon.

MR. GEORGE MILLER: Yes. Thank you. On Slide 16, I think I understand how this process works as you described it, but help me understand how you determine why the office rates, if we don't get cost data from the physician, is preferable over any other rate. How did we decide that's the right cost?

DR. ZABINSKI: Well --

MR. GEORGE MILLER: I mean, the assumption is you'll save two-point billion dollars if you align with the office rates. I understand that. But if you don't get cost data, how do you know that's the --

DR. ZABINSKI: Primarily because we know that access to the office visits is adequate. So, hence, in physician offices, and therefore, the payment rates are adequate.

MR. GEORGE MILLER: So access equates to cost?

DR. ZABINSKI: Well, access relates to adequate payment.

MR. HACKBARTH: So, George, it's sort of looking at it from a market perspective. If you've got people willing to provide the service at that payment level and access to the care is adequate, that means the rate is

adequate. People are voluntarily providing service at that level. And that's the way most markets work. People, when they negotiate about appropriate prices, they don't say, well, give me your cost reports. I want to analyze what your costs are. They say --

MR. GEORGE MILLER: So we don't need the cost --

MR. HACKBARTH: -- here's what I'm willing to offer, and the other party says, I'm willing to take that, and you move ahead.

MR. GEORGE MILLER: Got it. So we don't need to do cost reports anymore. Again, like I said --

MR. HACKBARTH: Well, as we discussed last time --

MR. GEORGE MILLER: [Off microphone.]

MR. HACKBARTH: The hospitals, I think, should be careful what they wish for, because if, in fact -- and we'll talk about this in round three --

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: -- the alternative approach to this is to say, well, we'll use access as the only measure of whether payments are adequate, and my guess is that that produces much lower rates for hospitals than current law. So, this is a big question, and, as I said, I want to talk

about it on round three, but let's not get into it in great detail now.

MR. GEORGE MILLER: All right.

MR. HACKBARTH: Jon. Or do you have another one?

MR. GEORGE MILLER: Yeah. One more quick. On page 17, the next one. The last time, a year ago when we did this, you gave an illustration of the APC. So, could I see the APCs? You remember I used a highly technical term when we did the analysis is that this is nuts, when we did analysis of the last one, could I see these 24 APCs so I could kind of just check up on you, if you don't mind?

DR. ZABINSKI: [Off microphone.] We don't have them.

MR. GEORGE MILLER: You don't have them, okay.

DR. MARK MILLER: They're in the June chapter, right?

MR. GEORGE MILLER: Yes.

DR. MARK MILLER: So, we'll just e-mail you --

MR. GEORGE MILLER: Oh, you have them there? Okay. So I'll see them.

DR. MARK MILLER: Yeah. They aren't published, but we can --

MR. GEORGE MILLER: Never mind.

DR. MARK MILLER: -- we'll shoot it to you.

MR. GEORGE MILLER: Never mind. If they're there, no problem.

DR. MARK MILLER: We just didn't repeat it in this paper, in this --

MR. GEORGE MILLER: All right. Thank you.

DR. CHRISTIANSON: So, it seems from the discussion that a lot of the concern going forward is sort of based on the projection that what we define as efficient hospitals -- even -- even efficient hospitals could have negative margins going forward. So, I think the definition that you put together of an efficient hospital, I mean, the different criteria are kind of -- you know, they're reasonable, but arbitrary, obviously. And I was wondering if the staff has done any sensitivity analysis on this question. If you tweak any of these different measures and come up with a different set of efficient -- another arbitrarily defined set of efficient hospitals, whether you get a different finding in terms of even efficient hospitals having negative margins going forward.

DR. STENSLAND: If you look at subsets of it,

whether you just focus just on readmissions or just on mortality, you would get basically the same thing, and I don't know what else we would use in terms of our -- what other kind of quality metrics we would use that we would have that much faith in.

DR. CHRISTIANSON: What about cost? What about --

DR. STENSLAND: You mean --

DR. CHRISTIANSON: The efficiency is a combination of cost and quality, as you point out.

DR. STENSLAND: In terms of cost, we're using cost in terms of standardized cost per case on the inpatient side. We've also looked at it on the outpatient side, and the costs are similar. Like, the efficient providers basically have six percent or so lower cost. I think that was the difference. But the relative difference between inpatient and outpatient is similar. So, whether we looked at cost using either of those metrics, it would come up with a similar result. And I think any efficiency equation, you're going to need the cost in there one way or another.

MR. HACKBARTH: So, before we turn to round two, let me just say a few additional thoughts about the package. Could you put up the Chairman's draft recommendation.

So, we have three parts here which I view as a package and I'm offering them as a package. I had two goals in mind in formulating this package. The first goal was to improve the projected margins for acute care hospitals, and I was focused on the fact that our projection is that the margin for efficient hospitals would go from being positive to negative, and I invite discussion on that point, and we'll have some focused discussion of it in round three. So, one objective was to improve margins for acute care hospitals.

The second was to address some of the issues that we've identified in different levels of payment for similar services provided by different providers and different payment systems for those providers. So it's trying to achieve both those goals at the same time. And, frankly, I was also mindful of the aggregate budgetary impact of what I was proposing, so I was trying to achieve the two goals within some sense of not wanting to blow the budget.

Among the -- I welcome your reaction to the overall package. Among the issues that I think deserve some discussion is the magnitude of the update above current law, here presented in the draft as a one percent above current

law, whether there should be some transition on the LTCH and hospital outpatient department changes. So those are two issues, in particular, that I welcome.

Obviously, there are some tradeoffs. To the extent that, for example, the LTCH change is stretched out, that means that fewer dollars will flow into the hospital, the acute care hospital outlier pool and thus limit the improvement in the projected margins for acute care hospitals. So, these things are interconnected in a variety of ways.

So, with that intro, Peter, do you want to go first.

MR. BUTLER: So, the chapter itself was really good this year. It always is. It was really well written and it's got some new elements like looking at the for-profit outpatient margins. I found some of that very interesting.

I think if we're going to advance the APC issue, I think neither in the presentation today or in the text does it kind of reiterate what those codes are and so forth. We reported them last June, but it kind of is a pretty high-level superficial review and I think it's important to

include that.

I was working on the elevator speech, but you already kind of gave it, Glenn, in that you're trying to triangulate between, I believe, what you need to pay an efficient hospital, fixing the most urgent pricing issues that impact either costs or patients directly and staying within kind of the Congressional expectations of our work. So that's what was driving my thinking, and that's just another way to say it.

So, if you turn to, then, the recommendations here, I do like very much how you've framed it here. Now we've got to get a little bit more specific, I realize, with transitions and exactly how we're going to do this, but I do feel very comfortable that we've got the right three categories to work on.

Now, with respect to the APCs, I like them as a focus more than the E&M codes, and I'll come back to the fact that we've already recommended E&M codes, and I like, within APCs -- I've said this before -- the cardiology testing in particular, which is about half the total, and perhaps an area that gets maybe, as Rita would say, maybe has less value than maybe even some of the other testing.

And so I like it, too, in the sense that if you think about the arguments for the E&M code reductions, you constantly hear it's a different environment, it's a different set of patients, it's a different infrastructure that you need for that physician interaction in an office. You can't quite make the same argument about tests. The tests are a test.

You're not providing a different kind of -- so I like, actually, this as an area of focus more than the E&M codes, and I don't think, in terms of transitions, it requires the same level of focus, for example, that the LTCH does, where we're actually going to see probably patients end up in totally different facilities because of the payment differences. It has much greater impact, potentially, on where actually the patients will be treated than something like the APC codes, which is really not going to affect the patients themselves, probably, as much. So I see less of a need for a transition on the APC issue than I do on the LTCH issue.

Now, having said all of this, I'm a little queasy about the fact we kind of reference E&M at the bottom, and oh, by the way, you can get another billion if you take this. So, we're a little unclear because the recommendation

here is clearly the APCs, LTCH, and a healthy update. You know, I might change my mind if you said -- and added a fourth bullet -- we'll take the E&M codes now, too, because then that sets in the aggregate things backward more. So I like very much as it's stated and very much the idea that this is a linked package of things that we're trying to do.

DR. SAMITT: So, what I like about the Chairman's recommendation is that it very much aligns payment rates in the way we've talked about wanting to do so before. In my view, it assures appropriate and equal payment for hospitals and LTCHs for services that they are uniquely capable of delivering, and in this particular case the higher complex CCI patients, and it assures appropriate and equal payment levels to physicians for services that they may be uniquely capable of providing, in this particular case several of the APC codes that we've talked about. So, we've talked about the imperative of aligning the right payment rights to the right level of care and I think this does that.

The only modifications that I would make do pertain to the transition. As we look at the degree to which a $2 billion impact on LTCHs will affect that industry, it's quite significant, so I think it needs to be

transitioned.

I think, to Peter's point, I'm not sure how we could transition one without the other. They seem to go hand-in-hand. Since one is an increase in payments and one is a decrease, I would imagine that you'd want to transition both.

And the only other thing that I would question is the one percent update, whether that is potentially too rich given the excess capacity that we see in the sector, and yes, I think we're concerned about efficient hospitals, but do we really require as large an increase as one percent, given that this will have a cost impact on total spend.

MR. KUHN: So, I, too, think it's an interesting proposal you put forward, and I think there's a lot of opportunity for the Commission to move forward when we vote in January.

But on the three specific areas, first of all, on the higher update, I am troubled by the fact that -- and I know there's many variables that we're looking at here -- but I am troubled by the fact that we are going to see the efficient hospitals look at negative margins in 2015 and I have a difficult time thinking that you wouldn't at least

provide a payment that permits them to cover their costs as part of the process. I just think that, at least for this class of hospitals, in terms of setting the standard out there. Now, I know we have issues of access and quality and other things and need to look at it as a package, but when I look at this margin for this type of hospitals that we have been kind of rallying around thinking these are the efficient folks, thinking that they are incapable of covering their costs is a concern to me. So, the higher update you're putting forward makes sense.

When it comes to the issues of the APCs and LTCHs, I think we need to think about transitions for both, and I'll talk about the transition specifically. But the overall transition that I'm interested in is the fact that beginning next year, CMS will move forward on a proposal that will implement the Decennial Census for the wage index for hospitals for CBSAs. And so when they do that, that will transition, then, ultimately to all the other payment silos that we have out there. And historically, when CMS has done the Decennial Census, they've done a three-year transition. We could assume they're going to do the same, but they may do something different. We don't know.

But either way, there's going to be a lot of volatility in the marketplace as a result of the change of that wage index and we will see movements in States and movements around the country as part of that. So, the fact that we don't know what that will be and then we overlay some of this thing on it, I think that, at a minimum, we need to think about transitions.

So, in that regard, on the APCs, I'm like Peter. I was one of the few Commissioners that did vote against the E&M because I was concerned about the impact that it was going to have, and particularly dealing with the rehospitalization issue and the fact that hospitals were using their ambulatory sites much differently and didn't want to kind of add this uncertainty until that kind of settled as part of the process.

But on this, these issues, in terms of the codes for the imaging activity out there, I'm kind of where Peter is. I feel a little bit differently about those. But I do want to think about a transition here because of the disproportionate impact on rurals and smaller hospitals. And then when we think about the Decennial Census and the wage index, and the wage index tends to be more impactful on

rural areas, again, the uncertainty, and I think we need to think about a transition there.

On the issue of LTCHs, that one, too, I think we need to think about some kind of transition there. I understand the eight days, but if you're a vent patient and the fact that you have to sit for eight days in one setting before you're eligible to go to another setting, I just want to think about -- I don't have an answer today, but that kind of concerns me a little bit about those arbitrary natures of a specific day, if there's other criteria that could be put in there. Also, I know where LTCHs are very active in the area of wound care, sepsis, things like that. Do all those folks need to sit eight days in an acute care hospital, in an ICU, as part of that process?

The other thing that I think a transition is important here is that a lot of these acute care hospitals might not have as robust of an ICU unit that they need, and so a transition gives them time to build out that capacity and be prepared for these kind of new incentives that are coming.

And then finally on the LTCH, I would be interested in what we might want to look at in the policy

realm of the 25 percent threshold for the hospital within a hospital. Does that continue to make sense in this environment in the future or not.

MR. HACKBARTH: Let me just go back to your first point, Herb, about the efficient hospital projected margin and what it would be in the wake of this package, if the draft were enacted as is without any of the transitions. Mark.

DR. MARK MILLER: Yeah. And, Jeff, we were talking about this yesterday and I'm just trying to recover the conversation. So, we ended up with our final estimate on the LTCH transfer as being about $2 billion and we were hovering --

DR. STENSLAND: Right.

DR. MARK MILLER: -- on that number for a while, and I was under the impression that when that gets into the mix, the efficient provider comes back to zero, is that --

DR. STENSLAND: Yeah. There's no precise estimate, but in the neighborhood of zero, give or take --

MR. HACKBARTH: And with the caveat that that's as written here, without any transitions or anything, this package would get the efficient hospital back to around

zero.

MR. KUHN: Thank you. That's helpful to know.

MR. HACKBARTH: Okay.

MS. UCCELLO: So, in terms of the APC alignment and the LTCH recommendation, I kind of already was very supportive of this direction as stand alone kind of policy. So, putting them in this package, I'm very comfortable with and I think it makes a lot of sense.

In terms of transitioning, I'm not sure I have much to offer on that except I would prefer implementing this stuff sooner rather than later. So, the shorter any transition can be, I think is better.

In terms of the 3.2 percent update, it seems reasonable. It seems to me what I'll call a Goldilocks test, because it's not too high, it's not too low --

[Laughter.]

MS. UCCELLO: -- so, it seems reasonable. But as a whole package, I very much support that.

DR. NAYLOR: So, in terms of the first recommendation, I also supported as a stand alone and would support movement as quickly as possible to reduce or eliminate differences in payment rates.

On the issue of adjusting -- so, I'll use that term instead of setting -- adjusting payments for non-CCI cases, I think that that, in terms of the LTCH policy, I would support that.

Here's where I am concerned. I am not sure where it is that we should be thinking about the best site of care for non-CCI patients. I'm concerned that the inpatient environment, where there is a pretty substantial body of evidence about the impact of hospitalizations on Medicare beneficiaries which are not positive, may respond by setting up and lengthening the ICU stays unnecessarily for a population that could be better served not just in inpatient or LTCHs, but maybe in the community.

So, if I were to think about this, I would think about what are the possible ways in which savings could be redistributed -- and I know this is about hospital update, and I'll come to that -- but to think about getting us to payment redistribution to really assure the best quality outcomes for patients.

I have to say, exquisite chapter. The discussion about hospitals and the decline in inpatient rates, the growing excess capacity, the analysis of the poor

performance in the 112 hospitals that we know that were included in that analysis and the impact on the beneficiaries, honestly, it raises questions for me about the update overall. So, I have to say that, although I totally do understand how we wouldn't want margins for efficient places -- I'm just being honest -- to be negative.

The one issue that I raised is the extent to which the contribution to those margins, as we currently know it, is uncompensated care and how we've adjusted the policy in response to earlier recommendations. So, I'm trying to take all of that into consideration.

So, I would support a policy that gets efficient hospitals to zero, but I'm not sure that we do this in a way that increases some incentives for increasing the acute care environment for a population that may be better served elsewhere. So, I'm torn.

MR. HACKBARTH: So let me just pick up on that really important point, Mary. I meant to mention this earlier but forgot. Of course, one of the interesting characteristics of LTCHs is that they're not uniformly distributed across the country. There are large portions of the country where there are no LTCHs at all, and they have

similar patients as to the markets that do have LTCHs, and they arrange to care for them differently through a combination of both acute-care hospital stays and other non-LTCH PAC services. And so there is some experience in dealing with complex patients without LTCHs.

We have recommended now several years, if not many years running, an adjustment in the SNF payment system where one of our concerns is that the current payment system overpays for therapy services and systematically underpays for the medically complex patients, which is what many of these patients are. And as a result of that flaw in the SNF payment system, we've been concerned that there is some impaired access for medically complex patients because the SNFs would rather have the high-therapy, high-profit patients instead.

So I also think of that as part of this package, and it, in fact, is part of the SNF recommendation that we will be reiterating, but it needs to be sort of called out here as well. We do need to assure that alternatives to acute-care hospitals are paid accurately, fairly, for handling these medically complex patients so they don't just stay in the ICU and they can move into other settings. So

thanks for raising that.

MR. ARMSTRONG: So fairly briefly, rather than reiterate some points already made, I do like this package of recommendations. I support the direction that we are heading in.

Glenn, I like the way that you described the goals for this and support those, in particular the fact that this is an opportunity for us to extend a position on policy, same payment for same services despite the different settings, in a way that's, you know, really very consistent with the policy direction we've set and studied extensively in the past.

A point about is 3.2 percent or the 1 percent increase or however you look at it the right amount I think is a judgment call, and I'm prepared to support this. I do think it is a balance between dealing with the fact that we have tremendous overcapacity in acute-care hospital beds in our country, and yet I don't think we should be setting payment policy that presumes costs aren't covered by our payment rates. And so I think what you've done is strike a balance that seems appropriate for us.

I do believe this puts into perspective the very

high margins that we will see in some other payment categories, and we should keep that in mind as we go through the course of the afternoon and tomorrow's agenda.

With respect to transitions, I would just take a position consistent with positions I've taken on many topics, and that is, I think we're generally too slow to move forward with these things, and I'm confident that care providers and care systems can deal with the implications of transitioning to these new payment structures and would encourage us to move quickly.

My final point would be we go through the December and January agendas and consistently express frustration by the fact that, you know, we're trying to deal with an overall system and yet our decisions are constrained to these different silos. Well, Glenn, it seems to me you found a way to bust through those silos through this package of recommendations, and I think we should keep that in mind and look for more and more opportunities to do the same thing.

DR. HOADLEY: So I have three comments. First is probably really more of a clarifying but it came up on Bill's comment in that round. The readmission refinements

that we had talked about last year, did that ever make it as a recommendation, or was that just statements to the effect of a sort of preference?

MR. HACKBARTH: We made it as a recommendation.

DR. HOADLEY: It did make it as a recommendation.

DR. MARK MILLER: It didn't go to a vote.

MR. HACKBARTH: Oh, it didn't?

DR. MARK MILLER: Right. What we did is we laid out in the chapter what we thought should happen with the refinement. Now, we made a recommendation on a readmission penalty. That is true and --

DR. HOADLEY: Earlier.

DR. MARK MILLER: -- you could be saying that. Then we said, you know, it's on the right track, but here are some refinements. It was stated very much as, "You should do this," but we didn't say, "Here is a bold-faced recommendation."

MR. HACKBARTH: Sorry, Jack. Remind me, Mark, would that require a statutory change, or is that something that CMS can do?

DR. MARK MILLER: Decidedly statutory.

MR. HACKBARTH: Okay.

DR. HOADLEY: So I don't know if that's something that's worth saying more about or where we stand, but I don't want to distract the discussion on to that right now.

In terms of the recommendation, I very much agree with a lot of the comments that have already been made. I think this is a really very balanced approach, and I like it in all the ways that others have said, that it puts together some good policy goals with also some attention to trying to get the numbers right in terms of the updates. And I won't add any more on that.

In terms of the transition part of it, I don't think I'm the expert on thinking about the right transition, but I agree with I guess both Scott and Cori, sort of doing this more quickly than more slowly is probably a good thing. So I would tilt towards shorter transitions.

Then, finally, I want to sort of mention, because it hasn't really come up very much, sort of the beneficiary perspective on this. And you did have numbers on the APC changes on sort of the aggregate savings for beneficiaries, but I want to highlight that there is a savings because of lower cost sharing in those things. And I think that's important to make sure we don't lose that in the discussion.

And it may be worth just sort of highlighting somewhere in the text that even what the sort of savings on any given imaging procedure might look like, so sort of an average per case kind of number, just to make it come to life a little more for people.

And then I think I'm reading correctly that there would be no financial beneficiary impact on the LTCH changes. Is that correct? Okay. So there, you know, whatever we talk about beneficiaries is just the broader issues about treating people in more appropriate settings and so forth.

DR. CHRISTIANSON: With respect to the first bullet, I understand and support, I think, the previous emphasis of the Commission on trying to eliminate payment differentials by site of care, and so that seems to make sense.

The comment on Slide 27 about how it may slow the shift of services from free-standing to hospital-based, yeah, it probably will, but it may not as much as you think since Medicare has a policy called ACOs that encourages that shift. So I'm not sure how much this will affect that in the long run.

Could we go back to the recommendation slide? With respect to LTCHs, again, being new on the Commission, I'm still trying to get up to speed on LTCHs. They certainly seem to be a complicated segment of the health care industry. But having an eight-day criteria or five-day or three-day, any criteria like that, seems to me to be subject to great potential for gaming, and I would wonder if we can't continue to work on something else that we could recommend than basing half of the patients on eight days in an ICU and some other treatment setting. It just seems problematic to me.

And on the final bullet point, the increased payment rates for acute-care hospitals and so forth, what strikes me in this whole discussion is the emphasis that we're placing on efficient hospitals and what precedent that will set for the Commission. I mean, if we're now going to very closely track efficient hospitals over time and if we see efficient hospitals, whatever we -- and I don't fully understand the definition. I appreciate Jeff's comments, but how stable that is, and we've got a group of hospitals that we as a Commission have decided are efficient. So is the process going forward that we always look year to year

and if in a particular year projection all are going to fall below into a negative, then we must do something, or we should do something? Maybe we should be looking at two years of projections. Maybe we should be looking at something like under the ACO reimbursement where the negative amount has to be below a certain number before we get excited about it.

It just seems like it's all important business, but really has a potential to set a precedent for how the Commission will respond in the future in terms of being concerned about making updates across the board based on this small set of hospitals that we've identified. So I would think we need to continue to talk about that and what we want this particular sub-group of hospitals to play in terms of informing our decisions going forward.

MR. HACKBARTH: So this last point that you raised, Jon, in fact, I want to come back to it even today in our Round 3. I also want to just quickly go back to the gaming issue that you raised, which I think is potentially a very important one, and ask Mark and Dana and Jeff about their thoughts on the potential for gaming. You're talking about using the eight days in the ICU.

DR. MARK MILLER: And I'm willing to -- I'm definitely willing to do that, but what was the gaming or selection problem that you had in mind when you said it?

DR. CHRISTIANSON: Well, again, we have a policy that's a Medicare policy and program that's encouraging vertical integration of health care facilities over time. And when you have the same -- and I understand that the bulk of LTCHs now are free-standing, for-profit chains. In terms of getting people -- keeping people in the ICU for a certain period of time so that when you discharge them into an LTCH, you get a different and better reimbursement rate than you would otherwise. Is that accurate in terms of -- like I said, I'm trying to understand LTCHs. So is that a potential behavioral response to an eight-day or a five-day or whatever requirement in terms of being in an ICU?

DR. MARK MILLER: Right, and I think at least a couple things, just to make sure -- and I think you've got this in your head, but to make sure everybody else in the audience and all that has it in their head. So the gateway into -- there would still be two different systems, inpatient PPS and LTCH. The gateway into the LTCH at the higher rate is only through eight days in an acute-care

hospital. And so one thing -- or, I'm sorry, acute-care ICU. I apologize. And so one thing we thought that we were doing with this policy, and others have been thinking about this, RTI-CMS people like that, is the doorway into the LTCH isn't controlled by the LTCH per se. The hospital also running eight days in the ICU, they also run the risk of getting into an outlier status, and that means that they also have to really think hard whether they want to extend that stay out because they may have to run a loss to do it. And so we felt that that had some mitigating effect on how fast people jump into that eight-day.

And then the last thing I'll say -- and I would really encourage you guys to respond as well -- is, you know -- and I know you know this but, again, just as an opportunity to say it out loud, the circumstance right now is kind of the other way where you can move the less complex patients pretty easily into the LTCH, and I think that's -- we were trying to look hard at that. And I know you've got that, but I'm just taking the opportunity to say it out loud.

Over to you guys if you want to add.

MS. KELLEY: Yeah, I think you covered it well,

Mark. Then the other thing to keep in mind is that LTCHs under Medicare rules have to have separate ownership. So the financial incentives are not directly aligned here, and the hope was that there's that friction there that will kind of reduce the incentive on the acute-care hospital side to increase the services that they furnish in order to help out a separate financial entity, the LTCH.

DR. MARK MILLER: The other thing, I should have said this at the top of the comments, because the other thing you said, Jon -- and if I'm not tracking your comment correctly, you know, speak up. I know you will. But you're right. Then you might also be saying, but, you know, we're trying to encourage people to go into ACOs and have more of an integrated system. And I'm just going to say this out loud, not having cleared it with anybody. The other thing that I've heard said among Commissioners -- this isn't a consensus or a position yet -- is, you know, if somebody jumps that fence and accepts risk in a more accountable care type of operation, we have said things among ourselves that maybe then you start relaxing these regulatory rules. So you could consider something like this eight-day rule and say you jump into an ACO, you accept risk. Knock yourself

out. You can decide when you want this patient to move around.

Now, I want to say that tentatively because there has been no agreement, but some people have said those kinds of words out loud.

MR. GEORGE MILLER: Right. Jon teed it up very perfectly because I did want to question -- and, in fact, I have in my notes to myself about the eight days versus what's appropriate care. While I understand there may be gaming on the front-end side, we don't want to create a situation that could be gaming on the back-end side because of the length of the days. I don't know if eight days is appropriate. Alice is an ICU nurse, and I've seen -- excuse me, ICU physician. I'm sorry. Alice is a physician and has talked about taking care of patients in the ICU. Physician, physician, physician. And the point is, what is appropriate? I've seen multiple train wrecks that shouldn't have been in the ICU at all, should have been in the higher level of care, and I've seen patients that blew past eight days that probably shouldn't have been in the ICU at all, should have been in just a regular inpatient bed.

So I don't know the definition of "appropriate

care," but by picking the opportune number, I think it could lead to abuse. And, again, talking about an ACO environment, as Mark just illuminated, seems to me that the rules get relaxed so that you can move folks between appropriate care, then that would be better.

Just going back a bit, the top of your recommendations, I support them, again, in the spirit they were written. I understand the APCs, particularly those tests versus -- still have trouble with the E&M. But I can support this recommendation. I support the LTCH recommendations, but I do think there has to be some period of adjustment. Whether it's long or short, as some of my colleagues have said, we'll have to figure that out. But there should be some method to moving to that type of payment.

But the argument about the -- I mean the discussion about the efficient hospital, we have had that discussion for two years, bought into it, reluctantly I bought into it, not totally there but I raised some of the same questions. But since we have that and they have negative margins, then I support the update. As you recommend going forward, until something is better than the

efficient hospital and they're losing money, I can support the update. And I do like the way all these three things are tied together across silos. That's very good.

Thank you.

MR. GRADISON: Were we voting on this today, I'd vote in support of it. I don't have to vote on it today, and the two things I just want to give a little more thought to have already been discussed by others. First, of course, is the -- not "of course," but the first is behavioral -- possible behavioral change. I've been kind of struck going through the material for today how dramatic behavior can be influenced by payment mechanisms. It's not new, but we have it in here and we have had it for some time with SNFs with regard to therapy reimbursement and with home health care with regard to the numbers of episodes. It's quite dramatic the way this can work out. I think that I'm satisfied on that point by the fact that these are separate institutions. I still want to think about it.

The other thing that I want to reserve judgment on -- I hate ever to say, "Wait to see what the Congress does," because I'm too old to be around necessarily to see what they're going to do. But in this instance, I do want to see

what, if anything, they do as part of this package that's wending its way through. It may be decided on in a week or two, but just to see how that might relate to what we're talking about, because if they do make changes in this area very soon, then I think we've got kind of a more fundamental question. Do we want to come back and suggest they change something that they just changed or gain more experience under whatever they come up with before we make a recommendation in this area?

DR. COOMBS: So I in general support all three bullets, including the fact that we've already kind of discussed Bullet No. 1. One of the things that I think I had spoken about earlier was just the notion of workforce maldistribution in terms of rural areas versus urban areas and what happens with an area that has one acute-care hospital and maybe no LTCHs or one LTCH, and how does the dynamics of what we do influence just in terms of patient flow?

On Slide 20, I hate to sneak ahead, but, Glenn, just for better elucidation, in our LTCH chapter we talk about the number one -- actually the top diagnosis for admission to LTCHs, and the ratio here is 36 percent of the

LTCH patients are CCI versus 64 would be geared into the IPPS base rates. But as an ICU doctor, if I had someone on the vent, and say the day rate dropped from eight days to five or maybe four or three, that ventilated patient would come in, there would be some different type of approaches to that patient in terms of saying this patient can go to an LTCH, I'm not going to even try and wean this patient that quick because I know that this time frame that I can actually transfer this patient is much shorter, and I don't have time to observe them if I wean and extubate the patient and the next day they crump and they're back here again.

So if they were to deteriorate rapidly after I've done a perturbation, I might be afraid and apprehensive to be more aggressive with actually freeing the patient from the ventilator, which actually puts the patient at a better state long term in terms of the development of nosocomial infections and all those complications.

So I know that shortening that period might be -- it might influence my approach to the management of that patient in that they might present themselves to LTCHs in more of an acute stage of illness than they would formerly. So I think that's a piece of just provider behavior that's

very different.

MR. HACKBARTH: This sounds important, so I want to really be sure I understand. So what is the shortening period that you're referring to? What is shortening?

DR. COOMBS: So say, for instance, if I said that to be an LTCH CCI patient you only needed to stay in an ICU for three days in terms of being able to define acuity of illness, if I on the back end knew that and I was moving people fast through the unit in terms of my turnover, length of stay, and all those wonderful data that comes forth as a benchmark for goodness within a health care system, I might be more apt to transfer patients without doing some interventions versus others.

MR. HACKBARTH: So if the requirement for the higher LTCH payment was not eight days in the ICU but three days, that might cause people to transfer to LTCH more quickly.

DR. COOMBS: Yes.

MR. HACKBARTH: And do you think that's a good thing or a bad thing?

DR. COOMBS: I'm not going to comment on the goodness of that, but I will say that that 36 percent that

you're looking at is going to change in terms of the percentage of CCI patients, so you've just shifted what you thought was going to be 36 percent, maybe now will be 45 or 50 percent, and then the realized savings in terms of shifting it to the IPPS system is not there anymore, so that $2 billion that you're looking at for savings to be able to redistribute to the acute-case hospital is not realized. And so that's one of the behavioral things that would change drastically, and as an ICU doctor, I would be less apt to do something that would actually fail in the LTCH for fear of readmission from the LTCH, so you might just say, well, I'm going to leave this patient in the current state. And I only say that in lieu of what we've seen in the chart that comes later in terms of the diagnosis that drives you into the LTCH, which predominantly are respiratory. Even though the top two diagnoses are respiratory, when you look at those other diagnoses way down there, they actually are respiratory, too. They're trach patients, they're pneumonia. You could throw them in with the respiratory and the number one diagnosis for LTCH admissions.

DR. NERENZ: Yeah, I will be generally supportive of the direction here. I think the part of it that I'm most

strongly in support of is just the higher update for hospitals. I am impressed by the data that we have about projected negative margins, and, frankly, as we look across a number of these chapters, often we see hospital-based home health, hospital-based SNF, hospital-based fill in the blank with lower margins than the free-standing equivalent. So I tend to favor that direction.

Also, even more specifically, I'm a little concerned that some of the presumed financial benefits to hospitals through the Affordable Care Act are not going to happen as quickly as projected or in the amount projected. Just as an example, the high out-of-pocket components of a Bronze plan for individuals in the exchanges I think is going to produce some high bad debt rates that perhaps haven't been fully planned out. So, in general, I think the situation for hospitals the next couple years is a little vulnerable, and, therefore, I favor that higher update.

In the particular domain having to do with the APC payment changes and then, by extension, back to the E&M, I would ask that we look back at the 2012 recommendation about some form of phasing in of that or some sort of camping of the negative effect on what I'll just call for convenience

"safety net hospitals." When we talk about changing the payment rate to that that applies to physician offices, I think without explicitly stating it, at least what I think has been in my mind is that we expect some sort of behavioral response where those services will, in fact, be provided more in the future in office settings where they can be done less expensively.

But in some communities, that physician office network doesn't exist. There's really no effective alternative to the hospital outpatient. So I would just ask us to keep that in mind, that in those sorts of situations there be some transition, some camp of negative effect, something so that you just don't expect a behavioral adjustment where none is possible.

The last thing then on the LTCHs, this is the element where I just have some concern about this, and it mainly has to do with the size of the impact. If we go to Slide 27, if I have my numbers correct in my head, we're talking about a $2 billion cut out of, what, a $5.5 billion base?

DR. COOMBS: That's it.

DR. NERENZ: So the numbers look significant. So

I suspect we'll have to think carefully about exactly how that gets accomplished and what that means to the organizations affected.

DR. REDBERG: I support the recommendations. I think they are, as people have said, consistent with our principles of, you know, adjusting payment so that it's site neutral.

And then I also think we should consider sort of our other principles of the value added for beneficiaries, and that is why I would favor a fast change for this payment, because as we've discussed previously, there isn't data to support value added for the LTCHs. You know, the areas where they don't exist seem to do just as well as areas where they do exist. The outcomes data hasn't been shown. And so I would favor an evaluation in that going -- you know, we have a lot of post-acute-care choices, and I think it's really important that we consider where resources are best used. And I don't think that has been shown for LTCHs. So I support the recommendations with a very -- because I think it said in one of our other chapters, the Medicare program should move expeditiously to correct overpayments. That's what we should do here.

DR. HALL: I'm in favor of the recommendations, and I particularly applaud us for taking an approach that looks at strategies that will have a positive impact on rationalizing the health care system overall. So, I mean, that's -- this is tremendous that we're doing it in this way.

In the conversation around the room, we talked about the ability and the incentives for acute-care hospitals to absorb some of these cases for a longer period of time. And while there's an excess of beds in the acute-care system around the country, I don't know that there's that same excess for people who need a higher level of care, particularly respiratory care.

In other instances where suddenly there has been a shift of patients to the acute-care hospital with respiratory needs, there have been real problems. Some years ago, New York State had a problem of placing Medicaid-eligible-but-not-received patients, older patients, into nursing homes for a whole variety of reasons I won't bore you with. But the upshot was that they stayed in the acute care hospitals, and those who had respiratory complaints ended up usually having fairly substantial needs. But even

what you might call the non-CCI types had needs that were not easily met in the hospital, so that almost every hospital that was faced with this set up some kind of specialized unit, a step-down unit or respiratory care unit, and 20 years later in our community we still have the legacy of that. We don't have LTCHs to deal with.

So I would say that as we go forward with the recommendations, we ought to take a very careful look in terms of Recommendation 2 as to whether this is such an incredible bonanza, not so much for the acute-care hospitals but for the patients who are going to be in there. And I'm not exactly sure how we do that in a short period of time, but that's the only part that bothers me a little bit about it.

DR. BAICKER: I'm supportive of the recommendations, and I think the bundled approach, surprisingly, is a reasonable one. I think there's a danger in overreacting to year-to-year variations in the margins. If we thought the margins really captured adequately potential losses on each patient, I might react to them differently. But there are some reasons to be hesitant about that, so considering the multipronged assessment of

payment adequacy seems like a good solution to that to me. And a lot of the things, as Cori noted, that are included here are things that we think are -- we would recommend independently. Put together, it makes me more comfortable with the somewhat ad hoc reaction to the negative margins, and I share Scott's and others' points that you don't want to drag out the transition indefinitely. And I think dragging our feet is more of a problem than acting too quickly these days. But I can see a reasonable reaction to a big jump in one year as not being a reasonable way to do business with people we expect to be providing care to our enrollees.

So, together, even though individual pieces on their own I think there are some questions about, together I think it makes a very reasonable and good reaction to the current set of circumstances, so I'm supportive.

MR. HACKBARTH: So in a minute I'll give Mike his chance in Round 2, but I also want to sort of tee up perhaps a 10- or 15-minute discussion of the role that margins should play in our decisionmaking about updates. And let me tee that up by just giving a little bit of history for people in the audience who may not be familiar with it.

So as we've said multiple times already today, margins are but one element of our payment adequacy framework that also considers access to care, access to capital, quality of care, et cetera. And I've been involved with MedPAC now for 14 years, and actually earlier in my tenure, margins probably played a bigger role than they play today, but it still is decidedly part of our framework.

In 2003, the Congress modified our charge to say that, in particular, we should look at the adequacy of payment rates for efficient providers, and that's where this focus comes from. And having talked to the member who sponsored that language and assured its enactment, his thinking at the time was that Medicare should not be worried about what the average is; we should be driving the system towards efficiency, so don't tell us what the average margin is or don't give us updates based on the average, tell us what the really efficient provider needs.

And so for a number of years now we have tried to calculate, first with hospitals and now with other provider groups, the margin of efficient providers, taking into account both cost and quality measures.

What makes this circumstance unique is this is the

first time where the projected margins for an efficient provider group have turned negative. For a number of years now, we've projected average overall margins for hospitals as being negative, but this is the first time where even the efficient provider margin has gone negative. As people well know, for the other provider groups, the margins are positive and in some cases really positive by a lot. So this is a unique circumstance, the first time we've faced this circumstance.

I offered a draft package that I thought would improve margins, including for efficient providers. I'm not sure -- I haven't decided in my own mind that the objective ought to be, oh, we have to get to zero, and I wanted to invite some discussion on that issue. Put a little bit more broadly, exactly what is the role that margin analysis ought to play in this payment adequacy framework? And, you know, Mike and I over the years have had several conversations about this, and so I've asked him to sort of kick off that.

DR. CHERNEW: I'm going to start with my Round 2--

MR. HACKBARTH: Please do.

DR. CHERNEW: It will be an elevator speech, but it will be a tall building.

So with regards to Round 2, I support the recommendations, where they're going, and my one concern, which I think about in a variety of ways, is how flexible or how game-able is the ICU day criteria? I've been sort of convinced that it's not that big of a problem. That is the one issue that I worry about that has come up.

Regarding the broader margin things or the issues in general, I think about this as one goal and, frankly, a very important goal for me is that we get the relative prices right, the site arbitrage stuff, you know, where the payment rates are causing organizations to other organizations and the building stays the same but the billing changes and stuff, I think it's an unproductive and not particularly useful thing.

Frankly, I could be convinced without much trouble to expand this to include aspects of ASC services that aren't really here, but that's not on the table, so I won't dwell on that. My preferred way is not to worry about how to get all these little fee-for-service schedules exactly right in harmony, but to move to a broader bundle, and I actually believe that organizations paid a broader bundle would do a better job at allocating people across the

different sites, and that's one reason why the broader bundle is appealing. It gets us out of having to argue this all the time. But the broader point is to the extent that we have to do this, which we do, getting the relative prices matters because we're not just moving money around, we're setting incentives. And we want to have those incentives set reasonably.

Although what comes up in these discussions, which is going to get to this issue of efficiency, is there are actually real financial consequences to particular organizations when you change the prices because there's cross-subsidies that were going on, and when you undo them, you have to worry about the consequences on the organizations that might end up on the short side of that stick. And my view of that, you know, the update's the main tool to deal with that, and we want to get the level right. So I believe that -- my personal belief is that margins are an important thing to look at, but they're not determinant for a variety of reasons that I'm just going to run through them and maybe not talk quite as quickly as I've been talking.

So I think the goal -- my overarching goal,

anyway, is that we make sure that Medicare beneficiaries have access to high-quality care, and I think the role of margins is to give us some insight as to whether that more important goal will be made as opposed to a goal in and of themselves. So I don't have any natural affinity for margins high or low. I care about the access and quality of care that folks get. And I worry a lot -- I'm not a fan of margins, as I've said in other contexts, in part because they suffer a lot of measurement issues. The biggest one relates to the general perception that some people have that costs are sort of fixed; here's our cost, now you pay us a margin above that. I -- and maybe it's just a professional hazard -- view costs as much more flexible, and so there's not -- I don't see there as being a cost that you pay a margin above. It's not what costs are. It's sort of what could they be.

So we've seen in a number of contexts that if things outside of Medicare are very generous, for example, costs go up. If things out of Medicare are not very generous, costs go down. Medicare changes its payments, costs move. And all the discussion we've had about behavioral changes that we've talked about suggests that, in

fact, costs respond to payment in addition to payment responding to costs. And so I don't like that circularity, and it makes me less inclined to focus on margins being determinant.

There's issues of average or variable costs, and that's important. There's a range of accounting issues I won't pretend to understand, but a colleague of mine at Michigan, Dean Smith, used to teach accounting, and he would teach, you know, there are certain things that you could do in the reports that might make things look better or worse, and I don't know what they are, so I will leave that to a discussion with Dean. But in any case, I just worry that we're measuring things accurately, accurate all the time.

So I think the last sort of point on this margin comment that I'll make is that we talk about efficient hospitals, but really we're not measuring efficient hospitals, we're measuring relatively efficient hospitals. So we're just saying they're efficient relative to others, but we don't know how efficient they could be or what else could happen.

One of the reasons why, of course, I'm comfortable with this is, in fact, we are having payment go up. It's

just we've assumed that cost rises a certain amount. But we have no idea that costs have to rise at that amount or there aren't efficiencies that could be taken. So I would be worried if we were always just moving our margins to do that.

So that's why I'm not a big fan of margins. That said, I do think they're important predictors of where the world might be going. I think it would be a bad case if we saw big access and quality problems. Frankly, I'm not worried about margins only for efficient providers. I'm worried about for all providers because, say there's a market where there's no efficient providers, I don't think we should assume they could just become efficient in some magical snap of the finger way, and if payments were inadequate or we saw real access problems there, we would have to figure out how to deal with that. I don't think we're at that stage yet. But I think across the board margins are a useful indicator amongst many of the health of the sectors that we discuss, and I think we should continue to look at them. My only point is that I don't think they should be determinant or, more to the point, I don't think we should have a rule. We need to make sure margins are

plus 2, minus 1, 0. I think we have to look across the board and then decide, do we think that the money that we're putting into the sector, the prices that we're recommending, are sufficient to guarantee access and quality? And if we are, I'm comfortable with those type of recommendations, and so I believe this recommendation, A, gets the prices right, which I care about a lot; and, B, provides a level of payment that I'm not now so concerned that access and quality will be adversely affected.

MR. HACKBARTH: Reactions on this issue of the role of margins in our final decisions?

MR. GRADISON: I'm pretty close to where Mike was. Let me explain why. First of all, if we do, as a result of trying to set wise policy and follow the direction of the Congress, have some kind of a rule with regard to efficient institutions and kind of a reasonable band of what we think would be a proper rate above cost, we sure as the deuce haven't followed it. I mean, when you look at the silos which have from time to time had rates of return based on our data in excess of 10 or 15 percent a year, and sometimes year after year, there's something wrong here. Or let me say it in a more direct way. If we're going to do this and

make a big to-do about the fact that we are doing it, I think we've got to go back and take a much harder look at the numbers that we're recommending for some of the other silos rather than just say, well, with regard to hospitals, we got to do it thus and such a way. That's my first point.

The second thing -- and this is -- I don't know how else to say it but very directly. I think the emphasis on always having positive margins can have a similar impact to cost reimbursement. Think about that idea for a while. If we've got to have a positive margin, that says to me that if costs rise, we've got to validate that increase in cost by our reimbursement so that we are diminishing the incentive for holding costs down if we are, in effect, assuring that at least our part of the reimbursement will always be in positive territory.

Finally, I think we should look at margins but not just Medicare margins. Overall margins I think are very important, too, and in an environment where, for example, with hospitals, with the average that they're getting from private payers is, what, 30 percent above cost, is that unimportant to us? I mean, if these private payers are silly enough to pay that much more than we do, I'd say,

"Thank you very much." Then maybe we don't have to pay as much, because we know as long as we're paying well above marginal cost, there's not a hospital that's going to turn away a Medicare patient.

So I just approach this with a degree of skepticism. I don't want us to get too driven into the numbers with regard to what the proper margin itself ought to be. There are other considerations that I think we need to take into account.

MR. HACKBARTH: Let me see if I can frame my question in an even more pointed way. So I for one am not willing to say margins are all that matter. They haven't been in the past for MedPAC, and that's not a direction I would even consider. I would not say that we ought to specify a target margin, and for some of the same reasons that people have mentioned here, so that's not on the table.

The issue that I've been wrestling with is, again, it's sort of a question of asymmetry. We're talking about, well, what happens when the margin for even our efficient providers goes negative? Is that a special sort of margin signal? Even if we're not, you know, obsessed with them in general, is this in particular something that we ought to

worry about? And a corollary of that question is: Should we, when that happens, be striving to, if not immediately, sort of start thinking about a path where we would get efficient provider margins closer to zero?

That's sort of the question, the narrow question that I'm wrestling with as opposed to the abstract, you know, let's talk about margins in general.

MR. GRADISON: May I respond just briefly? We're not suggesting here that the efficient hospitals, if we have an objective way of measuring them, are going to get more. We're suggesting everybody get more.

MR. HACKBARTH: That's a great observation, and so in one way, well, that's logical because the efficient ones have the lowest costs, and the other margins are even worse, but you could also turn that around and say, well, what we only want to do is reward the efficient ones and not the inefficient ones. We expect them to reduce their costs, and we don't want to give them extra money that will deter them from doing that.

MR. GRADISON: That's what we're doing with regard to readmissions, for example [off microphone].

MR. HACKBARTH: Right.

DR. BAICKER: So I don't think there's any bright line that I'd want to focus on for efficient hospitals getting a zero margin. Efficient is measured with noise. We're not sure. There's no magic subset of efficient hospitals. Margins are measured with noise. We're not even quite sure what they're measuring. So zero, even though it seems like a big difference between positive or negative, the difference between 0.1 and 0.2 and 0 and negative 0.1, I don't think there's a bright line. I think it's a continuum.

So I don't feel like we should have some very special alarm bell that goes off at that point, but I do think it's a really good additional signal. If we think that just average margins aren't quite capturing what we want, this is a very important additional piece of information that should give us pause and should make us re-evaluate what we think the overall increase should be. And I think it does make sense to say, sure, we care about high value delivery, but the update is going to apply to everyone. I don't think that we would say we just want to give more money to the guys who have the lower costs, and the guys who have the higher costs they should get less

money because we don't like them, which, you know, they're -- - I'll just stop right there.

[Laughter.]

DR. BAICKER: So I appreciate the focus on that group and think that it's great information, but I wouldn't recommend any kind of litmus test.

DR. NERENZ: I'm just curious what we know in terms of the day-to-day operating details that differentiate the efficient from the inefficient hospitals, because we describe them on a basis of some sort of global characteristics. But I'm curious sort of how those are different and whether the inefficient can, in fact, become efficient.

As a special point of that, I'm interested what happens when hospitals reduce costs, what changes? What costs are eliminated? Are there general points we know about that? Because I think a lot of our discussion is based on what goes is waste and that is good. Is that true? Is that really how it works?

DR. STENSLAND: There's a couple things in there. One is what are the efficient providers like, and I think I'll just defer that to -- there was a chapter a couple

years ago that we did when we kind of described the various characteristics of these guys, and we'll e-mail it to you.

The other question is: What happens when they reduce costs? And I don't think we have any direct studies on that. All we're saying here is it is possible to have your low cost and your good quality relative. Some of the academic studies that were in your paper looked at things of, well, what happened during some difficult times, like around the BBA? What happened when Medicare cut its rates at the same time? Back then, you know, things were very different. The managed care had some pressure, and so the overall total margins were fairly low. And what happened to quality then in some of these studies? Some of the ones that I think are a little bit more complete, kind of more connected all the dots, said they really didn't see much in terms of the effect of that on quality, meaning the reductions in expenditures really didn't reduce quality. And other studies said, well, maybe it did reduce quality a little bit. But they all are saying quality is improving; it just maybe doesn't improve quite as fast if they have less money. Some of the studies say that. Some of the studies say you really can't tell the difference.

There's also -- I guess I should say one other thing. The other thing that's going on here is there's hospital individual effects and then there's industry-wide effects, because a big part of what's happening, I think, in terms of industry-wide pressure is it affects the actual input costs. You know, we look at American input costs; they're 50 percent higher than every place else, probably because the aggregate pressure across the market, including private payers, is a lot less. I'll just leave it at that.

DR. NERENZ: No, I think -- I'm glad that was part of the response, because clearly hospitals aren't just sort of prime or original sources of costs. They have their own costs, and some of their responses can be passed out to the drug suppliers, device suppliers, everybody. So I'm interested in just how that whole network of relationships changes when cost pressures occur and costs, in fact, go down.

MR. HACKBARTH: Okay. I want to get a few more people in. Scott, then Bill and Peter, and then we're probably going to have to go to lunch.

MR. ARMSTRONG: Yeah, and it's kind of an interesting question, and t e hard part about this is that

we do, Glenn, as you were saying, we can talk really generally, and then we have to ask, well, what's the relevance to the payment policies that we're setting.

I would just disclose that I think health systems should make 2 to 4 percent margins, and we should peg our payment to try to achieve that, and that's how they replace their capital, period. Now, can we do that through our payment levers? I think that's a really difficult task. And Kate was saying this, and I agree. I think it's very directional.

I think the one thing I would add, though, is that for margin, as opposed to the other criteria that we use to assess adequacy of payment, the quality and the access, those you can really judge how the Medicare program is serving patients. But for margin, it's just so influenced by the cross-subsidization in different directions. For Medicaid, we often have talked about how much responsibility should we take for paying Medicare rates that are influenced by a high percentage of Medicaid patients or uncompensated care in a hospital. And then the flip side is -- by the way, I'm disclosing I'm the only commercial plan, I think, sitting on the Commission, and we do pay 30-plus percent

more than Medicare rates, not because we want to but for a variety of other reasons. And, in fact, you know, that has an enormous impact on whether acute-care hospitals versus some of these other sectors can live with smaller or even potentially negative margins. The question is: So to what degree should we care about that?

Anyway, I just think that cross-subsidization is particularly relevant and gets in the way of using margin as a measure of adequacy of our payment rates, and I just don't know how we reconcile that.

MR. BUTLER: So I think I'm where -- they said it very differently. Mike and Kate are kind of where I'm at. No bright line. It's all about access to quality, adequate quality services that are articulated in the benefit structure.

I agree with Scott that you need a 2 to 4 percent margin, but we shouldn't be guaranteeing that. It's just -- you know, but I think Medicare margins and total margins are important in understanding the health and willingness of an organization to treat Medicare, but also the ability to serve, you know, the population.

The one area that I get sensitive in, though, is

if a sector is primarily for-profit which is shown to have discipline around costs but also can adjust pretty quickly to the payment mechanism, but if it's a sector that's primarily for-profit and primarily Medicare and has high margins, you know that those excesses are going to shareholders and somewhere outside of health care, where in the nonprofit sector, at least in principle, they're supposed to all stay reinvested in the health of the community they're serving. So those areas are ones saying, wait a minute, those dollars are escaping health care altogether when we give those margins, and that's a little bit different for me than some of the other sectors.

MR. HACKBARTH: Okay. So we'll review the transcript and come up with a final recommendation, and as always, I'll be talking to you individually between now and January. Thank you all on the panel for the presentations. Well done.

We'll now have our brief public comment period before we break for lunch.

And let me see how many people want to go to the microphone. I've got three.

Okay, so we are cutting it off at three, now.

Please begin by introducing yourself and your organization. Limit your comments to two minutes. When the red light comes back on, that signifies the end of your two minutes.

As always, I would remind people this isn't your only, or even your best, opportunity to influence the work of the Commission. Talking to the staff is the best way. Also, please be assured that we read our mail and, in addition to that, we do have an opportunity on our website to lodge comments, as well.

So two minutes.

MR. LIND: Keith Lind, AARP.

Just a comment about the LTCHs. You might want to explicitly consider what Congress is considering now because my understanding was that there was an LTCH proposal in the SGR 30-day patch which they may pass. And I thought it had a three-day ICU stay, not an eight-day stay. You might just want to address that if you're going to talk about it.

MR. HACKBARTH: [off microphone.] We on the case.

MR. LIND: Great, I figured you might be.

The question that I have is in hospital inpatient and outpatient margins and payment, did you consider the impact of SGR? And if not, why not? What is the impact of

SGR?

I just didn't see -- maybe I missed it, but I just didn't see it up there.

Did I say SGR? I'm sorry, sequester. I didn't hear sequester. Sorry.

MS. KIM: Hi, I'm Joanna Kim with AHA.

We appreciate the recognition that hospital payments will fall below the cost for relatively efficient providers and the recognition that hospitals require a higher update to correct that discrepancy. But we're troubled by a couple of aspects of the conversation today.

First, is the assertion that the sequester is temporary and therefore not under consideration during this meeting. The 2 percent sequester is current law and is in place through 2021. And I suppose technically that is temporary, but to exclude from this conversation a current law provision that will be in place for almost the next decade doesn't seem warranted.

Second, we're extremely puzzled, to say the least, as to how a draft recommendation to fundamentally alter the structure of the LTCH payment system can be put forth without any data on the impact it will have on the LTCH

field. Reducing payment for 64 percent of LTCH cases is a very extreme cut and will certainly impact beneficiaries' access to care. But this discussion today really focused solely on the payment rates and there was no discussion of financial impact, no discussion of access to care. And that is deeply disturbing to us.

Even if the data on the impacts is presented at the next meeting, as was mentioned, that doesn't give adequate time to consider and evaluate in time for a January recommendation the serious magnitude that this could have on the field and on beneficiaries.

So we urge the Commission to withdraw that recommendation until enough information is available to fully consider and think through all of the consequences it could have, unintended and otherwise.

And then lastly, regarding the recommendation on the 66 on the outpatient side, CMS issued an outpatient final rule on November 27th that introduced sweeping changes to the outpatient system, including on bundling and E&M and we would urge you to take those into consideration when looking at that recommendation.

MR. KALMAN: Good afternoon. My name is Ed

Kalman. I'm with the National Association of Long-term Care Hospitals. I just have a few observations I'd like to invite your attention to.

The payment policies you are considering bases payment on ICU assignment and there is variation in ICU assignments throughout the United States for the same case. The financial incentives that you are installing will intensity -- may intensify that variation. That's my first point.

My second point is these are very sick cases we're talking about, and you all know that. And therefore, they should be assessed, in terms of outcomes and payment and savings, over an episode of care that is longer than the index acute hospital episode of care.

The assessments that you have made in terms of cost and savings relate to an index initial acute hospital of care only. They do not relate to what happens 180 days out or 365 days out. And that is what is most important in terms of readmissions, mortality and spending.

There is some data on that that has been provided to you recently.

Thirdly, I want to make you aware that you are

paying for these cases on an IPPS basis and enhanced CCI rates in the most expensive setting because acute hospitals -- as opposed to long-term care hospitals -- qualify and receive IPPS add-ons: IME, GME, DSH, low-volume, technology, and geographic area reassignment. Those increased payments are baked into the policies that you are considering.

I think worse are the next two. The wound care cases are completely excluded.

Also, there is a significant issue about -- it's not just access. It's care and dislocation of patients in rural areas and in small urban areas. Because the incentive is for these payments to be in large urban areas where some of these cases go, but the wound care cases stay in their communities and those hospitals will be at the most risk.

Also, slide 7 is inconsistent with your recommendation. The recommendation is that LTCHs should be paid at the same rate as acute hospitals for non-CCI patients. Slide 7 says IPPS equivalent.

IPPS equivalent is defined by regulation to be IPPS payment on a per diem. It's not full IPPS. The integrity if IPPS payments is an averaging. You've got some low cost cases that are balanced off by high cost cases. So

the IPPS equivalent is a distortion of that.

I understand why it exists, but it should be augmented with to make sure there are cost outlier payments and that where patients are direct admits -- because what we're doing, and we endorse this -- we've endorsed this in the legislation that was introduced by the Rules Committee -- is we're creating low-cost acute hospitals which really go great with the ACOs for the non-CCI patients that they're taking care of.

But I think the distortions I have identified are something that you should consider.

I'm sorry if I went over my time. Thank you.

MR. HACKBARTH: Okay, thanks. We will adjourn for lunch and reconvene at 1:20, 50 minutes.

[Whereupon, at 12:33 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:24 p.m.]

MR. HACKBARTH: Okay. It is time for us to get started again.

[Pause.]

MR. HACKBARTH: Okay. So, we've got four more update sessions, the first of them on LTCHs, and I want to set the stage for this. So, we just finished before lunch a discussion of a possible change in the method of payment for LTCHs. Here, we are undertaking the task of focusing on what the LTCH update should be, and, obviously, at some level, those may be interrelated with one another.

For the sake of this discussion that we're about to embark on, I think it keeps things simplest to think of this as what would our update for LTCH be in the current payment system, and that's how the presentation and materials are organized.

So, with that preface, Dana.

MS. KELLEY: Good afternoon. This morning, you discussed how savings from an LTCH reform proposal might be used to increase payments for the most costly critically ill patients in acute care hospitals. As I said then, our work on this issue is ongoing and will be presented in more depth

in January. So, today, this afternoon, we'll just turn to the question of how payments to LTCHs should be updated for the current --for fiscal year 2015.

First, let me remind you of some basic facts about LTCHs. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average Medicare length of stay of greater than 25 days. Due to these long stays and the level of care provided, care in LTCHs is expensive, averaging more than $39,000 per case in 2012.

Medicare pays LTCHs under a per discharge PPS. The LTCH PPS uses the same MS-DRGs as the acute care hospital PPS, but with different weights and with different base payments, as well. Payments can be adjusted upwards for cases with extraordinarily high costs and downwards for cases with short stays.

Beginning in fiscal year 2014, all LTCHs are subject to a 25 percent rule. The 25 percent rule creates a disincentive for LTCHs to admit a large share of their patients from one acute care hospital. CMS's goal in implementing this policy was to prevent LTCHs from acting as a step-down unit for an acute care hospital. With some

exceptions, if an LTCH admits more than 25 percent of its cases from one acute care hospital, additional cases above that threshold admitted from that hospital generally are paid at IPPS rates. Patients who are high-cost outliers in the acute care hospital do not count toward the threshold and continue to be paid at the LTCH PPS rate, even if the threshold of admissions from that acute care hospital has been reached.

Following implementation of the LTCH PPS in fiscal year 2003, Medicare spending for LTCH services grew rapidly, climbing an average of 29 percent per year between 2003 and 2005. At that point, CMS implemented a number of regulations that stemmed this growth. Between 2005 and 2008, growth in spending slowed to less than one percent per year. After Congress rolled back or delayed implementation of some of these regulations, spending for LTCH services began to climb again, rising 12 percent between 2008 and 2010. Since 2010, small updates to payments, including an actual reduction in the payment rate in 2011, have slowed spending growth once more.

To determine the update recommendation for fiscal year 2015, we review payment adequacy using our established

framework. We examine beneficiary access to care, quality of care, provider access to capital, and payments and costs.

Our first consideration in our analysis is access to care. We have no direct indicators of beneficiaries' access to LTCH services, so we focus on changes in capacity and use. As you know, this product is not well defined and it's often not clear what Medicare is purchasing with its higher LTCH payments. There are no established criteria for admission to an LTCH, so it's not clear whether or which patients treated there require that level of care. Remember that many Medicare beneficiaries live in areas without LTCHs and so receive similar services in other settings. Research has shown that outcomes for most medically complex beneficiaries who receive care in LTCHs are no better than those for similar patients who do not have an LTCH stay.

To gauge access to services, we first look at available capacity. This slide shows growth in the number of LTCHs nationwide in green and the number of beds in blue. Growth in these numbers has directly reflected the LTCH payment policy environment. From the late 1990s until 2005, when there were few constraints on Medicare's payments for LTCH services, the number of LTCHs more than doubled. You

can see the very tail end of that growth here. Beginning in 2005, as CMS began to regulate LTCH payments more closely, facility growth slowed markedly. Although Congress temporarily eased some of those regulations between 2008 and 2012, facility growth remained low due to a moratorium on these facilities --on new facilities. The moratorium expired in December 2012, but as we will see, uncertainty about future LTCH policy continues to have an effect on facility growth.

The number of LTCH cases increased slightly between 2011 and 2012, but did not keep pace with growth in the number of fee-for-service beneficiaries. Controlling for the number of beneficiaries, the number of LTCH cases declined one percent. As you know, 2012 saw decreases in volume in other settings, as well. Acute care hospital discharges were down, which may have affected admissions to LTCHs. In addition, the limited growth in volume is likely due at least in part to the moratorium on new facilities and beds.

Turning now to quality, LTCHs only recently began submitting quality data on a limited number of measures to CMS. Until these data are available for analysis, we

continue to rely on claims data to examine trends and in-facility mortality, mortality within 30 days of discharge, and readmission to acute care to assess gross changes in quality of care in LTCHs.

In 2012, these rates were stable or declining for most of the common diagnoses. The aggregate mortality rate shown here reminds us of how sick some patients in LTCHs are. On average, 25 percent of LTCH patients die in the facility or within 30 days of discharge. This ranges from a high of 50 percent for patients with septicemia and prolonged mechanical ventilation to a low of four percent for patients with cellulitis without major complications or comorbidities.

In the near future, we hope to have better measures of quality in LTCHs. In October, CMS began a pay-for-reporting program based on three measures: Catheter-associated urinary tract infections, central line-associated bloodstream infections, and new or worsened pressure ulcers. Beginning in January 2015, CMS will collect data on MRSA and c. difficile infections in LTCHs, as well.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access

capital, it might reflect problems with the adequacy of Medicare payments, since Medicare accounts for about half of LTCH total revenues. However, for the past few years, the availability of capital says more about the uncertainty regarding changes to regulations and legislation governing LTCHs than it does about current reimbursement rates.

Since 2007, the moratorium on new beds and facilities imposed by MMSEA and subsequent amendments has significantly reduced opportunities for expansion and the need for capital. As I mentioned, the moratorium expired one year ago.

It might seem reasonable to expect that LTCHs were poised to expand existing capacity or open new facilities once the moratorium expired. However, the industry appears to be taking a wait and see approach. Policymakers' continued scrutiny of Medicare spending on LTCH care and uncertainty about possible Congressional action has prompted a great deal of caution, both in the financial community and in the LTCH industry itself. Some LTCHs have been seeking ways to diversify their interests and position themselves to be partners with ACOs and in other coordinated care arrangements.

We saw some evidence of this wait and see attitude yesterday after the announcement Tuesday of the House budget proposal, including a provision allowing higher LTCH payments to cases with three or more ICU days during and immediately preceding IPPS stay. Stock prices were up yesterday for the two major LTCH chains. Select Medical stock was up almost 20 percent.

Turning now to LTCHs' per case payments and cost, LTCHs historically have been very responsive to changes in payment, adjusting their cost per case when payments per case change. As you can see here, payment per case increased rapidly after the PPS was implemented, climbing an average 17 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower rate.

Between 2005 and 2007, payment per case grew an average of 1.3 percent per year. Growth in cost per case slowed, as well. Since 2007, LTCHs have held cost growth well below the market basket. Cost per case increased less than one percent per year between 2009 and 2011, and grew 1.6 percent between 2011 and 2012.

Margins have, of course, tracked the trends you

see here, rising rapidly after the implementation of the PPS to a high of 12 percent in 2005. At that point, as growth in payments leveled off, margins began to fall. However, after 2008, with cost growth well under control, LTCH margins began to increase again.

This slide shows 2012 Medicare margins for all LTCHs combined and for different LTCH groups, as well as the share each represents of total providers and total cases. As you can see in the top row, the aggregate Medicare margin for 2012 was 7.1 percent. There is wide spread in the margins, similar to what we see in other settings, with the bottom quarter of LTCHs having an average margin of minus-12.8 percent and the top quarter having an average margin of 20.5 percent.

Margins were higher for for-profit LTCHs, which care for more than three-quarters of all cases. There are a number of factors that might explain this discrepancy. For-profits tend to be larger, so they have more economies of scale. For-profit LTCHs may also have an advantage if they are owned by one of the large chains that also own other types of post-acute care facilities within the same market. These facilities may be better able to control the mix of

patients and costs. Overall, for-profits have been more successful than nonprofits at controlling their costs.

One thing I do want to note, it is difficult to evaluate differences in the mix of cases in for-profits and nonprofits. By some measures, for-profits appear to have a sicker patient population. For example, they have a higher average case mix. But by other measures, nonprofits appear to have a sicker population. Nonprofits have a slightly higher share of patients who were high cost outliers during their immediately preceding IPPS stay, for example, and more of their patients reach high cost outlier status in the LTCH, as well.

We looked more closely at the characteristics of established LTCHs with the highest and lowest margins. This slide compares LTCHs in the top quartile for 2012 margins with those in the bottom quartile. As you can see in the top line, high margin LTCHs tend to be larger and to have higher occupancy rates, so they likely benefit more from economies of scale. Low margin LTCHs had standardized costs per discharge that were 37 percent higher than high margin LTCHs. Total payments per discharge were very similar.

Note, however, that high cost outlier payments

make up a much larger share of the average payment per discharge for low margin LTCHs. High margin LTCHs have fewer high cost outlier cases and fewer short stay cases, and you'll recall that short stay cases often have reduced payments. Finally, high margin LTCHs are much more likely to be for profit.

We estimate the aggregate LTCH Medicare margin will decline slightly in 2014. Updates to payments in 2013 and 2014 were reduced by PPACA-mandated adjustments. CMS also made a budget neutrality adjustment in both years that further reduced the payment updates. This adjustment was intended to correct for CMS's underestimate of how much LTCH spending would increase in the first year of the PPS. We also expect aggregate payments in 2014 to be reduced slightly by changes in CMS's short stay outlier policies.

Overall, though we expect cost growth to continue to be below market basket levels, we think it will be higher than payment growth. We expect LTCHs to make changes to their admission patterns in response to the 25 percent rule if it is fully implemented, so we do not expect much of an impact on the aggregate margin. Thus, we have projected a margin of 6.5 percent in 2014.

So, to sum --

DR. MARK MILLER: I'm sorry. The only thing we would add here is if the sequester were in place in 2014 --

MS. KELLEY: Yes, if the --

DR. MARK MILLER: -- two points less.

MS. KELLEY: Exactly. Yes.

So, to sum up our update analysis, the moratorium stabilized the supply of facilities and beds. Growth in the volume of LTCH services per fee-for-service beneficiary declined one percent, consistent with what we've seen in other settings, and as expected, given the moratorium and the policy environment.

We have little information about quality in LTCHs, but mortality and readmission rates appear to be stable.

Given uncertainty in the policy environment, both the industry and the financial markets appear to be taking a wait and see approach to growth at this time.

Our projected margin for 2014 is 6.5 percent, with minus two points in the event of sequester, and our projected decrease in the aggregate margin from 2012 is consistent with expected effects of Congressional mandated and regulatory reductions in payment updates.

We make our recommendation to the Secretary because there is no legislated update to the LTCH PPS. The Chairman's draft recommendation reads, the Secretary should eliminate the update to payment rates for long-term care hospitals for rate year 2015.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2013 will produce savings relative to the expected regulatory update, even assuming the PPACA-mandated reductions.

We don't anticipate any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

So, with that, I will turn it over to you.

MR. HACKBARTH: Thank you very much.

Round one clarifying questions. Herb and Jon. Anybody else? Okay. Herb.

MR. KUHN: Just two. The first one, on page two, you mentioned the mean payment per case of $39,500, and that's much higher than the IPPS rate. Percentage-wise, how much more are LTCHs paid? Do we know?

MS. KELLEY: The --I think we established that the

mean payment per case in IPPS is about $10,000.

MR. KUHN: Okay.

MR. PETTENGILL: For the mix. For the mix of cases that LTCHs treat, IPPS payments would be around $10,000 per case.

MR. KUHN: Okay. Thank you.

And then the second question I had, on page five, where we talk about how many beneficiaries live in areas without LTCHs and receive similar care in other settings, do we see a noticeable difference in terms of length of stay in those areas, on the inpatient side?

MS. KELLEY: We don't. We do not. I would just say that the share of IPPS cases that go on to use LTCHs in aggregate, and even in areas that have LTCHs compared with others, is very small and likely would be swamped by lengths of stay for all patients. So, it's very hard to control for case mix in these analyses.

MR. HACKBARTH: Does anybody else have clarifying questions? Okay. Let's go to round two. Kate, do you want to start round two. And so, just as a reminder, I'd like your reaction to the recommendation, and if you have concerns, please say what would need to be done to address

your concern. Kate.

DR. BAICKER: I think, based on the data presented, the recommendation seems very reasonable to me, and clearly, we want to be thinking about this in the context of the previous discussion about payments here versus inpatient payments and about other things that are going on with how we're defining the patients. But I think in the context that you set out, this seems quite reasonable and seems unlikely to adversely affect health outcomes, which is one of the important criteria that we consider.

DR. HALL: I'm in favor of the recommendation based on what we've talked about today and in our book and previous discussions.

I'm struck once again on page ten of our book, just the map of distributions of LTCHs. Almost all of them are east of the Mississippi River and a very small percentage in the West, very disproportionately. And I think LTCHs grew up at a very different time in the whole structure of health care delivery, and because it only represents a relatively --well, a minority, but a substantial minority of States, I think it's going to be a difficult problem to fix and I think that we've looked at

this from the standpoint of margins and of quality and I think I'm quite secure that we aren't going to influence the quality of health care to our recipients by this recommendation.

DR. REDBERG: I support the recommendation. I think it's consistent with the findings in the chapter and also with our overall goals to provide the best care for beneficiaries. I don't think there should be an update.

I do note the high mortality, and certainly these are sick patients, but, you know, I think some of these patients perhaps should have had end-of-life kind of goal discussions before entering long-term care facilities, and I think at some point we need to think about sort of when people are leaving the hospital very ill, that we really are informing them, having those discussions, and that they're going to the right places, because I don't think with a 50 percent mortality for ventilator patients in the LTCH is necessarily in the best interest of our beneficiaries.

DR. NERENZ: I'm basically comfortable with the recommendation. I'm wondering if you could talk through a little more detail, though, about this issue of higher payments to LTCH than to an acute hospital for presumably

the same patient. It's mentioned several times in the chapter and then there's a specific example given on page 32. So, I wonder if you can just walk me through it.

I'm starting with the presumption that the prototypical LTCH patient starts in an acute care hospital and then is transferred because of this issue of how many days in the ICU and so on and so forth. So, the LTCH stay starts on a day, it has an end, and there's a prospective payment calculation. What, then, is the acute care hospital comparison for that? Is it the remaining tail of the stay that would have occurred if that patient stayed? Is that how the comparison is done?

MS. KELLEY: So, you've hit upon the main problem in trying to tease out these differences.

DR. NERENZ: Okay.

MS. KELLEY: Typically, what studies have tried to do is look at the episode of care, and that obviously requires truncating it at some point, so that what's being compared is total payments and costs in some of the studies for cases that start in the acute care hospital and go on to LTCH care versus comparable --and then that's the other sticking point --versus comparable patients that started in

the acute care hospital and go on to other types of post-acute care or not at all to post-acute care, depending. And so the studies try to compare total payments for different facilities, if appropriate, for those patients.

So, in that case, you would compare, say, a patient who had an acute care hospital stay and then went to a SNF with a patient who had an acute care hospital stay and then went to an LTCH, and then depending on where you're ending your episode, there may be additional facility-level care, as well, for both patients, and that's what the studies have tried to compare.

DR. NERENZ: Okay. So, just to make it concrete, so let's just say for a given patient who starts in acute care who then could either go to --say, stay in acute care or go to LTCH, and let's say that transfer occurred at day 20 and then the end of the episode was at day 60, when we're comparing payments in the LTCH, we're talking about day 20 to day 60. We're then comparing that to the payments that would have occurred 20 to 60 in the acute care?

MS. KELLEY: No. When --

DR. NERENZ: No?

MS. KELLEY: Like, earlier in the discussion, when

we were just talking about the average payment for the case, we were just talking about the average payment per case for LTCHs versus the average payment for patients of the same case mix in an acute care hospital. So, their lengths of stay would surely be different, and the LTCH patient, most of the time, had an acute care hospital stay before that. So, you're right, but you're --

DR. NERENZ: Which gets rolled in?

MS. KELLEY: No, not in our base payment discussion.

DR. NERENZ: Okay. Okay.

MS. KELLEY: But it does give you some indication about where they are in their course of illness.

DR. NERENZ: I understand.

MS. KELLEY: Right.

DR. NERENZ: I'm just trying to find where the apples and apples are here and whether --

MS. KELLEY: And that's been --

DR. NERENZ: -- the excess payment was --

MS. KELLEY: -- a historic problem here.

DR. NERENZ: Okay.

MS. KELLEY: Absolutely.

DR. NERENZ: Deep water here. Okay.

MS. KELLEY: Yeah.

DR. MARK MILLER: And that they responded the way they did to Herb's point is if this were a patient that -- and let's just for the moment pretend we could all identify such a patient, okay --that we all agreed could be treated in either a hospital setting or an LTCH setting, I think their response to Herb is, basically, what's the base payment difference between those two, I think is what they were trying to answer. And then if you want to go episode and different classes of patients, then I think it gets much more complex in trying to say --although we've done those kinds of analyses in the past and we could grind you through that, too.

DR. NERENZ: I guess I --and I won't belabor this beyond this one comment --the difference was so large and striking in your example on page 32, I was just trying to decide, what drives that? What justifies that? If we're already talking about a patient who's been through the acute management that goes on in the ICU in the acute care hospital, what's left to be so much higher, then, later?

MR. PETTENGILL: The average stay in an IPPS

hospital is around five days, and the average stay for a patient in a long-term care hospital is at least four times that.

DR. NERENZ: But, presumably, that same patient in an acute care hospital would stay also that very long time.

MS. KELLEY: Yes, although those --several of the studies have found that the lengths of stay for those patients that stay in an acute care hospital, for example, because there's not an LTCH in the area, tends to be shorter --well, a little bit longer, but not as long as the acute plus the LTCH. So, a little bit longer and then perhaps on to a SNF.

DR. CHERNEW: This is either a clarification or a clarifying question, and we'll figure out which in a second.

[Laughter.]

DR. CHERNEW: On Slide 2, when you say mean payment per case, the $39,500, that's only the amount that went to the LTCH. It doesn't include the preceding hospital stay --

MS. KELLEY: That's exactly right.

DR. CHERNEW: But the hospital stay that they compare it to is just that acute care hospital stay portion.

DR. NERENZ: [Off microphone.]

DR. COOMBS: So, on Table 3, page 17, you know, as I looked through the diagnosis of what's common, it appears that, if you were to lump these into --and this is important, I think --into respiratory, kind of pulmonary, vent management support, that the preponderance of these diagnoses fall somewhere within that. And then there could be another lumper into the post-septic shock, circulatory failure, cardiac as it relates to that.

So, these patients are really at high morbidity, mortality, anyway, even if they stayed in the acute care hospital, and I think LTCHs are needed for these very types of patients. Even though the mortality is very high, it doesn't argue the fact that --I mean, there is also --there should be end-of-life discussion, but there are some things in which if a patient stayed in an ICU are worse in an acute care hospital, and those things include the nosocomial pneumonias and all of the hospital-acquired infections and also the effect on workforce in terms of throughput and how that impacts other beneficiaries.

I support the recommendations, but I do want us to just be cognizant of the fact that there are dynamics that

go beyond just LTCH versus acute care hospital, because sometimes on the surface, we don't appreciate as much. But the diagnoses here are really impressive in terms of the severity of illness, and I think it's very hard sometimes to kind of tease out what severity of illness just based on DRG diagnosis alone.

MS. KELLEY: Sure. I guess I just have two responses to that. The first is that I was interested in that, as well, and we took a look back at ventilator patients in the LTCH and what their preceding use of ICU stay was during their IPPS stays, and it's actually a very high share of them had eight or more days already. So, even in the current environment, which of course, would encourage an acute care hospital to move these patients as quickly as possible to an LTCH if one were available, they're still staying for fairly long stays in the ICU.

The other thing I would just point out is that because of the geographic distribution of these facilities, I think you're right that in some communities they are a very important part of the current structure of care. But in other communities, they're clearly not, and these patients are being cared for in other settings or in

specialized settings in the acute care hospital.

DR. COOMBS: Thank you for that information regarding backtracking and looking at, well, how long did these patients need to be in the ICU, because that's really important. Thank you.

MR. GRADISON: I support the recommendation.

MR. GEORGE MILLER: Yes, I support the recommendation. I do have a question about the mortality rates, though. Do we have the opportunity to compare the rates here with those hospitals in similar cases and those states that had no LTCHs whatsoever? And is there a difference?

MS. KELLEY: We don't have any way to risk adjust, and so I think those comparisons would be difficult to interpret.

MR. GEORGE MILLER: I got it. Okay.

DR. CHRISTIANSON: I support the recommendations.

DR. HOADLEY: Yeah, I support the recommendation as well, and I just, you know, as several people have asked, it's really frustrating that we don't have this ability to figure out how to risk adjust enough to really do comparable patients, because trying to understand the difference

between those communities with these facilities and those without or some of the other variants on these questions would really help us understand the role that they play. And as Rita's question raised, I mean, it is clear from some interviews I did a few years back that, you know, the presence or absence of an LTCH does influence the likelihood the doctors have those kinds of end-of-life discussions.

So, you know, just analytically, it's just frustrating that we can't figure out a way to do it, but I get it. I mean, it's clearly not easy to do.

MR. ARMSTRONG: Just to clarify for a moment what the recommendations end up looking like in terms of projected margin or net increase to the payment rate, because there are a lot of moving parts here. So my understanding is that the recommendation generally gets us to something just under a 1 percent increase to the payments? I'm sorry. The update otherwise would have resulted in something just less than a 1 percent increase?

MS. KELLEY: That's right.

MR. ARMSTRONG: Okay. And that's before taking into consideration the discussion we had earlier with respect to the hospital acute care services?

MS. KELLEY: Right. That's right.

MR. ARMSTRONG: And so do we have a sense for -- I just lost track -- of what the impact on the payment would be, just from the previous recommendation, setting aside this recommendation, to LTCHs?

DR. MARK MILLER: What I would say if I had to answer that --

MR. HACKBARTH: You do.

DR. MARK MILLER: I know. I figured. And I got the look from Dana that said, "This is yours. You'll be leading this one off."

So there's two ways to think about it. First of all, just to make a separation in your mind, if you go back to the conversation of this morning, you know, we should be all crystal clear. I'm going to use round numbers, Dana. You know, $5 billion plus in LTCH spending, and we're going to take a portion of that spending, we're going to put it over in the outlier. If there was no behavioral response on the part of the LTCHs, they didn't change their patterns of patients, which patients they took, and they didn't change their cost structure at all, then their margins are going to plummet. But when you think about that proposal, what

you're thinking is they're going to change their behavior and they're going to do it in one of two ways. They're either going to start focusing on CCI cases where they have an equal opportunity to be profitable -- and keep that in mind because I'm going to bring that back over in this conversation -- or they're going to figure out that they still want to do the other cases and they're more efficient than standard acute-care hospitals and they stay in that game. And we've heard both as we've talked -- a lot of yelling, but we've heard both.

MR. HACKBARTH: And on that second point, you know, part of our proposal would be to eliminate the 25-day requirement on the non-CCI cases. So they would have more flexibility in terms of how they care for the non-CCI cases.

DR. MARK MILLER: So in a sense, a bloc of dollars moves -- make no mistake about it. We tried to lay that out really clearly, and if there was no response on the part of the industry, which would be highly unusual, then their margins would plummet. Put a pin in that. Step over to this side. For whatever -- we're today talking about the current law system, because this is 2015. Given all that information, we're saying their costs and all the rest of

it, zero update, as for you to consider.

And then the other way to think about it, if you really want to force the discussion back together, is to say for those cases that would still be under the LTCH system, this would be the update. But I want to be really clear in that sentence. We're talking about a 2016 change for that.

MR. ARMSTRONG: Oh.

DR. MARK MILLER: This discussion is a 2015 change, and it would still be current law. So I don't want to put you off from thinking about those things together, but at least in a year-by-year basis you don't have to shove them together, if I'm following what's going on here.

MR. HACKBARTH: And just to add one more variable to this, if we were to decide on the LTCH payment change that we discussed this morning, to have a transition, that, too, would obviously affect the bottom line financial performance.

MR. ARMSTRONG: Thank you. That answered my question. It was really help just to kind of put this into perspective. And I would say I'm supportive of the direction the recommendation is taking us in. Frankly, part of my question was whether this goes far enough, I mean

whether this is still paying on a per unit of service basis at a rate that's higher than we should be paying. And so that's why I was trying to think about how these other pieces fit together. But having heard all of that, I think this is getting pretty close.

MR. GEORGE MILLER: Could I just point out, just to frame it, though, it still includes the question for all the Medicare patients, and this one is the heavily dominated Medicare user.

MR. ARMSTRONG: I completely understand this does not reflect the effect of sequestration.

MR. GEORGE MILLER: Right.

DR. NAYLOR: I also support the general direction of the recommendation and wanted to echo earlier comments about the really important opportunity here to think about introduction of palliative care or substitution of palliative care, hospice services, and then thought about -- to build a little bit on David's comments about apples and apples, have we looked at something like the DRG 207 ventilator support plus for 96 hours, acute plus post acute, acute long-term care, acute equal amount of home care or SNF or hospice?

MS. KELLEY: We have not done that analysis. My concern about doing it would still come back to an ability to risk adjust well. The patients who end up in DRG 209 in an LTCH may have started out at a different DRG when they were in the acute-care hospital. So if I were to compare the DRG 209 patients in the LTCH with patients who had that same DRG assignment in the acute-care hospital but never went to the LTCH, they might not be the same patient. Some of the 209 patients had a major bowel procedure that went terribly badly, and they ended up on a ventilator. Their IPPS assignment is going to be the major bowel procedure. But when they get to the LTCH, then they'll be in 209. That 209 patient may really be different from the patient who entered the acute-care hospital and got a principal diagnosis of 209.

DR. NAYLOR: A way to make them comparable is to select people whose diagnosis in the acute-care hospital was respiratory system failure, on ventilator.

MS. KELLEY: Mm-hmm.

DR. NAYLOR: In other words, we're talking then about the episode, so it's not -- I do appreciate exactly what you're saying, but, I mean --

MS. KELLEY: It might be interesting, though, to look.

DR. BAICKER: Just a follow-up suggestion on that, I don't think that this is important for understanding the import of the recommendation, but if we wanted to drill down a little more, you could use the variation across areas in the propensity of admitting people to LTCHs versus areas where there aren't LTCHs so they aren't used at all. So you could map the group of people who are forecast to have high likelihood to go into an LTCH in an area where the LTCH is used a lot, take that whole group and compare them to a group of people who would have the similar characteristics but in an area where there isn't an LTCH, or in an area where there's less likelihood of an LTCH. So use as a source of variation the variation across areas and propensity to admit to the LTCH. That's an intellectually interesting thing. I don't think it's, you know, something needs to get done this week.

DR. NAYLOR: I don't think it needs to get done this week either, but I think it's more than intellectually interesting. I think if we're going to try to grab hold of what an experience could be and should be for medically

complex, chronically ill people, understanding the variations and options and how they result, I mean, we're going to get data from LTCHs. I understand quality data has started to be submitted, et cetera. So we're going to be able then to do a little bit more mapping, and this I think could very much help our conversations on these --.

MS. KELLEY: I just don't want to get your hopes too high on the quality data, because we still will not have patient assessment data. So we'll know some of their outcomes, and we'll know infection rates and pressure sores, things like that. But we won't have any information on other patient characteristics that definitely impact outcomes of care, and so --

DR. NAYLOR: Hopes are dashed.

MS. KELLEY: Yes. I'm sorry.

MS. UCCELLO: Well, it wasn't for this week, right? Next week.

[Laughter.]

MS. UCCELLO: I support the recommendation.

MR. KUHN: I, too, am generally supportive of the recommendation, although I am looking forward to see how we continue to develop the recommendation from this morning,

because I want to understand the transitions and hopefully some of the interactions here as we go forward, so that will be important to me.

And then one other thing that I just want to be real clear about, that if maybe in this chapter or the chapter that we talked about this morning, is that regardless of these changes, whether we make the changes this morning, or regardless of these changes, this should not stop the continued forward movement on a better assessment of these patients. And so whether it's the CARE tool or some other assessment tool, we shouldn't sit back and say, hey, we've made our recommendations, we're done. That work needs to continue, and that needs to be really critical as we go forward.

DR. MARK MILLER: So just a little commercial. Skip one session, then the SNF session comes, and that is discussed in there. And we have a draft recommendation on it. So nice setup.

MR. BUTLER: So I, too, support the recommendation, and now that we're on to using all this excess time that the staff has --

[Laughter.]

MR. BUTLER: I was thinking about this geographic variation, too, and it seems that we showed them with the dots on the map, and as I think Bill pointed out, they're east and south, not west and north. If you flip forward to the rehab, it's the same kind of pattern. It looks like places like Louisiana has everything, you know?

So I thought it would be interesting from the supply side to take the institutional beds, say hospital, rehab, LTCH, and SNF, and look at the total capacity per population of all of the institutional beds in a market, and then also the utilization of all of those in a market and see if there were patterns statistically that popped up that maybe the graphs that we show don't -- it would begin to see are there tradeoffs or not that are occurring in what are the institutional beds.

And I know when we look at episodes, we get at some of that, when we look at the post-acute care spending, but this would be a little bit more of the supply-driven look at it in terms of beds and maybe the utilization of those beds for future reference.

MR. HACKBARTH: So now we're building this analysis that would also be interesting to look at.

[Laughter.]

MR. HACKBARTH: In all seriousness, a question I've often had is what do the SNFs look like in places where there aren't LTCHs and what's their cost structure and how does it compare to SNFs in other places. So figure that out, too.

MS. KELLEY: January, is that when --

[Laughter.]

DR. MARK MILLER: No, that was this week.

DR. CHERNEW: I support the recommendation, and I support the general attitude of thinking about this in an episode or bundled way, which I think is common across all of these various suggestions.

MR. HACKBARTH: Okay. What's that, Peter?

MR. BUTLER: Round 3.

MR. HACKBARTH: Round 3. No, we're not doing Round 3 on LTCHs. We are finished with LTCH. Thank you very much, Dana and Julian. And we will now move on to ESRD.

[Pause.]

MS. RAY: Good afternoon. Outpatient dialysis services are used to treat most patients with end-stage

renal disease. In 2012, there were about 370,000 dialysis beneficiaries treated at about 5,800 facilities. Total Medicare spending was about $10.7 billion for dialysis services in 2012.

My presentation is composed of three parts. First, I will summarize the new prospective payment system for dialysis services that began in 2011. Then I will proceed with the adequacy analysis and provide you with information for your assessment of the adequacy of Medicare's payments for dialysis services and the Chairman's draft recommendation for the 2015 payment rate. Lastly, I will discuss several concerns that we continue to have about the new prospective payment system.

MIPPA mandated that CMS modernize the outpatient dialysis payment method. The statute implements a MedPAC recommendation to broaden the dialysis payment bundle. The broader bundle includes dialysis drugs that facilities were paid separately in prior years. The new prospective payment system adjusts for the patient-level adjusters that are listed on this slide.

The new system also includes a low-volume adjustment and an outlier payment policy. In 2012, payment

is linked to quality under the ESRD Quality Incentive Program, the QIP. The QIP affects up to 2 percent of a facility's payments. In 2011, nearly all facilities elected to be paid under the new payment method instead of being paid under the four-year transition.

So let's start our payment adequacy analysis. We will look at the factors listed on this slide.

We look at beneficiaries' access to care by examining the industry's capacity to furnish care. Between 2010 and 2012, growth in dialysis treatment stations and facilities matched beneficiary growth. In 2011, the latest year we have closure information, the roughly 70 facilities that closed were smaller, more likely to be hospital based, and nonprofit. Few beneficiaries -- about 1 percent -- were affected by these closures. Affected patients received care at other facilities. There are few differences in the characteristics of patients treated at closed facilities compared to all facilities.

Another indicator of access to care is the growth in the volume of services. We track volume growth by assessing trends in the number of dialysis fee-for-service treatments and dialysis beneficiaries. As you see from this

chart, the two measures closely track between 2010 and 2012.

We also look at volume changes by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs accounted for about one-third of Medicare's payments to facilities in 2010, the last year Medicare paid separately for them. Now that dialysis drugs are in the payment bundle, providers' incentive to furnish them, in particular ESAs, has changed. Our findings are consistent with GAO and CMS. Between 2007 and 2012, ESA dose per treatment declined by 45 percent; the dose per treatment of the top 12 drugs declined by 39 percent.

Next, we look at quality by examining changes between 2010, the year prior to the new prospective payment system, and June 2013. CMS is the source of these data. Mortality and ED use, while high, have remained steady. Hospital admissions during this time period are declining. Home dialysis is associated with improved quality of life and patient satisfaction. During this time period, the percent of dialysis beneficiaries using home dialysis has modestly increased from a monthly average of 8 percent in 2010 to 10 percent in the first six months of 2013.

As we just discussed, under the new PPS, use of

ESAs, which are used to manage anemia, has declined. The reduction is good for clinical reasons. The cumulative proportion of beneficiaries experiencing negative cardiovascular outcomes associated with ESA use continues to decline. As expected, hemoglobin levels have declined. Of concern is the modest increase in the percent of dialysis beneficiaries receiving a blood transfusion from a monthly average of 2.7 percent in 2010 to 3.3 percent in 2013. I'll come back to address this issue at the end of the presentation.

Regarding access to capital, indicators suggest it is adequate. As described in your briefing materials, an increasing number of facilities are for-profit and free-standing. Also as described in your briefing materials, private capital appears to be available for both the large and smaller-sized chains.

Moving to our analysis of payments and costs, in 2012 the Medicare margin is nearly 4 percent. The Medicare margin is higher for the two large dialysis organizations that account for roughly 70 percent of all spending compared to other facilities.

The aggregate Medicare margin for rural

facilities, which account for about 15 percent of total spending, is 0. The lower Medicare margin for rural facilities is related to facility capacity and treatment volume. Rural facilities are on average smaller than urban facilities. And as presented on this table, the Medicare margin is related to total treatment volume; the margin increases as total treatments increase.

The 2014 projected Medicare margin is 2.9 percent. This margin reflects statutory updates in 2013 and 2014. It includes the estimated reduction due to the ESRD QIP. It also includes policy changes implemented by CMS that result in increasing payments in 2013 and 2014. Finally, it includes the 3.3 percent rebase of the base payment rate in 2014. And, finally, if the sequester is in effect in 2014, the margin would be about two points less.

So regarding the rebasing, recall that the use of dialysis drugs has declined under the new prospective payment system. The law requires the Secretary to rebase the dialysis base payment rate by the reduction in per patient drug use between 2007 and 2012. CMS will phase in the rebasing, beginning in 2014, over a three- to four-year period. For 2014 and 2015, CMS intends to offset the

rebasing amount with the payment update and other positive factors so the overall impact will be 0 percent compared to the previous year's payments.

Other policy changes to occur in 2015 include the statutory update of the base payment rate of 2.5 percent; the reduction in total payments by 0.17 percent due to the ESRD QIP; and as I just said, in 2015, the rebasing amount is expected to be offset by other positive impacts so its net effect will be 0.

Here is a quick summary of the payment adequacy findings. Access-to-care and access-to-capital indicators are favorable. Quality is improving for some measures. The 2012 Medicare margin is nearly 4 percent.

And here is the Chairman's draft recommendation. It reads: The Congress should eliminate the update to the outpatient dialysis payment rate for calendar year 2015. Regarding rebasing, we think that it should be considered year by year. Costs needs to be looked at broadly, not just for dialysis drugs. Looking at the payment rate year by year accomplishes several goals. It moves the payment system toward greater accuracy, and it protects beneficiary access and gives the Commission the ability to report back

to the Congress on any developing access issues. There is no change to spending relative to current law. We do not anticipate this recommendation impacting beneficiaries. There may be increased financial pressure on some providers, but we do not anticipate that it will impact their willingness or ability to furnish care.

I'd like to shift gears now and discuss three features of the new prospective payment system that may need attention. We have raised these issues in past years. This year the Chairman is asking Commissioners to consider making a draft recommendation on them.

The first issue concerns the design of the low-volume adjustment. For existing facilities as of the end of 2010, CMS does not factor the distance to the next facility for determining the adjustment. In 2012, nearly half of all low-volume facilities were within five miles of another facility. A low-volume adjustment should focus on protecting facilities critical to beneficiary access. The Secretary has the authority to redesign this adjustment by applying a distance requirement to all facilities.

The second issue concerns the change in anemia management and the reduction in the use of ESAs. There are

positives and negatives associated with this change. We are concerned about the incentive to undermanage anemia under the new prospective payment system. Beginning in 2013, the ESRD QIP does not assess anemia undermanagement. The Secretary has the authority to include a measure in the ESRD QIP that assess the outcomes of anemia undertreatment. We envision that such as measure would assess treatment outcomes such as blood transfusions or hospital admissions rather than hemoglobin levels.

The last issue concerns the accuracy of dialysis facilities' cost reports. This sector has experienced a major change under the new prospective payment system. The accuracy of cost reports under the new system has not been examined. The last audit was conducted more than 10 years ago. Prior ESRD audits have found that facilities' allowable costs ranged from 90 to 96 percent of submitted costs. If providers' costs are overstated, then the Medicare margin would be understated. It would be good fiscal management to assess the accuracy of cost reports under the new prospective payment system.

So here is the Chairman's draft recommendation. These are regulatory improvements that the Secretary has the

authority to implement. And I will read it: "The Secretary should redesign the low-volume adjustment to consider a facility's distance to the nearest facility, include a measure in the ESRD Quality Incentive Program that assesses anemia undertreatment, and audit dialysis facilities' cost reports.

The spending implications of this draft recommendation are indeterminate. We largely view this recommendation as budget neutral. For beneficiaries, dialysis access to care and quality may improve. We do not anticipate that it will impact providers' willingness or ability to furnish care.

That concludes my presentation.

MR. HACKBARTH: Thank you, Nancy.

Round 1 clarifying questions?

MS. UCCELLO: I have two questions. The first is I'm just a little confused about the relationship between the rebasing and the update. It doesn't have any spending effect --

MR. HACKBARTH: That shows you're paying attention. If you're not confused, then you're probably not listening.

DR. MARK MILLER: Nice job, Nancy.

[Laughter.]

MS. RAY: Okay. Your question is about the relationship between the rebasing and the update. So the Secretary -- so the law requires -- the law sets a statutory update. So in designing the rebasing amount for 2014, what the Secretary did is set it at the sum of all the positive impacts, and the positive impacts include the statutory update, outlier changes that the Secretary estimated will pump more dollars into the system, as well as other changes.

So the rebasing amount is a negative 3.3 percent, and the positive updates are 3.3 percent, positive 3.3 percent. So the net -- so they cancel each other out.

The Secretary stated that she intends to do the same thing in 2015.

MR. HACKBARTH: So saying the same thing, approaching it from a little different direction, the Secretary and the Congress in the statute are using the term "rebasing" in a little different way than we customarily use it. You know, when we talk about rebasing, we're talking about reducing the prevailing base rate. And the way it's used here and also in the home health provisions is, well,

it's rebasing after the statutory update. So the rates go up, and then they come down, and that counts as rebasing, even for results that are net higher and that increase in the base rate. And that's a little different than we've customarily used it.

So although we don't characterize our draft recommendation as rebasing, rather as a zero update, we get to the same endpoint as the Secretary using the statutory approach.

MS. UCCELLO: That's helpful, both of you. Thank you.

And I might be channeling Mitra here, but in terms of the low-volume facilities and the share of those being within five miles, do we know a breakdown or a percentage of which ones of these are in rural areas versus which ones are in urban areas?

MS. RAY: I can definitely get that to you next time. I'm just double-checking to make sure it's not in the -- but I will definitely bring that to you next time.

MR. GEORGE MILLER: Yes, thank you. Two questions. Slide 10, please. Of the mortality rates here, I assume that's both home and peritoneal dialysis, both of

them. Do we have the mortality rates just for home dialysis separately? And is there a difference in mortality rates?

MS. RAY: I can bring them for the January meeting, but they are only updated -- I believe they're only updated -- it's a different data source, only updated through 2011.

MR. GEORGE MILLER: Okay.

MS. RAY: But, yes, I can show them to you.

MR. GEORGE MILLER: Okay.

MS. RAY: Now, you also have to remember, though, in comparing home dialysis patients to in-center, there is that case mix difference. And so there is some adjustment but maybe not all adjustment.

MR. GEORGE MILLER: Sure, sure. Okay. I'd just be curious. And then on Slide 13, do we know if the two largest dialysis -- I think I read it in the reading, but I just want to be clear. Do they also have equal distribution of or appropriate distribution of sites in rural areas as well? Do they make up this 15 percent? Or any percentage?

MS. RAY: The large dialysis organizations, just because there are so many of them, are in rural areas. The exact percentage I will come back to you with.

MR. GEORGE MILLER: I guess my question, is it the same percentage as the equal distribution of all the other sites comparing those two?

MS. RAY: That's a very good question. I will come back to you with that.

MR. GEORGE MILLER: Thank you.

DR. MARK MILLER: Nancy, I'm keeping a list of questions, so if you just want to focus on what they're saying, I'm getting everything else. Okay?

MS. RAY: Okay.

DR. MARK MILLER: I see you scribbling. Just focus on what they're saying. I got it.

MR. HACKBARTH: I have Jack, Alice, and Jon still with clarifying questions. Anybody else?

DR. HOADLEY: My question was essentially Cori's question, but the additional piece that I was going to ask was because of the reduction of the rebasing is phased in over a three- to four-year period -- this is on Slide 15 -- is there a sense that there's something left in like 2016 or '17 if they go four years that will be more negative? Or is there some way to say what's going to happen further down the road?

DR. MARK MILLER: If you are asking in a margin sense, we don't -- or haven't, in any case, projected beyond 2014. And I think the other part of our answer would be if we looked at net costs and we were approaching, you know, a point that concerned the Commission, without saying what that point is, we would be saying don't go further if that was the collective judgment.

For the purposes of this conversation, out to 2015, we're pretty much in the same place they are, CMS, in the rebasing, just by different routes. Does that --

DR. HOADLEY: I guess what I'm trying to figure out is in this way that they're limiting the effect of the rebasing the first two years is there's a big lump left over.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: Oh, I see.

MR. HACKBARTH: So the statute says that the Secretary's objective in rebasing is to make up for the fall in drug use --

DR. HOADLEY: Right.

MR. HACKBARTH: -- between 2007 and 2012, I think it is. And so that's X percent, so many dollars.

DR. HOADLEY: Right.

MR. HACKBARTH: And I think what Jack is asking, if the first two years they take the approach that we've described, basically offset the update with the rebasing calculation, how much is that going to leave for the last year for them to recapture in order to hit the statutory target?

DR. HOADLEY: So would there suddenly be a 10 percent cut --

MR. HACKBARTH: Right.

DR. HOADLEY: -- at some point because they've limited what they do in the first two years, say? Or maybe we just don't know.

MS. RAY: I think we just don't know at this point what's going to happen in 2016 -- so you're talking about what's going to happen in 2016 and 2017, if it's a four-year phase-in.

MR. HACKBARTH: Yes.

MS. RAY: I mean, what I can tell you is that the drug offset for 2014 was $8 and change. The full drug offset amount is $29 and change.

DR. HOADLEY: That's about a fourth, roughly, of

some --

MS. RAY: Right.

DR. MARK MILLER: Yeah, that's kind of the way I was --

DR. HOADLEY: Okay. That's helpful.

DR. MARK MILLER: It sort of goes in even increments over the four years.

MR. HACKBARTH: Yeah, that's what we were looking for.

DR. HOADLEY: That does it.

MR. HACKBARTH: So, Rita, was it on this particular point?

DR. REDBERG: It was. I don't remember the details now, but there was an article in the Times, which I didn't see in here, that I thought was about the rebasing because there was some discussion over whether the money was going to go back to CMS and DaVita was lobbying to have it get redistributed back to the dialysis centers because the drop has been more than predicted. Does that sound familiar? I'll have to find the --

MR. HACKBARTH: Yeah, it does ring a bell for me. So we'll look into that.

DR. COOMBS: Thank you very much. I really enjoyed reading this chapter. On page 36, Appendix A,

MS. RAY: [Off microphone.]

[Laughter.]

DR. COOMBS: Well, I couldn't help but think about the clinical indicators that have been included here and outcome-like measures. And one of the areas that I noticed is the area of renal transplant in African Americans as well as percent of prevalent dialysis patients waiting for a kidney transplant in both of those blocks. And I'm just kind of curious. Are they able to confirm that the wait list -- the time that you spend on the wait list for African Americans seems to be proportionately longer for whatever reasons, just to look at why -- is this something with shared decisionmaking or is it something that we know as a true -- we've talked about this as a health care disparity in the past, that African Americans don't get kidney transplants as often as other races.

MS. RAY: Right, and we have discussed and written about this in the past. Access to kidney transplantation is multifaceted, and I know -- well, it -- many different factors affect it, starting with patients knowing that it is

a treatment option, so being informed about the treatment option from their nephrologist, from their dialysis facility, and understanding the information, so that is where shared decisionmaking would be an important role.

For those patients that do get on a transplant wait list, then they're of the transplant center, and their policies and who they -- you know, at some point they have their own factors in deciding, in making decisions regarding kidney transplants. And there are lots of different factors involved there, including socioeconomic status, including -- I just read a recent article about if you're unemployed, you're less likely to get on the kidney transplant wait list, and even if you do get on, you're still less likely to get a kidney transplant wait list.

Of course, there are the biological factors, and I think that's -- and this is where I'm speaking completely over my head, where it may affect rates of transplant for certain groups. And then, of course, there are differences between donation rates, live donation rates, and those do tend to be -- the last time I looked at those numbers, they tend to be lower among African Americans.

So it's multifaceted. Yes, outpatient dialysis

facilities have a role, but lots of other players also have a role, is I think the bottom-line message.

MR. HACKBARTH: So I say this with admiration, Alice. You've become very skilled at Round 1 question --

MR. GEORGE MILLER: Yeah, that was a Round 2 --

MR. HACKBARTH: -- based on a table that raises big issues.

[Laughter.]

MR. GEORGE MILLER: She went down my Round 2. I'll wait until Round 2. She teed it up for me.

MR. HACKBARTH: Okay.

MR. GEORGE MILLER: She teed

DR. CHRISTIANSON: Just a couple quick questions, Nancy. If you could go back to Slide 10? So the last bullet point, I guess I would characterize that as maybe not so modest. A 20 percent increase in a three- or four-year period seems something to think about. What I was wondering is were we seeing similar increases prior to 2010. Has this just been a general big trend upward?

MS. RAY: Between 2000 and 2009, it's been relatively constant. So this decline is since 2010.

DR. CHRISTIANSON: Well, it's an increase in home

dialysis.

MS. RAY: Yeah. Oh, I'm sorry. That's what I meant to say. Yes.

DR. CHRISTIANSON: Is that triggered by something?

MS. RAY: I mean, again, you started seeing this increase beginning in 2010, so that was the year prior to the prospective payment system, but it certainly has continued into the new prospective payment system.

DR. CHRISTIANSON: Yeah, okay.

MS. RAY: The extent to which home dialysis is more profitable for providers, you know, you would think that that rate is only going to go up.

DR. CHRISTIANSON: So my related question then is: That's listed as a dialysis quality measure. Can you talk to me a little bit about home dialysis is higher quality and so you want more people to get it? Or what's the thinking on that as a quality measure?

MS. RAY: Home dialysis, when surveying patients, home dialysis versus in-center patients, home dialysis patients are generally more satisfied with their care.

DR. CHRISTIANSON: So it's a patient experience measure of quality. Okay.

MS. RAY: Yes, yes. And they have a higher quality of life. And they are also more able to work, be employed.

MR. HACKBARTH: It may be helpful just to remind us about how the payment works. So the prospectively determined payment to the dialysis facility is the same whether it's in-center or at home, and the costs may be lower at home, and that's why it could be more profitable and thus increase. Is that what you're saying?

MS. RAY: That is correct. For adults it is the same rate. Yes.

MR. HACKBARTH: Okay. I think we covered all the Round 1 clarifying questions and a Round 2 from Alice. Cori, do you want to go ahead and start Round 2?

MS. UCCELLO: Sure. Assuming I understand the update recommendation correctly, which might be a big assumption, I am supportive of it. In terms of the recommendations on Slide 22, I am inclined to support all of them. Just my one question about the urban-rural thing is just -- well, one thing I'll say about this. In the text, not in the presentation, you actually talked about some facilities that got the adjustment being at the same address

as other -- I mean, that's just crazy. And that will make the newspaper, I'm sure.

[Laughter.]

MS. UCCELLO: So, I mean, this is definitely something we need to make a recommendation on. You know, going back to what five miles is, what is the right mileage and how that may differ, you know, I don't know what the exact answer is, but I think this is the right direction.

In terms of the anemia undertreatment, I think as part of this -- and correct me if I'm wrong -- you know, the issue -- we've raised this in the past about using the hemoglobin, or whatever, and that's not the right way to do it because there's not really a scientific -- a clinical measure here, so that's why we need to look at the blood transfusions or other things, right?

MS. RAY: Right. So when the FDA came out with the revised label for ESAs in 2011, they did not give a floor for the hemoglobin level. So there is no official floor. What the FDA basically -- how I interpreted what the FDA said is give just enough ESA so the patient avoids blood transfusions. So that's why CMS -- CMS had a lower-bound hemoglobin level in the 2012 ESRD QIP, and they removed that

beginning in 2013 because of what the FDA did.

MS. UCCELLO: Okay. So, yes, I am supportive.

DR. NAYLOR: So, I'm going to operate on the same assumption that Cori has, which is that I understand and support the direction of the Chairman in terms of the update and all of the recommendations in terms of improving redesign measurement and audit.

MR. ARMSTRONG: Yeah, same. Nothing more to add. I do support the direction you're heading in.

DR. HOADLEY: Yeah. I support the various recommendations in this chapter. I guess I'm interested in along the lines that -- just being asked about whether the -- how this measure of assessing anemia under-treatments relates to the FDA recommendations and so forth, but to some degree, that's up to the Secretary to figure out, I guess.

DR. CHRISTIANSON: Yeah. I support the payment update recommendation and also the two recommendations here on Slide 22.

MR. GEORGE MILLER: Yes. I support the Chairman's draft recommendation, but I would like the Chairman to consider on the quality measure adding something that links improvement, especially for African Americans and for other

minorities who fall below the threshold, both for the wait lists and transplants. As we talk about trying to bundle payments and bundle quality of care together, I think this should be one of the measures.

African Americans have disproportionately higher use of renal dialysis but yet have the lowest for the -- on the list, and the renal transplant, getting the transplant. While I understand many of the factors -- I understand them -- it may be more difficult, it may be hard, but it still should be an incentive to provide a whole continuum of care and just not do fragmented part of care, and I think this is one of the quality measures that should be certainly considered, to especially improve the dialogue and the education. And there are many reasons why folks don't get them, get to the list. I'm a little concerned about why they don't get to the list, but more importantly, why they don't have -- the lower rate for transplants is a concern. So, I would like for us to design, make a recommendation on quality measures to deal with that very issue.

MR. HACKBARTH: So, Nancy, has this been -- generally speaking, on this and other sectors, we often draw our measures or quality measures from work that others have

done, and that's certainly been true in the ESRD area. Has this been considered as a quality measure by other organizations, and if they haven't adopted it, is it because of the multi-factorial character of it, or what's the status of the history?

MS. RAY: I mean, it certainly is considered -- the information I provide you on kidney transplantation is from the U.S. Renal Data System that tracks outcomes of ESRD patients and, of course, that includes kidney transplantation.

MR. GEORGE MILLER: I appreciate the information.

MS. RAY: CMS has not proposed using such a measure in the ESRD QIP. I would need to go back and double-check with other quality, you know, like the NQF and other quality organizations, and I can report back to you about that.

MR. HACKBARTH: Okay. Thank you. Bill.

MR. GRADISON: I support the package.

MR. HACKBARTH: Alice.

DR. COOMBS: So, it was a year ago, I think, we discussed ambulance and transport of dialysis patients to dialysis units, and I remember when we discussed that, that

that contributed a large portion -- it was a considerable cost. And what I was wondering, and several people around the table said, well, could we bundle transportation services under the general bundle as a whole, and so I don't know if you could add a fourth bullet, but one would be to consider those services that were under the umbrella of getting to dialysis, and maybe -- I don't know if you can include some of the ancillary services like ambulance service.

I was thinking as George was talking that maybe we should include something like shared decision making as it pertains to all of the things with the dialysis patient, including transplantation.

I support the recommendations.

DR. NERENZ: I'm generally supportive, a little nervous, though, and I will commit the error, perhaps, of being too focused on margin. I'd just like to briefly walk through a little calculation.

If you can go to Slide 14, please, on top here, we've got 2014 projection, 2.9 percent, and a number of things in the bullet points feed that. Then sequester takes two percent from that, right, so now we're down to 0.9. And

then we flip to Slide 16, market basket, 2.8, a couple other things go on. If we don't do an update, does that make the projection of margin for 2015 negative, on average?

DR. MARK MILLER: [Off microphone.] I think we can answer this more precisely -- it turns on what the --

MS. RAY: The sequester.

DR. MARK MILLER: Sorry?

MS. RAY: No. You go.

DR. MARK MILLER: Well, the cost growth that we're assuming for the period that he's talking about, which I don't happen to have.

MS. RAY: Right, but -- so your question is, if you do take into account the sequester --

DR. NERENZ: Yes.

MS. RAY: -- what would the margin -- the margin would -- well, the margin would come down about two percentage points in 2014, so that's roughly one percent.

MR. HACKBARTH: So, implicit in Dave's question, I think -- and correct me if I'm wrong, Dave -- is that he was using, in the absence of other information, that costs would grow by the rate of the market basket increase.

DR. NERENZ: Exactly.

MS. RAY: Right.

MR. HACKBARTH: Right.

MS. RAY: Right. Right.

MR. HACKBARTH: And, in fact, that may not be the case, and --

MS. RAY: Right, and if the cost per treatment is less than the increase in the market basket, then the margin will be a little bit higher. Yes.

MR. HACKBARTH: And remind me what the cost growth was this year.

MS. RAY: The cost growth was roughly two percent between --

MR. HACKBARTH: Okay. And what about the year before?

MS. RAY: Between 2011 and 2012.

MR. HACKBARTH: It was two percent.

MS. RAY: Yes.

MR. HACKBARTH: Yeah. Okay.

DR. NERENZ: Okay. And then just the context around this is that Medicare is such a dominant payer for this group as opposed to others that can offset a negative margin elsewhere. That's just -- I'm rolling that all

together and being a little nervous, that's all.

DR. REDBERG: I support the recommendations. They're correct. I was just trying to find -- there was a note somewhere in the chapter about the trend towards earlier dialysis in the U.S. and whether we could in the future incorporate that, because -- I can't find it now, but it's definitely been documented in multiple studies that we have started dialyzing people earlier, and certainly earlier than in other countries, and there has been no benefit in outcomes. Obviously, there's considerable, besides cost, but inconvenience, I mean, decrement in quality of life, and so whether that would be a future quality measure, I think, would be worthy of consideration.

And I also think the trend, the small increase in home dialysis with the benefits on quality of life was very positive and would hope we could encourage that, as well.

DR. HALL: I'm in favor of the recommendations. About 25 percent of the Medicare dialysis population is over age 75 now, and that's probably going to be increasing because the procedure works. It does keep people alive. And it's another example where we really need some concrete measures of function and we need to talk about quality of

life, one of five or six areas we've discussed where we desperately need these scales and I hope that we can keep our eye on what is available and what's in the pipeline.

DR. BAICKER: I'm supportive, and as a side note, I found the figure in the reading and that you showed of the change in use of drugs and number of drugs with the payment reform very striking and telling about how these payment reforms may have real impacts on utilization and not -- improve patient outcomes or not harm them.

DR. CHERNEW: I'm supportive of the recommendations, but I have two questions. The short question is, just it looked like in the chapter that they were doing audits of the cost reports every three to five years or something, until 2001, and then they stopped. Is that basically right?

MS. RAY: Yeah. You know, the BBA required CMS to do some audits, and then there has not been --

DR. CHERNEW: But there were, like, four or five regular audits, like every few years, and then they stopped doing them, like, a decade ago or -- that's what it seemed to me.

MS. RAY: Right. Yes.

DR. CHERNEW: I just -- all right. I just wanted to make it clear that this isn't, like, the first time these cost reports have been ever audited.

The second comment has to do with the quality measures, and this is really a clinical question that I know nothing about. There's different types of quality measures, and some of them look good, in fact, even improving, and others might be a little more concerning. And I'm curious clinically how these types of measures are related.

So, for example, you might think you take someone off of a set of drugs and then you solve some problems and they look better on some quality measures, but other things might happen more common that look like it was getting worse. So I'm not sure, clinically, the extent to which a provider has the ability to move each quality measure sort of individually, or more to the point, if they try and, say, get hemoglobin at a certain level, they risk more of some other complication. I just don't know if that's the case, but I think in other clinical areas, it is.

And so what that means is, or my question is, are there sort of -- can we think of maybe macro measures that think they're doing a good job as opposed to looking at a

whole slew of them and saying, oh, they're doing great on these five but not so good on these ones, so -- because it might be that they're connected in ways clinically that I don't understand.

MS. RAY: Right. I mean, I think your assessment about the different clinical measures being related is correct in this area, although I am not a clinician. You know, the Commission in our comments on the ESRD QIP has advised the Secretary to move towards fewer outcome measures, outcome measures including rates of admission, rates of mortality, and, you know, at least those two measures do capture -- of course, needless to say, lower rates capture higher quality care.

We've also focused on home dialysis measure because of the improvement in patient satisfaction and quality of life, and kidney transplantation.

DR. COOMBS: I just want to say, if you can transplant someone, you've actually eliminated, in terms of the cost, a great deal of cost. The up-front cost is expensive. But, over time, you've actually benefitted the patient both in quality of life and in terms of costs associated with chronic renal failure.

DR. CHERNEW: I understood it to be true. I gather the limitation on transplantation is the limitation in the number of organs you have to actually transplant, so it gets into a whole other set of issues. I was more interested in things like whether or not the reduction in stroke, heart failure, and AMIs could reflect -- if those things were side effects of some other type of treatment, if you got rid of that other type of treatment, you'd get rid of those other things, but there's tradeoffs, and I just -- I think -- I still don't understand, but I understand better.

DR. MARK MILLER: [Off microphone.] Well, I think there is --

DR. REDBERG: I think that was the reduction -- I mean, those were associated with the higher ESA use, so I think with the reduction in ESA, there was a reduction in stroke, heart failure, and --

DR. CHERNEW: [Off microphone.] Exactly. Right. But then hemoglobin levels may have declined. And so it's odd to sort of treat them the same, right, because when you do one thing -- it's hard for us to look at -- these things declined, great. But, oh, hemoglobin declined, as well.

Oh, that's a problem. Now we want -- you know, because they're tied together into how they all behave.

DR. REDBERG: I don't think the hemoglobin going down is a problem. And actually, the increase in blood transfusions, I think, is a problem, because it -- that's very soft and you don't have to transfuse. But I think there's somewhat of -- and I don't know everything behind it, but sometimes there's this reflex to transfuse when you see a lower hemoglobin even though that may not be beneficial for the patient.

DR. CHERNEW: And so talking to Rita about good quality measures is really good.

DR. HALL: So, we should remember that you don't just wake up one morning and say, I think I need end stage renal disease treatment. These people all have very complex comorbidities, principally diabetes, so that by getting to this, to the stage of being dialyzed, you already do have a number of things that would seem to be complications, a high propensity for myocardial infarction for stroke, and that's why it's so hard to develop quality measures.

There's a subset of older dialysis patients that are brought to dialysis units, usually by an ambulance

staffed for space travel in terms of the technology in the ambulance, who really don't know where they are, who wouldn't be able to recognize that they'd been dialyzed, and go back without much in the way of cognitive function. So, there are all kinds of issues here and that's, I guess, why I made an appeal that we need to have other kinds of measures to really assess what we're doing as this population ages.

MR. HACKBARTH: And I think that this dialogue is a good illustration of why MedPAC should not be in the business of specifying quality measures. It really is a field for expert. I feel comfortable when we make general directional statements like, you know, so far as possible, we ought to be using outcomes as opposed to process, things like that. But actually developing a clinically sensible set of measures is way beyond our expertise.

DR. CHERNEW: I agree completely with that, at least my and your expertise. But I do think because quality is one of our criteria, knowing how to interpret the quality measures that are put in front of us actually does become important.

MR. BUTLER: I support the recommendations.

MR. KUHN: I support the recommendations, but I just have one additional question on this quality measure recommendation. So, during the presentation, you talked about the ESAs and the 45 percent drop we've seen, which is a good thing, because as a result of that, as you mentioned, a decrease in heart failure, stroke, and AMI. At the same time, we're seeing a bit of an uptick in transfusions, you said, from 2.7 to 3.3 percent. So, on that level of transfusion, is that, basically, are we in a lower bound, mid-point, high range in terms of concern, or kind of where are we in that space right now? Any sense of that?

DR. MARK MILLER: If I were asked that question, and fortunately, it's Nancy, so I don't have to answer --

[Laughter.]

DR. MARK MILLER: -- I'm a little bit unclear. And we saw an uptick and it was coincident with the move to the PPS and the drop in the ESAs --

MR. KUHN: Right.

DR. MARK MILLER: -- and so -- and for the things that you said, so we're concerned. On the other hand, it's a fairly low frequency.

MR. KUHN: Right.

DR. MARK MILLER: When we were having conversations with -- and this relates to the whole conversation that you've been having on the quality stuff -- we were talking to CMS and we were saying, you know, we're concerned about this under-management of anemia, but we recognize clinically the notion of getting to hemoglobin-level types of measures, or hematocrit or whatever the right thing is, is probably not easy to do, and they were saying, yes, it's not easy to do and so please don't ask us to do it.

And then we said, well, are there other measures that by proxy you could say, okay, I'm confident that you must be doing a good job because you're not hitting the hospital or your mortality rate, and we said, what about the transfusion rate? And they said, again, because it's so low and infrequent, it's a pretty noisy measure to use. And that's where the conversations stand at this point.

And so, yeah, there's some concern because it's an uptick and it does seem related to what's going on, but exactly how much urgency and what is happening given things like Rita is saying, I think it's hard for me to say.

MR. KUHN: Yeah. And, you know, I, too, have been

kind of watching this somewhat from afar because I do know about the label change in 2011, and so that makes it even a little bit more difficult here as we go forward.

But I think the one thing I like about this particular recommendation, because I know CMS now has an active claims surveillance program that's very sophisticated, to the point where they can almost get real time information on kind of what's going on, so with that kind of system in place, if they came in with some better ways to assess, the actions that they can take are so much more quick. They don't have to wait a year, 18 months for that data. They're almost getting it real time, I think as close as four to six weeks when it's coming in. So I think this is a very good recommendation and could be very helpful for the care for these patients.

MR. HACKBARTH: Okay. Thank you, Nancy. Well done.

We will now turn to skilled nursing facility payment.

[Pause.]

MR. CHRISTMAN: Okay. Next we are going to talk about PAC reform. This presentation builds on a discussion

we had last month about better data for reforming PAC payments.

For many years, the Commission and others have been concerned about the multiple PAC payment silos in Medicare. The BBA established separate PPSs for the four PAC providers, and there has been concern that these separate systems have discouraged coordination across silos and led to inefficient payment.

These separate silos exist even though these providers often overlap in the services they provide and the patients they serve. Medicare payments for similar patients can vary significantly between settings because each setting has its own approach to setting base rates and measuring patient case mix.

Medicare's current approach to collecting patient assessment data is siloed. It mandates unique assessment tools for the SNF, IRF, and home health and does not collect patient assessment information from LTCHs. The silos' use of dissimilar data makes it difficult to compare patient severity and quality.

The lack of common data makes it difficult to compare the resource use and outcomes across the silos. For

many years, the Commission and others have sought to consolidate some or all of the PAC silos and do a more uniform system of payment, but the current use of multiple assessment approaches makes it difficult.

MedPAC and others have desired a unified assessment tool for some time, but progress towards this goal has been sluggish. In 1999, the Commission recommended the Secretary select a core set of patient assessment information across all PAC settings. We have reiterated the need for this data at many meetings and annual reports since then. The Deficit Reduction Act of 2005 required the Secretary to conduct a demonstration to develop and test a tool. CMS successfully developed, validated, and tested a uniform tool, the Continuity Assessment Record and Evaluation, or CARE, tool in the PAC PRD demonstration. CMS completed the demonstration in 2011 but has not yet announced plans for replacing the current PAC assessments, the common tool.

The results of the CARE demonstration suggested that a cross-sector assessment tool could reliably measure patient severity across settings. The CARE tool developed and fielded for this demo was tested in each of the four PAC

settings and inpatient hospitals. The evaluation of the statistical reliability of the CARE assessments, such as inter-rater reliability and cross-sector reliability, indicated that the data collected were comparable to current assessment instruments in their accuracy.

The demonstration also found that the CARE data on patient severity could be used to measure resource use and compare outcomes across the sectors. The evaluation of quality suggested that the sites achieved similar outcomes when they served similar patients. There was little difference among the settings in the rate of readmissions, and the average functional gains were also comparable.

The results of the CARE demo suggest several elements that a common assessment instrument should include to facilitate cross-sector analysis. The chart on this table highlights the assessment items that proved useful for comparing resource use and outcomes and would be good candidates to include.

Most of these items are collected on the current siloed assessment tools but not in a standardized way. Standardized items from CARE or similar assessment tool with demonstrated utility of cross-sector assessment could be

phased in to the current tools, replacing similar items over time. Not all would necessarily have to be added at once, and if it minimized the burden, they could start with the items that had the greatest statistical power for risk adjustment, and additional items could be added over time.

CMS completed the CARE demo over two years ago, and currently they have two announced follow-on projects. The first will evaluate the use of CARE assessment items in place of the siloed assessment items currently used in the PAC PPSs. Second, it has a project underway to develop CARE-based functional measures for IRFs and LTCHs. However, CMS has not announced a timeline for implementing a common assessment tool.

This lack of a path forward for fielding a common assessment tool is troublesome because many PAC reforms would benefit from better comparative data. A common patient assessment tool would permit a better understanding of cost and outcomes across settings, allowing us to better understand the overlaps that are suggested by existing patterns of utilization. This information would be valuable for beneficiaries in the program. It could be used to guide beneficiaries and physicians when selecting the PAC site of

care.

In addition, having a common assessment tool would leave Medicare better prepared in the future to develop and implement a refined PAC PPS that combines at least some of the existing PAC PPSs into a single system.

The CARE demonstration suggested that a common approach to patient assessment is possible in PAC and that a more unified system of payment may be feasible. However, there is no clear plan for moving forward with a common instrument that would enable these further reforms.

For these reasons, the Chairman has offered a draft recommendation for your consideration that would set a deadline to begin implementation. The draft recommendation reads: The Commission should direct the Secretary to implement a common assessment tool for use in home health agencies, skilled nursing facilities, inpatient rehabilitation hospitals, and long-term care hospitals by 2016.

The recommendation would set 2016 as the deadline, but the changes to the assessments could be phased in over time. CMS could start by adding common assessment items as a supplement to the existing tools in 2016. In 2017, they

would retire the items on the original assessment form that cover the same domains as the new common assessment items and use the new common assessment items in the existing payment system when necessary.

Through 2019, CMS could continue to replace each silo's unique assessment items with common assessment items, eventually establishing a single common tool for the four PAC silos.

The spending implications are that there will be administrative costs in the short term as Medicare develops and fields the new common assessment items. These costs may be lower in the long run if CMS is successful in reducing the number of silo-unique assessments it has to maintain. Beneficiaries will have better information about the quality of providers and for selecting the side of PAC care. Providers will have better data to improve care transitions and tie outcomes to core processes, and providers may incur costs to implement the new tools and train staff.

This completes my presentation, and now Carol will talk about SNFs.

DR. CARTER: Before I get started, I wanted to thank Lauren Metayer for her help with the Medicaid section

of this chapter.

I'll start with an overview of the industry and then present information related to the update and end with a summary of the Medicaid trends we are required to report.

Let me start with a brief sketch of the industry. There are just under 15,000 providers. About 1.7 million or about 4.5 percent of fee-for-service beneficiaries use SNFs. Program spending in 2012 was just under $29 billion. And Medicare makes up about 12 percent of days but 23 percent of revenues.

We'll be using our standard update framework to work through the adequacy of Medicare's payments. I'll be going through this material quickly, but there is more detail in the chapter.

Access is adequate and stable. Supply has been steady between 2011 and 2012. Three-quarters of beneficiaries live in counties with at least five SNFs, and the majority live in counties with ten or more. Bed days available increased slightly, and occupancy rates were unchanged from 2011 to '12 at 87 percent.

Between 2011 and 2012, covered admissions and days declined, paralleling the decline in inpatient hospital

stays, which is a prerequisite for covered SNF care. Because the decline in days was smaller than the decline in admissions, the length of increased slightly.

Turning to quality, before I go through these trends, I want to point out that we revised our rehospitalization measure this year to better reflect Commission conversations about defining readmissions that are potentially avoidable. The details of these refinements are in the paper.

The risk-adjusted rates of discharge back to the community and potentially avoidable rehospitalization show small improvement between 2011 and 2012. The community discharge rate increased from 29 percent to 30.8 percent in 2012.

We looked separately at rehospitalization rates during the SNF stay and during the 30 days after discharge, and both declined slightly. Combined, the potentially avoidable rehospitalizations declined from 14.7 percent in 2011 to 14 percent in 2012. These declines are likely to reflect a focus by both hospitals and SNFs to lower their readmissions.

This year we worked with a contractor to develop

measures of the changes in functional status of beneficiaries treated in SNFs. We developed two composite measures: the average share of a SNF's stays with improvement across three measures of mobility and the average share of stays with no declines in mobility, given a beneficiary's functional status at admission and how much improvement they would be expected to make. In looking at risk-adjusted rates between 2011 and 2012, we found essentially no change in either measure. Although the average SNF share of stays with improvement did not change, they were successful at preventing declines in functional status.

We also found large variation in all of the risk-adjusted quality measures, and here I have listed the 25th and 75th percentiles for three measures. The amount of variation represents large opportunities to improve beneficiary care, realize program savings, and increase the value of the program's purchases. There were not consistent patterns and quality by type of facility or location, but nonprofits had better rates of quality across all five measures.

In terms of access to capital, industry analysts

report that capital is generally available and expected to continue for 2014. Some lenders are reluctant to lend to nursing homes, but this reflects uncertainties about the federal budget, not the level of Medicare's payments.

In 2012, the average margin for free-standing facilities was 13.8 percent. This was the 13th year in a row that the average was above 10 percent. Across facilities, margins vary more than four-fold. One-quarter of SNFs had margins of 4.8 percent or lower, and one-quarter had margins of at least 23 percent. There continue to be large differences between nonprofit and for-profit facilities, with nonprofits having considerably lower margins than their for-profit counterparts. Compared to SNFs in the lowest quartile of margins, SNFs in the highest quartile had considerably lower cost per day after adjusting for differences in wages and case mix, and they had higher payments per day, in part reflecting their provision of more intensive therapy.

Hospital-based SNFs, which make up 5 percent of the industry, continue to have very negative margins -- negative 62 percent). However, hospital-based units contribute to the bottom line of hospitals, allowing them to

lower their inpatient lengths of stay. Prior work we've done found that hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs.

We estimated the 2014 margin for free-standing SNFs to be 12 percent. We assumed that costs grew at the market basket, revenues would increase at the market basket minus productivity, and we accounted for changes in bad debt policy, as required by law. If the sequester is in effect, the margin would be about two points lower.

Each year we look at efficient providers, using three years' performance to identify SNFs with relatively low cost and high quality. And we use a very similar definition that Jeff walked through with the hospitals this morning. We found 11 percent of SNFs were relatively efficient. Compared to the average, they had costs that were 3 percent lower, community discharge rates that were 16 percent higher, and rehospitalization rates that were 11 percent lower, yet they still had average Medicare margins of 17 percent.

In 2012, the Commission made a two-part recommendation. For the update year, you recommended that

the PPS be revised, with no update. Then in the second year, payments would be lowered by an initial 4 percent, with subsequent reductions made during a transition until payments were more closely aligned to costs. For those of you who were not here, I want to explain the logic of that recommendation.

With margins so high for so long, the Commission believed that Medicare payments needed to be lowered. However, we also knew that margins varied widely and reflected systematic shortcomings with the PPS. More importantly, payments are driven by the amount of therapy furnished, and payments are not targeted to patients with high non-therapy ancillary costs, such as drugs. In addition the PPS does not have an outlier policy. The Commission believed that before rebasing began, the PPS needed to be revised to correct these biases. The Commission first recommended revising the PPS in 2008.

Without raising total spending, the design would shift payments within the industry. We estimated payments would decrease 10 percent for SNFs that furnish a lot of intensive therapy and would increase 17 to 18 percent for SNFs that treat a high share of medically complex patients.

Based on a facility's mix of cases and their therapy practices, payments would shift from free-standing SNFs to hospital-based facilities and from for-profit to nonprofit facilities -- that is, from the highest margin providers to lowest margin providers.

The second part of the recommendation stated that payments would be rebased, beginning with a 4 percent reduction. The Commission reviewed many pieces of evidence that supported this reduction.

First, the average Medicare margins for SNFs has been above 10 percent since 2000. The variation in margins is related to the amount of therapy and cost per day, not differences in -- other differences in patient mix. Large cost differences remain after controlling for wages, case mix, and beneficiary demographics. Our analysis of efficient providers shows that it is possible to furnish relatively low-cost, high-quality care.

In addition, we compared fee-for-service payments to MA payments for four publicly traded companies and found that fee-for-service payments average 25 percent higher. We compared the average age, risk scores, and beneficiaries' ability to perform activities of daily living between MA

enrollees and fee-for-service beneficiaries and found small differences that are unlikely to explain the differences in payments.

Last, the industry has responded to the level of payments in two ways over time. First, since 2001, cost growth has outpaced the market basket every year except for 2012. And, second, when payments were lowered, the industry shifted the mix of days and therapy modalities that increased their revenues or dampened the impact of the reductions.

The payment adequacy factors indicate that the SNF landscape has not changed during the past year. The Chairman proposes to rerun the recommendation with a discussion about why these changes are still needed. For 2015, this would provide a zero update while the PPS was revised, and in 2016, rebasing would begin with a 4 percent reduction in payments.

As required by PPACA, we examine Medicaid trends in spending, utilization, and financial performance for nursing homes. About 15,000 facilities participated in Medicaid, and that was a small decrease from 2012. Between 2009 and 2010, the most recent year of data, the number of

users decreased slightly to 1.5 million. Spending is estimated to be $51 billion in 2013, and that's a 5 percent increase from 2012. The non-Medicare margin for 2012 was negative 2 percent, and the total margin was 1.8 percent. Both of these declined from 2011, reflecting Medicaid rate freezes in some states, reductions in some states, Medicaid reductions in some states, the shifts in enrollment in Medicare from fee-for-service to MA and the associated lower payments; and in the case of total margins, the corrections and the lowering of Medicare's rates in 2012.

The industry consistently posits that facilities lose money on Medicaid and they need the high payments from Medicare to be viable. Using Medicare payments to subsidize Medicaid payments is poor policy for a number of reasons. First, it does not target payments to facilities that need the assistance the most. Second, when Medicare raises or maintain its high rates, it could encourage states to either freeze or lower their own rates. And, finally, it diverts trust fund dollars to subsidize payments from -- subsidize the payments from Medicaid and -- Medicare's payments to Medicaid and private payers. If the Congress wishes to help nursing facilities with high Medicaid payer mix, then a

separately financed, targeted program should be established to do this.

And with that, I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Carol and Evan.

So just as a reminder, this is one of the areas where we do not have a vote on a new recommendation. Physicians, SNFs, and home health we have passed multiyear recommendations, so we would simply be rerunning those recommendations in this year's report.

Round 1 clarifying questions?

MR. ARMSTRONG: Thank you. This is really interesting. But these are really two different topics we just talked about, right? One is across post-acute services how we can rationalize the way in which case is organized and how we evaluate actually the value we get from different of those payment silos that we talk about. And then the second was really much more specifically around SNF and the SNF payment updates and so forth.

What I lost in here was -- I should probably know this, but what's the status, on the first topic, which relates to the second topic, of demonstration of bundled payments and some of the recommendations that we've made in

the past around those?

DR. CARTER: So the BPCI is ongoing right now. I think it began -- participants began this year, and I think it's a three-year demonstration. They have selected an evaluator, but obviously that's years away from now. It will be a tricky evaluation because each participant has designed their program differently. But there are some common parameters across the programs in terms of the kinds of waivers that they allowed providers, participants to be excluded from in terms of current Medicare policies. So that is ongoing, and we don't have any results per se from that at this point.

MR. ARMSTRONG: And so it's just getting started, and it will be three years before we expect some result from that demonstration or those pilots? Three years, you said?

DR. CARTER: That's right. Yes.

MR. HACKBARTH: Okay. Clarifying questions?

MR. BUTLER: So in Evan's presentation, on page 4, which I think we do vote on a recommendation here, right?

MR. HACKBARTH: Yes [off microphone].

MR. BUTLER: Which seems like an easy recommendation. But as efficiently as you did this, I

really didn't understand the third point and what you meant by limited differences in outcomes.

MR. CHRISTMAN: Sure. The CARE demo looked at two types of outcomes across settings, and the novelty here is that -- they looked at readmissions and they looked at change in function during the post-acute stay. And the important thing they had for the CARE demo is they finally had a common set of risk factors for adjusting across the settings so that they could accurately compare the patients in the different settings without, you know, worrying about whether they truly had comparable data. And readmissions for SNF, home health, and IRF, there was not any significant risk-adjusted differences in the rate of readmissions across the sites.

The LTCHs were a little lower, but the LTCHs are tricky because they are a hospital level of care, and they may be able to treat patients in the LTCH that the others can't because they're not hospitals.

The second set of outcomes looked at function, and they looked at mobility and self-care, which you can essentially kind of think of as upper body and lower body. And I believe on self-care there was no significant

differences among the sites in the average gain in self-care ability when they risk-adjusted across the sites. On the mobility one, that was mostly true. The home health was slightly better than some of the other settings, and I think IRF was slightly better. But it was really a few points on a 100-point scale. It wasn't really established that there was a clinically significant difference in the outcomes.

MR. BUTLER: I guess then my question is: You're really talking about not validating the tool itself, but, in fact, this addresses the differences for case mix adjusted patients, and it's already saying, oh, the tool's good, let's see if there are differences across these settings, and that's what you're referring to.

MR. CHRISTMAN: That's right. And I think -- that was part of the CARE demo, is they were just sort of seeing if we could -- you know, if the information collected would be analytically useful, what would you find? It gives you a preliminary sense of how, you know, questions we've been asking for many years, how these sites vary in their ability and in terms of quality and in resource use.

MR. BUTLER: Okay.

MR. HACKBARTH: Part of this was to, in fact,

validate the tool and all of the things that people who do such work know how to do that I don't understand.

MR. CHRISTMAN: Right. They also did an analysis that looked at how well the care items could be used to predict resource use, the idea being that you could use the functional information and the other information from CARE to build a common payment system across all of the sites. And they looked at how well the CARE items would predict nursing and therapy costs across the four sites, and it worked, you know, on a level that was comparable to the existing payment systems. It worked better to group all of the inpatient settings together kind of in one common system and keep home health separate. But, you know, the key point was that if they had -- if a common tool was in place, it could be used as sort of the engine for building a common case mix.

MR. BUTLER: So one other follow-up. We haven't really mentioned ICD-10 today and the enormous millions of dollars it costs to put that in this year. But I realize functional status is captured I think in a different way, but we go to almost a 15-fold increase in the number of codes we're collecting. Is there any value of any of that

to this tool?

MR. CHRISTMAN: My understanding is that ICD-10 is principally looking at clinical diagnoses and doesn't really get into capturing functional severity very well. There are some different types of codes that sometimes move into this territory a little bit, but, you know, there is an entirely -- there is actually the ICF, the International Classification of Function, which is sort of the functional analog of ICD, and it's much more complex in terms of what it captures in terms of function. Nobody has really even experimented with using it in Medicare. I think it would be much more complex and burdensome than the types of functional collection we do in CARE, the existing tools.

MR. HACKBARTH: Bill, with a clarifying question? Anybody else? Okay.

DR. HALL: It was mentioned two or three different places in the materials we had and also in the presentation here that Medicare Advantage seemed to have been able to negotiate lower rates in SNFs. It was presented very qualitatively. Is there any way you can quantitate that a little bit more? Is this a common phenomenon? And do we know -- do we have access to any --

DR. CARTER: It's interesting you ask that because we were wondering the same thing. We don't know.

DR. HALL: Okay.

DR. CARTER: So I just know for the publicly reported and traded firms. We don't know how widespread that is.

MR. HACKBARTH: So let's shift to Round 2, and so would you put up the draft recommendation, Evan? So the draft recommendation we're considering here is not an update but rather on the implementation of the CARE tool. And, let's see, Dave, do you want to start Round 2?

DR. NERENZ: I'm generally in favor, just maybe a clarifying question. Would the common assessment tool replace the current different ones or be in addition to, if this recommendation were --

MR. CHRISTMAN: The thinking is it will ultimately replace the current assessment tools.

DR. NERENZ: How long is "ultimately"?

MR. CHRISTMAN: It would take -- I think what -- the way we have talked about doing it is phasing it in over time. And part of that is driven by the need to, you know -- the payment systems use items from the current assessment

tools, and we would need to collect -- and so to phase out the old items, we have to -- fully phase them out, we have to gain experience or gain data of the -- we have to collect the new items so that we can sort of, you know, when we drop the old assessment items, we can use -- we have some basis for forecasting the case mix using the new items. So we're kind of -- what we've suggested here is that you could start -- you could phase it in over time to give people some ability to sort of gradually get used to the new tool.

DR. NERENZ: Okay. Just an obvious observation that there's a cost involved to gathering the data and using it. So the less duplication for the shorter period of time, the better.

DR. COOMBS: I support the recommendation.

MR. GRADISON: As I do.

DR. CHRISTIANSON: And I.

DR. HOADLEY: Yeah, I support the recommendation, as well as, you know, going forward on the reprint of the SNF payment ones. And I guess I had one small question on the Medicaid discussion, and with some of the states now going to managed Medicaid long-term care. Has there been any thought about how that may play in and change the

impact? Or that's something obviously you could look at eventually over time?

DR. CARTER: We can look at that over time, yeah.

MR. ARMSTRONG: Yes, I support the recommendation as well. But I do have to express a frustration at how slow this is. And I think, Dave, your point, there's a cost associated with redundant reporting tools. My view is there's a tremendous cost in this taking so long.

First of all, there's no disagreement that post-acute care services need to be better coordinated, and the kind of tool we're talking about is a basic tool that will allow us to do that work better than we've done in the past. And reading the material -- correct me if I'm wrong -- our first recommendation to do this work was in 1999, which is basically a 20-year lag before this recommendation would actually implement this idea that there's very little disagreement about.

So I support this, but I would ask if there's any way of moving it a little more quickly.

DR. NERENZ: [off microphone.]

MR. ARMSTRONG: Yeah.

DR. NAYLOR: Yes. The answer is yes, we should do

this, and I would encourage, as Scott and David have said, that we rethink the recommended phase-in plan. I honestly -- I think that this is such an extraordinarily high priority for us as a Medicare program to understand the experience of care and transitions in care and use of health services over time. And I think when you recommend incremental adjustments to MDS and all of these other systems, you're talking about real costs in just doing that and when you could set an aggressive timeline for everybody to convert to the same system. So I support fully the recommendation and recommend reconsideration of the phase-in plan to be much more aggressive.

On the SNF, obviously support re-echoing the plan proposed update, but wonder also -- just a couple of comments because of the work that's been done on these measures, readmission measure and functional status, I think they're so much improved. I do wonder -- I mean, I think the demonstrated emphasis on functional decline that you made so clear in the chapter is really important so that we don't always think about function improving in an 85-year-old or 90-year-old or 100, et cetera.

I also wonder if further analysis around those

steps, so when you talked about mobility and transfer -- the chapter did, I should say -- that might be an extraordinarily important way to understand, so someone who moves from two-person transfer to one-person transfer as a result of this could be, in fact, a very substantial improvement. Certainly it is for the family caregiver to whom the person is being transitioned.

And the last thing I would mention is on the Medicare margin I'm wondering if we could pay a little bit more attention to uncovering the impact of the change that we're already accepting on the nonprofits, on the very small SNFs, et cetera, because their margins obviously are 5.4 versus 16 percent for the nonprofit and for-profit. So I just wonder if we could pay more attention to that. But really great work.

MS. UCCELLO: I, too, support the recommendation and agree with Scott and Mary that we -- I mean, I'd be very comfortable with trying to move as aggressively as we can. I think this is such an important thing to help make sure that beneficiaries go to the site that makes the most sense for them, and also to help us as a Commission move forward on some of the payment reforms that we'd like to do.

In terms of the SNF, I agree with repeating our recommendation, but I just wanted to highlight something that was in the text but you didn't mention that I just found very interesting and wanted to say it out loud. The statement that acuity differences between Medicaid and Medicare translate to payments that would be 84 percent higher for Medicare patients, I thought that was just quite interesting and helps kind of provide some information about some of the differences in payments there.

DR. CARTER: I mean, people often talk about how low the Medicaid rates are, and Medicaid rates are low, but the patients are also really different. So that's why I put that in there.

MR. KUHN: I strongly support this recommendation. I think it's long overdue, and I think this is a good proposal.

One additional thing I'd like to kind of talk a little bit about on the SNF issue is the Jimmo case. We talked about it around here before. It's the improvement standard. It's the settlement that CMS reached on that. They started the implementation last Friday with the issuance of instructions for program manual updates as part

of the process, and what concerns me a little bit here -- and maybe I'm being oversensitive here -- is that, as we know, in the SNF benefit it's a 100-day stay. So we also know that observation days are going up. In order to get into a SNF, you have to have a three-day prior hospitalization so they're seeing some decline in terms of some of their volumes as a result of more observation use perhaps and triggering -- at least coming in under the Medicare benefit.

What I'm wondering here is at least begin some surveillance or something here is that when folks move into the SNF benefit, they're not being kept for longer than necessary because of now the improvement standard being changed as a result of that. Could there be some incentives here that could drive certain providers to want to run up the full 100 days as part of the process?

So I think this is just one that we ought to be aware of. I don't know if we need to have any kind of text box or something in the copy there or just something we want to monitor in the future. But I think this is one that you could see the opportunity for gaming, and I think we just need to be very careful and monitor that in the future.

MR. BUTLER: I'm in support of the recommendation, and on the SNF front, I'm afraid these hospital-based units are an endangered species, maybe at best. We made the recommendation to revise PPS in MedPAC five years ago, and it shows, according to your Urban Institute numbers, it would be a 27 percent increase for hospital SNF units based on different kinds of patients they're treating. But we're down to 3 percent of all payments going to hospital-based SNF units, which is half of what it was, you know, six years ago. So I don't know what to do, but I would say that when you comment and say, gee, if you have a SNF, your total margin is likely higher because you can have a lower length of stay and that's what the data, in fact, shows, it suggests that the way you say it is this is a good deal, so, you know, if you just understood it, even under current rates, you know, you ought to -- it makes sense, economic sense. Well, it must not in the ideas of hospitals because these things are fading away quickly.

So I would caution using that as a kind of language even though I realize that the statistics show that hospitals that have these are more profitable than ones that don't.

DR. CHERNEW: So I also support this. I would echo what Herb said, which is even if the -- so I believe in having a common assessment tool strongly. But even if it's very predictive now, that doesn't mean that it's necessarily the right thing to do if people can game different aspects of it. So having a common tool and then how to use it are sort of two separate things, and sometimes once you decide how you want to use it, you might want to change aspects of the tool. But that's not really what's on the recommendation here. So we'll stick with I'm supportive of the idea of having a common tool. I think that's a great step forward.

The only other thing I'd like to say is I don't want to give the impression, given my earlier comments, that the driving force behind all the recommendations is simply the margins were high and we wanted to, therefore, lower the margins. I think my view of that is it looks like all of the other measures are fine and there's reason to believe that there might be room to reduce rates. Note we do it slowly, we don't go and take the margins down to whatever we think they are right away, because I think one motivation for that is you want to, as you go along this process, make

sure that the other indicators are not doing too badly. And so while I'm supportive of the recommendation, I don't want to give the impression that it's just the idea that we need to get the margins down.

DR. BAICKER: I, too, am very supportive of the recommendation. One slight note of caution in the transition period. I'm very sympathetic to not transitioning too slowly and that it's taken too long already. But just to echo something that Evan said, there's a huge return in data quality and measure validation to have both for a substantial overlap period so that you can make sure that the new ones map to the old ones the way you thought they did, that you can continue to use the old measure as an input into generating the new formulas. So I'd very much be in favor of starting the new ones right away, but ensuring -- we don't want any language that suggests that there shouldn't be both for, you know, at least a couple of cycles so that that validation and mapping can proceed with good data.

DR. HALL: Very supportive of this. And, Scott, in answer to your question about why did this take so long, I think it required a different sort of interactive

environment in the hospital for this to catch on. If this had been an imaging test or a series of lab tests, it would have been done in two days. But to do these assessments accurately, everybody on the team has to be talking to each other in the hospital setting. Sometimes silos exist within silos, and -- but the world has changed considerably over these past 15 years, so it's a good idea and its time has finally come. Kudos to MedPAC for thinking about this in '99.

DR. REDBERG: I heartily support the recommendation and agree with my fellow Commissioners that sooner would be better, and even for the goal of getting people to talk to each other by implementing this tool is a great unintended consequence.

MR. HACKBARTH: I just want to raise again the point that I raised this morning when we were talking about LTCHs. I do think of the SNF case mix improvement that is part of the recommendation that we're rerunning as related to the issues around LTCH. You know, we want to make sure that if these patients are going to go to places other than LTCHs that we are paying appropriately at those new sites, and we do have a longstanding belief that the current SNF

payment system does not pay appropriately for medically complex patients because of, among other things, how it handles the non-therapy ancillaries.

Now, as I understand it, CMS has done little on that but not enough, is the bottom line. And so I think we need to consider how, in addition to having it in this chapter, we can place this so that it reinforces other things that we're saying about LTCHs in acute-care hospitals. We may need to have it a couple places.

DR. MARK MILLER: Right. You made the connection this morning that that helped with having another location when a person leaves LTCH [off microphone].

MR. HACKBARTH: Yeah. Just a way of heightening its importance and visibility to have it in more than one place.

MR. ARMSTRONG: Just one other comment. I think particularly as we're looking not just at the SNF payment but the coordination of post-acute services and payment structure changes and so forth, this would be one area where, if we're not planning to do this already, we really should encourage diving deeply into how Medicare Advantage plans are coordinating post-acute care services. At least

the one I am familiar with just does -- we've solved for the communication issues. We've solved for, you know, the disruption from transitions between these different settings. And I really think the quality and service and cost outcomes are quite a bit better, but that's just an opinion. I think through this process, to the degree we can learn from those experiences, it could be tremendously valuable to us.

MR. CHRISTMAN: We've got two projects underway that will get at that. One is we have a project where we are interviewing private sector entities on how they manage PAC care, and looking at Medicare Advantage is one piece of that. And then if my understanding is correct, we will finally next year get access to the MA encounter data -- take that as a vote of confidence -- and be able to look at PAC services, and we're very eager to do that.

MR. HACKBARTH: Okay. Thank you, Evan and Carol. So we are now off to home health.

Oh, Right. Evan is going to hang around.

MR. CHRISTMAN: Sure. Here we go. We're going to look at home health next, and as a reminder, here's our framework. It's the same one in earlier presentations with

one twist, that after we review the framework, we will also examine a potential policy to reduce hospital readmissions for beneficiaries in home health.

And just as a reminder, Medicare spent about $18 billion on home health services in 2012 and has over 12,000 agencies in the program. We provided about 6.7 million episodes to 3.4 million beneficiaries.

We begin with supply, and as in previous years, the supply of providers and the access to home health appears to be adequate. Ninety-nine percent of beneficiaries live in an area served by one home health agency. Eighty-four percent live in an area served by five or more. And in terms of supply, the number of agencies was over 12,300 and there was a net increase of 257 agencies in 2012. Growth is concentrated in a few areas, such as Texas, Florida, and Michigan. Many of these areas also have higher utilization.

Next, we look at volume. The volume trends in 2012 declined slightly. However, this break in growth comes after several years of rapid increases. Home health spending declined by 1.5 percent in 2012. This decline was mostly due to a slight reduction in the base rate and a

slight decline in episode volume, and though volumes for this year show declines, keep in mind that since 2002, users have increased by over one-third, episodes have increased by more than 60 percent, and spending has almost doubled.

Next, we look at quality, and this table shows the risk adjusted rates of functional improvement among those patients not hospitalized at the end of their home health episodes. Across the two years, you can see that the rates of functional improvement slightly increased on most measures, implying a modest improvement in quality, and these measures are similar to what we've seen -- to the changes we've seen since the quality indicators were started in 2004.

In terms of capital, it is worth noting that home health agencies are less capital intensive than other health care providers and relatively few are part of publicly traded companies. Nonetheless, financial analysts have concluded that publicly traded agencies have adequate access to capital, though because of the payment reductions in the PPACA, the terms are not as favorable as prior years. For agencies not part of publicly traded companies, the continuing entry of new providers indicates that smaller

entities are capable of getting the capital they need to expand. As I mentioned earlier, the number of home health agencies increased by over 250 in 2012.

Here, we look at margins, and you can see that the overall margin for freestanding providers is 14.4 percent. We show the margins here for different categories of providers, and the trends you see here are similar to prior years in terms of the spread.

I would also note that these data rely upon the Home Health Cost Report. CMS audited a sample of 2011 cost reports and found that costs for Medicare services were overstated by eight percent in 2011. If reported margins were adjusted for this error, our home health Medicare margins reported for 2011 would have exceeded 20 percent last year. While it is speculative to apply the eight percent to other years, the results suggest the very high margins we report for home health could be higher.

This year, we also examined the performance of relatively efficient home health agencies compared to others. Relatively efficient providers had a cost per visit that was 15 percent lower than the other agencies and Medicare margins that were 23 percent higher. Relatively

efficient providers were typically larger in size, providing about 25 percent more episodes in a year. They had lower hospitalization rates, but they provided about the same mix of nursing therapy and aide services to their patients and they served a similar number of dual eligible patients.

We estimate margins of 12.6 percent in 2014. This is a result of several payment and cost changes. There is a three percent add-on in effect for rural areas in 2013 and 2014. The payments in 2013 were adjusted downward by a reduction to the market basket and a coding adjustment. Payments in 2014 were also adjusted to reflect several payment policies, including a payment update, grouper changes, and payment rebasing, the last of which I will discuss on the next slide.

We assumed cost growth of half-a-percent a year in 2013 and 2014, a conservative rate that is a little higher than recent average rates of growth. Our estimates here don't include the sequester. With it, the margins would be about two percent lower.

The PPACA includes a rebasing provision intended to lower Medicare payments. Under this provision, payments will be adjusted downward by $81 per episode for each year

in 2014 through 2017. However, this reduction is offset by the annual payment update, which adds back much of what the rebasing adjustment removes.

MedPAC's recommendation to rebase did not include the payment update, and this chart shows why. The net effect is that the base rate will fall by 0.2 percent to half-a-percent a year as a result of rebasing. Cumulatively, the base rate in 2017 will be 1.6 percent less than the base rate in 2013. These small reductions are unlikely to change margins significantly.

I would also note that these cuts may be further offset if providers are successful in lowering their costs or increasing their payments, as they have done in the past when faced with these types of reductions. And it is important to remember that the rebasing adjustments do not take into account the eight percent overstatement of costs found in home health cost reports.

Here is a summary of our indicators. Beneficiaries have good access to care. The number of agencies continues to increase, reaching over 12,300. The number of episodes and rates of use declined slightly after several years of rapid increases. And quality shows

improvement on most measures. Access to capital is adequate. Margins for 2014 are estimated to equal 12.6 percent, again, without the effect of the sequester. And I would note that these are average margins. And our review of quality and financial performance for relatively efficient providers suggests that better performing agencies can achieve better outcomes with higher profits.

Since our indicators for 2014 are mostly unchanged, the Chairman has proposed that we rerun our payment recommendations from earlier years. We recommended a more robust form of rebasing that would address the historically high margins of home health agencies. Our recommendations also address a payment vulnerability in the PPS. We recommended that CMS eliminate the use of the number of therapy visits provided in an episode as a payment factor in the PPS. This change is budget neutral, but it would increase payments for agencies that do less therapy, which have typically had lower than average Medicare margins.

We have also advocated that CMS fully use its authority to address fraud and abuse in the home health benefit. There are many areas of aberrant utilization that

suggest enforcement efforts are still needed.

Finally, we have also recommended that Medicare establish a copay for episodes not preceded by a hospitalization or PAC stay.

Next, we'll pivot away from payment adequacy to discuss establishing a readmissions reduction policy for home health. Reducing readmissions is a major goal of many of the new models of payment in Medicare, such as the Hospital Readmission Reduction Program and others, such as ACOs and medical homes. Extending an incentive for home health agencies to lower readmissions might be appropriate because home health is the most common site of post-acute care and many of the beneficiaries in these new models will be served by home health. Adding an incentive for home health would align their incentive with those of other providers seeking to reduce readmissions. Adding an incentive is also important because readmission is a relatively common occurrence in home health. About 29 percent of post-hospital home health stays ended in readmission in 2010.

The broad regional and provider-level variation and readmission rates suggest that there may be substantial

opportunities for improvement. For example, providers in the top quartile of readmissions, those with the highest rates, had a rate of 58 percent, while the rest of agencies averaged 26 percent. Across the States, readmissions were highest in four States that also had very high rates of home health utilization. Providers in Texas, Louisiana, Oklahoma, and Mississippi averaged a readmissions rate of 38 percent. If providers in regions with higher than average rates were able to lower their readmissions closer to those achieved by better performing providers, beneficiaries would experience fewer readmissions and Medicare spending would fall.

A home health readmissions policy would have several parts to it, and first, I will take you through the basics of how a financial incentive could work. I would note that these elements are based on the Commission's review of the Hospital Readmission Reduction Program that was included in our 2013 June report.

For each year, Medicare would establish a benchmark based on the industry's past performance, say, the 80th percentile. Agencies with readmission rates in excess of the benchmark would be subject to the penalty. The

penalty would be equal to the amount Medicare paid for home health services provided in the stays that resulted in excess readmissions.

The key part of this incentive is that the benchmark readmission rate an agency has to be below is set in advance and does not change. Agencies would assumedly know how their performance in prior years compared to the benchmark and those with high rates could avoid the penalty by working to lower their readmissions rate.

The policy should also include some other features to ensure appropriate incentives. Agencies that serve more dual eligibles generally had higher readmissions rates, so it would be appropriate to compare a home health agency to a peer group of providers who served a similar share of low-income beneficiaries. This would lessen an incentive to avoid these patients to improve care.

The time period of the measure should include the entire home health stay plus 30 days after discharge. Including a post-discharge period would be appropriate given that a successful return to the community is a typical goal in home health.

Finally, the measure should focus on potentially

preventable readmissions and exclude those readmissions that are not necessarily attributable to home health.

Again, many of these policies are applying the principles the Commission has laid out for future changes to the HRRP.

To get a better sense of this policy, we modeled its impact using 2010 data. For this exercise, we identified agencies that were above the 80th percentile on readmissions rate compared to other agencies that serve similar shares of low-income beneficiaries. We only had one year's worth of readmission rates to work with, so what we will show is how many agencies crossed the 80th percentile benchmark based on 2010 data. Keep in mind that if the policy were in effect, those above the benchmark would likely work to lower readmissions, so fewer would be subject to the penalty.

Overall, 20 percent of agencies would be at risk, a result of setting the benchmark at the 80th percentile. The shares would vary by group, but they broadly track the trends and readmissions rates by various agency characteristics. For example, for profit agencies would have a little bit more than 20 percent of agencies above the

benchmark. Government and nonprofit would have a lower share above the benchmark. Freestanding would have relatively more above the benchmark. The rate for urban and rural was about equal. But perhaps most strikingly, 36 percent of agencies in the States with the four -- excuse me. Thirty-six percent of agencies in the four States with the highest rates would be above the benchmark.

In sum, adding a Home Health Readmissions Reduction Program would align home health agency incentives with those of other providers seeking to reduce readmissions. It would encourage providers with the highest rates to improve, and it would recognize that avoiding readmissions is a primary goal for post-hospital users of home health.

With these considerations in mind, the Chairman has offered a draft recommendation for your consideration. The recommendation reads, the Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk adjusted rates of readmission.

For spending implications, this policy would lower Medicare spending, either through lower payments to home health providers that incurred the penalty or lower spending

for inpatient care when agencies are successful in lowering their readmissions rates.

In terms of beneficiary and provider implications, beneficiaries may experience fewer readmissions and the recommendation should not adversely affect beneficiary access to care or affect providers' willingness or ability to care for Medicare beneficiaries.

This completes my presentation. Please let me know if you have any questions.

MR. HACKBARTH: Okay. Thank you, Evan.

Let me just say a little bit more about the context for the draft recommendation on readmissions penalty. I think it was 2008 when we first recommended the hospital readmission penalty, penalty on excess readmissions. When we did that work, we said -- we identified readmissions as a potential problem, not just on cost but quality grounds, as well, and said, broadly speaking, there were two paths available to us to address that issue.

One would be to move towards bundled payment, whereby you would bundle in the hospital payment with post-acute care payments and establish one party as having both

the clinical and financial responsibility for managing the care transition and making sure it goes well for patients. And, at that time, we recommended the creation of a Hospital Admission Bundling Project, which is only now, in fact, getting up and running, as I understand it, and somebody correct me if I'm wrong, but it's really just beginning now. Who's the right person to answer that for me, confirm that for me? Is that true?

MR. GLASS: [Off microphone.] Second year.

MR. HACKBARTH: Second year? So it's beginning the second year of three, is that right, David?

MR. GLASS: [Off microphone.]

MR. HACKBARTH: Okay. So it's 2013 now and we're up and running and then there will be the phase where we wait for the data to be analyzed and reports to be written and all that. So, hopefully, at some point in the not-too-distant future, that will prove to be a productive path.

Realizing in 2008 that that journey may be a long and complicated one, we said the other path that we can pursue perhaps more quickly is to institute a penalty for excess readmissions, and we made such a recommendation for hospitals, and subsequently we've talked about how to refine

that to make it more effective and fairer, for example, to institutions that have a lot of lower-income patients.

Now, a common critique of the hospital penalty is that, wait a second, you're holding us responsible for things that happen outside our institution and that's not really fair. And our retort to that has always been, well, that's one of the problems with payment silos. Not only do they silo payment, they also silo responsibility, and people don't want to look beyond their silo, be held accountable, and we need to start breaking down silos, so this is one step in that direction.

But we also concluded that it would be both fairer and potentially more effective if hospitals had some willing partners in this effort to reduce avoidable readmissions, and so we recommended that there be a sort of analogous incentive created, first for skilled nursing facilities, and now with this draft recommendation we would be doing the same for home health. And my thinking here is very simple, some would say simplistic. I want to be sure that when a hospital says, this is a problem that I'm eager to try to solve, that it has willing partners coming to the table, namely skilled nursing facilities and home health agencies,

and that's why I'm bringing forth this draft recommendation.

I should also note, incidentally, that CMS has in the Physician Fee Schedule included a new code for coordination of care post-discharge, and so that's sort of another payment piece of this picture.

So that's the history that's behind this draft recommendation.

So, let me see hands for round one clarifying questions for Evan. Mary, then Cori.

DR. NAYLOR: Thanks, Evan. Can you clarify the definition of efficient home health, because here it says, page 23, either low cost or low rehospitalization rate, and I was trying to figure out -- in other definitions of efficient, there seemed to be some combination. I know you're looking for the --

MR. CHRISTMAN: Well, it may be a choice of -- I'm sorry. I didn't mean to cut you off. It may be a choice of words, and I may have -- we should be -- we've gone to lengths to make sure we're using the same definition of efficient provider, where we look at three years of data for a set of providers and, you know, you have to be in the top third on quality or cost and not in the bottom third of

either. I can look at the language in the chapter, but we're using the --

DR. NAYLOR: The same exact --

MR. CHRISTMAN: The same definition, yes.

DR. NAYLOR: Thanks. And the second question, and thank you for looking at distinguishing the distinct populations post-acute care, those getting skilled after hospitalization versus those who start in the community. Have you looked at the differences in margins for those two groups, one having 1.4 episodes per beneficiary per year, the other 2.6. So I'm wondering if there are differences in agencies that serve primarily one versus the other.

MR. CHRISTMAN: We looked at -- I don't know that we were looking at it specifically that way, but we did look at -- we did split agencies into, you know, quintile groups based on profitability in one analysis we did, and sort of the share of community-admitted patients was not that different among the low margin and the high margin providers.

There's sort of -- the community admits could cut two ways in terms of an agency's profitability. One way is they -- those episodes typically use more visits in an

episode, but often a slightly cheaper mix of services, and that might push their costs up a little bit. But on the other hand, what we've observed for a variety of reasons is that the community admits can be a big source of volume and larger agencies that provide more episodes generally seem to find economies of scale that smaller agencies can't. So, if you specialize in community admits and are very good about, you know, and it helps push up your agency size, it may ultimately get you some efficiencies there.

We can go back and look at this a little bit more, but nothing so far leads me to believe that there's something gross that -- a difference in profitability among the sort of community admits and the people who do primarily post-acute care.

MR. KUHN: Evan, a quick question on 11, Slide 11. So, I see the run rate that you have here in terms of the CMS rebasing plus the market basket updates and other interactions here, so it almost kind of washes out here. At the same time during that four-year period, we have cost growth for the industry. So, that cost growth, when we did our margin calculations, all this stuff was kind of rolled up and captured. Did I understand it right?

MR. CHRISTMAN: Right, and to be straight, we've only presented margins here for 2014.

MR. KUHN: Right, for the first year.

MR. CHRISTMAN: Right. And so the -- you know, forgive me for saying this, but the old joke Yogi Berra made was that predictions are hard, especially about the future. And what makes this hard is that agencies have proven an ability to nimbly recalibrate what they do when what Medicare pays changes. And in the interest of time, I'll only give you a few examples, but the canonical one is the one that got us here in the first place, when CMS went from per visit payment to per episode payment. The number of visits they provide in a comparable episode dropped by, like, a third.

And so as you think about what's going to happen going through 2017 as they face these things, you know, they've been able to retool in the past and they may well in the future. There's a couple of things that they've done in the past to offset these types of reductions, and one is they pushed up the amount of therapy they do, which frequently can improve their payments and their profitability. The ability to do that is a little bit --

it's a little bit harder now because of some changes CMS has made, but it illustrates that they can be resourceful.

The other thing is they've been able to bring down the visits per episode they provide. That analysis, I can take you through a little bit more if you're interested in. And there's -- other examples are they've been able to substitute lower-skilled, cheaper practitioners, like, they'll use LPNs instead of full RNs when they can do that.

So, in the past, they've been able to maintain these high margins, even though in most years the market basket has been reduced, for example, so --

MR. KUHN: Yeah, so not only to be able to manage the program, but manage their costs more effectively, things like that.

So, the other question I had in the margin calculation, and I think I remember this from the reading, but just to be sure, we use both the data from freestanding as well as hospital-based to develop the entire margin calculation?

MR. CHRISTMAN: The numbers we show here are just for the freestanding agencies.

MR. KUHN: Okay. That's why I just want to be

clear. Okay. Thank you.

DR. MARK MILLER: Back on the calculations of costs and that part of the exchange, it's true we take our margins only through 2014. We take that into account. And you're saying it's hard to predict and all the rest of it, but the historical run-out on cost has been extremely low cost growth. And if you've been seeing some other numbers which are being circulated, the people who are doing that analysis have assumed much more aggressive cost growth than has been seen historically, as well as a couple of other assumptions.

So, while it is hard to predict some of the behaviors, even if you just sort of doubled the cost growth that we've seen historically there, you still would have very aggressive margins left here in 2017, all other things being equal. In other words, you shouldn't look at this and assume two-and-a-half percent cost growth for three more years eating up all the remainders of their margins. It hasn't been growing anywhere near that. It's been, like, half-a-point types of --

MR. HACKBARTH: [Off microphone.] And even lesser --

DR. MARK MILLER: -- yeah, of growth. So, a lot of people think of cost as two and two-and-a-half. Not here.

And then -- well, I'll stop there.

MR. HACKBARTH: Okay. Peter, did you have a clarifying question?

MR. BUTLER: Two questions. The eight percent differential on the cost report audit caught my attention, and I'm sure some others, as well. So that in 2001 is when we went to PPS and home health agencies have continued to supply cost reports and those have been the basis for our calculations. That's the way I understand it. And then you go along and audit and said, whoops, at least for one year, 2011, there was an eight percent difference, right --

MR. CHRISTMAN: Right.

MR. BUTLER: -- and as you said, you could speculate it's eight percent across all the years. We don't know. Was there anything systematic, though, in the reporting in the audits to say, well, they all considered this kind of expense this way and that would explain the difference, or is there something --

MR. CHRISTMAN: It -- you know, the publicly

available information on the cost reports doesn't go into great detail on what they did. It typically was, you know, very high-level information in that what we know about is things like including non-covered services, like their private duty nursing costs, and then including extraneous things -- as CMS characterized it, including extraneous things that must have been errors, such as personal purchases and things like that.

MR. BUTLER: But their errors are all in one direction, it sounds like.

MR. CHRISTMAN: Oh, I'm sorry. I didn't see that question. No. That's right. It wasn't all in one direction. The majority of them were overstatements, and it was somewhere around 70/30, 80/20 in terms of the majority of them were overstatements, but some were understatements, and that eight percent is a net number.

MR. BUTLER: Okay. The second question relates to the episodes that occur prior to the hospitalization versus post, and I think they're increased, or increased at maybe double the rate or something that the post-acute episodes have occurred at.

MR. CHRISTMAN: Right.

MR. BUTLER: And so the readmission rate, if we go forward with this, really just addresses the post-acute piece, right?

MR. CHRISTMAN: That's exactly right.

MR. BUTLER: And just to clarify myself, the incentives, one could argue that there's an incentive to cut -- to actually have preventable admissions in the pre-hospital stay because of the way episode payments work. You get in trouble and say, let's ship them off to the hospital sooner rather than later. So there's really -- it doesn't really address that incentive issue, the policy that we'd be adopting, is that right?

MR. CHRISTMAN: That's right. It won't -- for the community-dwelling beneficiaries, the readmissions incentive obviously doesn't pick up their hospitalizations. After the patient -- assuming the patient returns to home health after their hospitalization, that would be in.

MR. BUTLER: [Off microphone.]

MR. HACKBARTH: That's what I was thinking.

[Laughter.]

MR. HACKBARTH: Okay. Round one clarifying questions, anybody here?

Okay, Peter, let's begin round -- no, you've already gone first. How about Bill Gradison. You can start round two. Round two. So, I need to know what you -- so, round two, and in particular, what I need to know is -- where's our draft recommendation, Evan -- is your thinking about the draft recommendation.

MR. GRADISON: I support the recommendations. I'm intrigued by the possibility that with this readmission policy, the hospitals themselves, when they discharge into home health care, they're going to be asking a lot -- gathering data and asking a lot of questions about how good a job did this home health agency do, and I think it -- and perhaps it's already been covered adequately, I won't dwell upon it -- but it seems to me that that could be a very positive, powerful, actually, incentive in sort of sorting out these organizations in terms of quality by who gets the business from hospitals, because the hospitals have a huge stake at that point because they're going to get dinged, too, if there's excessive readmissions.

DR. COOMBS: So, I was thinking along the lines of our discussion last year, specifically about the patients who are admitted to home health from a physician referral or

provider referring them. And just to follow up with that, if you are an agency that actually receives patients who are not quite ready to be discharged from the hospital, so that puts you in a whole different conundrum in terms of your vulnerability as an agency.

So, how that happens and what that does, actually, to the decision making for the home health agency is that they may begin to be more selective in the process. I certainly would be if I was an agency in terms of looking at the history of a hospital when they refer or a provider that's referring patients from a hospital. So, I don't think that this gets at that. At some point, it will have to be addressed.

MR. HACKBARTH: So, and this is successive comments. Bill sort of focused on the hospital perspective and said, boy, I want to be selective about the home health agencies I deal with, and you sort of gave the opposite perspective. Well, as a home health agency, I may be worried about what the hospital is doing.

And in a siloed payment and clinical accountability system, the problem we have is that nobody is really responsible. And so my objective here is real

simple. Get them to go to the table and say, we've got a mutual stake in working this out.

Dave.

DR. NERENZ: Supportive of the general direction. The devil is in the details, as it is in so many things when we look at this. I'm thinking, for example, that the phrase "reduce payments" could actually be implemented in several different specific ways. It could be a one-time penalty, as it is in the hospital case. It could be that the payments for all episodes in a subsequent time period would be reduced. You could actually apply a much more stringent reduction to those episodes that resulted in a readmission, kind of like the same philosophy that applies to "never" events in hospitals.

So, I guess this may be a question. Are any of those three or any other part of what we're thinking about when we do this, or is it details left open in the future?

MR. CHRISTMAN: I think that the way we were thinking about this was largely the template from the work we did looking at the HRRP. And so there would be a -- you know, you would sort of total up the Medicare payments for episodes that resulted in what we're calling these excess

readmissions and then you would -- for a given year -- and you would sort of figure out how much that total amount, say, $10,000, was equal to sort of if you spread it out over all of the episodes an agency provided in that year. So you'd get like a sort of a per episode reduction amount, and then that amount comes out of the next year's payments. That's sort of when the penalty takes place.

And I should note that, generally, like when this was implemented in the HRRP, there is sort of a stop loss. I believe, ultimately, when it's fully phased in, the penalty can reduce a hospital's payments by no more than three percent. And so you would have to eventually think about a similar feature for home health, sort of the size of that upper limit. You know, it would be -- I would think about it -- realistically, you would have to relate it to what agency margins were. If you're successful at rebasing, maybe it would look more like what the HRRP looks like with three percent. If margins continue where they are, three percent is not going to be a lot to motivate a lot of agencies, so you might have to think about a different benchmark.

DR. NERENZ: Okay. But at least in principle,

there could be even quite different approaches --

MR. CHRISTMAN: It could be a different approach. I guess I'm not sure. Is there one that you're leaning towards or --

DR. NERENZ: No, no. I'm just observing that there are several somewhat distinct ones. I guess I'd have to say, in terms of the clarity of the signal, a penalty that applied to a specific episode resulting in a readmission would be a more immediate, clearer signal than something that takes two years to calculate and is -- sort of goes through some arcane formula. But we'd want to see a model of that applied.

Now, another thing I wondered about -- it was not mentioned in the chapter or your briefing -- is there a bid process that goes on now for home health agencies through which agencies become eligible to participate in Medicare, or am I misconnecting something that doesn't --

MR. CHRISTMAN: Well, it's sort of an any willing provider for people who meet Medicare's accreditation requirements and, you know, there's State licensing in there and things like that. I wouldn't -- you know, the word "bid" suggests there's some sort of competitive element, and

in terms of getting into the program, I don't think it is. I think there's been concerns that the program is too easy to get into and that has opened the door to too many agencies, areas being flooded, and made it easier for marginal providers to get in.

DR. NERENZ: Okay. I may be confusing DME, for example, with home health, and -- okay. I was just trying to clarify.

I guess just to extend the thought, though, conceivably, that would be another avenue of dealing with this, that if a barrier to entry was created, or a barrier to staying in was created for those with excess readmissions, that would just be another approach. It might be a very stringent all or none approach, but at least that would be on the table, as well, just as a means to accomplish this.

MR. HACKBARTH: If you really want to shake up home health, moving to a bidding type system would be one path for doing that, yes.

DR. MARK MILLER: A couple people in the audience just seized up.

[Laughter.]

DR. MARK MILLER: Just to respond to a couple of other things that you said, so the way it would work in the report is, and this is not atypical, and I know you have some experience but also still working your way in, this is a general statement, but the text would describe the process that Evan went through with you. And the reason that we're following that path is we took the Commission in rigorous detail through the readmissions penalty process, got to a consensus point on that, and, by the way, it adjusts for things like SES and has the limitation and would work the penalty in the same way that Evan described. And so we would say, here's a way you could do it, and write it out in the text, although we might not be dogmatically taking a position that it has to be that way.

The other thing I would comment on, and I think we should continue this conversation perhaps offline, but there was lots of discussion early on and out in the field about whether a penalty specific to this admission or a penalty specific to a rate that suggests you're off the charts, and lots of concern both technically and in the field over specific, because any given readmission may not be easily avoidable. But a rate that suggests you're way out of line,

people tended -- to the extent that they would support any of this -- thought that that was preferable. But we can talk offline.

DR. REDBERG: I support the recommendation. I think it's very positive. I mean, I think home health agencies do have a lot of potential to avoid -- help avoid -- improve health and avoid readmissions, and the idea of getting hospitals and home health agencies to work together with the goal of improving beneficiaries' care is great.

DR. HALL: I also support the recommendation. I think it's going to be hard to -- this is a hard thing to implement. Are there legal or other reasons why one couldn't consider a two-sided risk model such as we're doing with successful ACOs, Pioneer ACOs?

MR. HACKBARTH: Say more, Bill, of what you mean on two-sided --

DR. HALL: So, both the hospital and the home health care agency have something to gain as well as lose by cooperating --

MR. HACKBARTH: Mm-hmm.

DR. HALL: -- as opposed to just having them point their fingers at each other, who was responsible for the

readmission. I can see lots of legal reasons why this might not work with a not-for-profit entity and a profit entity.

MR. HACKBARTH: So, let me -- we can talk some more about this. You know, one of the reasons that just a bundled payment approach appeals to me is then you can get the parties around the table and say, here are the resources we've got. If we can improve the care within these resources, we can share in those gains, and we will agree among ourselves on how we divide those gains --

DR. HALL: To be sure.

MR. HACKBARTH: -- or, potentially, losses. And, to me, this kind of approach that we're talking about here is the second best alternative to that, albeit one that I think is necessary because it's been such a difficult, time consuming thing to try to get to a bundled approach.

DR. HALL: Mm-hmm.

MR. HACKBARTH: So, we can talk more about that.

DR. HALL: Yeah.

MR. HACKBARTH: Kate.

DR. BAICKER: So, I'm very supportive of this and I think it's really important to get those incentives lined up the way you describe. I think it could serve to amplify

the incentives that the hospitals and the home health agencies face if they're both on the hook for the same adverse event we're trying to avoid.

The first line of argument against such a thing which I think we want to be prepared to address is the risk adjustors aren't good enough. You're just punishing agencies that are taking care of sicker patients, more disadvantaged patients, you know, that that's not fair.

The material in the chapter dealing with the sort of overall SES of the group, that takes care of one bucket. I didn't see a lot of detail, and maybe it's too hard at this point, on some of the other buckets like health status. I don't think that that needs to hold this up at all, but it might be helpful to bolster the case, to be able to show that the risk adjustors -- there are risk adjustors that would do a decent job. We don't need to say exactly which risk adjustor is right, but I think you'd want to be able to dispel the argument that you're not able to capture patient underlying risk well enough to avoid creating a disincentive to care for very sick patients. But I say that only because I'm very supportive of this direction.

DR. CHERNEW: I'm also supportive and I echo

Kate's point about worrying about the potential, how you're going to deal with unintended consequences. I'm not particularly worried, but I agree with Dave that the details of how you do this matter. I actually view this as a subset of a broader notion of sort of quality measures that could apply outside of just people who came for a hospital risk of readmissions. You could think of a whole series of ways that you might want to hold the home health agencies accountable for various types of quality and better care that would extend beyond the patients who came from a hospital.

I think because of the coordination issues that are rife here, I think this is a fine way to begin to explore. I like the general lack of specificity, actually, in the recommendation because it gives time to sort through some of those details without us having to get hung up on exactly the details.

MR. HACKBARTH: Peter.

MR. BUTLER: So, to start with a -- I still have time in round two?

[Laughter.]

MR. BUTLER: So, I was looking at the --

MR. HACKBARTH: [Off microphone.] Oops, out of time.

[Laughter.]

MR. BUTLER: I'm watching the red light.

[Laughter.]

MR. BUTLER: So, I was looking at the sectors and there's $29 billion in SNF, $18 billion in home health, around $6 billion or a little less in IRF and LTCH, kind of the four kind of options, just to put it in perspective. And the other three are all big costs of entry and big costs of exiting, and we've always said home health is not. It's an easy cost to enter and easy cost to leave.

I would add on to that, it also has an operating model that is pretty easy to change year to year compared to the institutional setting. So, you really can't -- so, it's not just the capital in. They can kind of respond pretty quickly in the way they do things. I think that's a good thing, but it also means that they're much, much more sensitive to payment changes.

And those of us, you know, that look at the array of post-acute providers see this is the -- we talk about tradeoffs and site neutral between IRFs and SNFs and LTCHs.

This is the big tradeoff, if you can make home health work, because it is so much cheaper and potentially effective. But it is all the more reason that the -- if you can use very aggressively, and you can be pretty sure they're going to respond to whatever the changes are. So that's context for my comment.

I strongly believe we ought to have a readmission one. I also think that the teeth in it might be stronger, in other words, if you really put more dollars into it, I bet you they would really aggressively work on this in a much different way than -- and the hospital, we put a percent or something like that, you could put probably some pretty significant dollars on this. And I would do a sliding scale, probably, not just at or above 80 percent, because I think you'd want to engage as much of the industry as possible. And if you just say, I'm going to go after the high guys and they're the only ones worried about engaging, you don't have an opportunity there to kind of get everybody thinking about it in some ways.

I thought, Bill, you were going on the two-sided risk, have some bonuses for ones that are on the positive end --

DR. HALL: Right.

MR. BUTLER: -- and maybe you could. Maybe you could. If they're really the low ones, maybe there's an opportunity not just to take money away but, in fact, give more money to the home agencies that are really doing a heck of a job.

MR. KUHN: This is a good benefit and it really does help a lot of Medicare beneficiaries. So, I think the notion that we're talking about here of the readmission policy for better alignment makes all the sense in the world and I strongly support it.

Evan, I did want to ask you one question, though, about the rebasing issue when it came to the Low Utilization Payment Adjustment, or the LUPA, the fact that that is an interesting part of the benefit, because it does deal with keeping, I think, five or fewer episodes, so you pay them at cost, and it keeps them from going into a 60-day episode, so it makes a lot of sense. But yet under the rebasing scenario we have now, they're paid well below costs, I think 20 to 35 percent, I think, in the information that you shared. I've heard some people say it's even higher, as high as 50 percent.

Is there anything that can be done in this area to make sure that that part of the benefit stays firm, because, again, I want the incentive in order -- we don't want to encourage those folks into longer episodes when they don't need them. And then, per the conversation or the thing I mentioned earlier with the Jimmo decision, the fact that now, I think, maintenance therapy is going to be much easier, that does worry me that the LUPA benefit might not be totally functional here.

MR. CHRISTMAN: So, what happened with the LUPA was important. I guess what I would say is that when CMS did the rebasing relative to what we would have wanted them to do, they ended up taking out too little from the 60-day episode rate, and I took you through that, and they didn't -- when they rebased, they didn't bring up the LUPA payments enough. And that was, in part -- a big piece of that was the PPACA limited how much they could change rates. And so in the case of the LUPA, they found that on a -- the way the LUPA works is if that there's fewer than five visits in an episode, Medicare simply makes a per visit payment for each episode, and the analysis CMS did found that the LUPA rates were somewhere between 20 and 40 percent too low and the

PPACA provision only really permitted them to bring payments up by -- the math varies, but it's 12 to 14 percent. And so that leaves a significant gap.

Overall, LUPAs are around 12 to 14 percent of episode volume and they're one percent of dollars. They're not the biggest part of the action. But as Herb mentioned, they're a key part of -- they're sort of the short stay outliers in this system and ensuring that agencies sort of have the right incentives to do LUPAs when they're necessary is important because the average LUPA payment is, you know, it's going to be around $400 and that's going to cover, roughly, four visits. If they do the fifth visit, they're going to get bumped into the full episode payment, which averages $2,800. So they could do one visit and push their payments up by $2,400.

So, you know, I think under our recommendation, we would want things to be rebased to cost, not have these arbitrary limits on what CMS could do, and that would help to ensure that the short stay rates are where we want them to be.

MR. KUHN: So our existing recommendation that we have in play now would address that as part of it. We

wouldn't need to rewrite anything --

MR. CHRISTMAN: Right.

MR. KUHN: Okay. Thank you.

MS. UCCELLO: So, I am supportive of this recommendation, and when we think about some of the details of implementation, I want to talk, or think out loud, almost, about the SES issue. If we think back to the hospital readmission recommendation where we talked about peer group comparisons, and part of the issue there -- correct me if I'm wrong -- is that there was a concern that the hospitals don't necessarily have full control over what happens outside as well as you don't want hospitals to avoid certain risky people.

And if we think about those things in terms of home health, I think you can make the argument that the home health agency has more control over what happens outside the hospital in the community, so maybe that's less of a big deal. On the other hand, it may be easier for a home health agency to avoid certain risky people, patients. So it just might be worth kind of thinking about that a little more.

And I would also request that, similar to the hospital readmission recommendation, text around it when we

talk about the QIO targeting, to also include that within this discussion.

DR. NAYLOR: So, in terms of the recommendation, I support the general direction of this recommendation. I think achieving alignment is extraordinarily important.

I know -- I saw in the text it was -- we moved away from thinking about preventing avoidable index hospitalizations, somewhat because of our conversation. But I really think we need to revisit that in light of the data in this report about the rapid growth of community-based home care admissions, and in alignment with what Cori said, not wanting to create an environment that incents community-based admissions when people need post-acute care following hospitalizations.

I also want to comment a little bit in terms of the text on what the -- my question around the efficient providers. What happened, I think, is worthy of just at least thinking about. In this analysis of efficient providers, it turns out that a much higher -- well, I shouldn't say -- 41 percent versus 33 percent are coming from the community versus post-acute hospitalization. The efficient provider is offering about an average of one-and-

a-half fewer visits per episode.

So I think we really need to be -- I guess what my final plea is, that we continue our effort to think about post-acute home care following hospitalization differently than community-based care. I think the 1.4 visit per episode is right in line with what the evidence suggests people coming -- Medicare beneficiaries coming from a hospital need for good transitions versus these large numbers of visits that are coming to community-based, almost double that of post-acute care. And so as we think about payment updates, we begin to really crystalize that these are distinct populations, that we want to promote great hospital and post-acute care through home care and great hospital care, and we may not want to be creating the incentives for more community-based home-based care.

I think that's it. Thank you.

MR. ARMSTRONG: So, just a few brief points. Actually, I want to come back to what Mary just said.

First, in terms of the proposed draft recommendation, again, I like what we're trying to do, leaping silos, you know, trying to create connections between them, and then this idea that rather than just

paying for volumes, we're paying for some other kind of outcome, like reduced readmission rates is, again, extension of the policy that we're looking for or trying to advance.

To Mary's point, I just have to say, while I support going forward, that one issue I have is just that that's like paying more to reduce what's a very high rate of readmissions, which is not good. And so it's, like, if we're -- I mean, to me, home health is a pathway for patients to efficiently and really with great care get back home. And patients get there through the hospital, through skilled nursing facilities. Some come into home care from home. And while paying more for lower readmission rates or penalizing them for higher readmission rates deals with an issue, it doesn't exactly pay for what we're trying to achieve.

And so, anyway, I don't have a particularly well thought out next point there, but it just --

[Laughter.]

MR. ARMSTRONG: It seems like the readmission rate payment connection accomplishes some goals, but it's really just, I think, a compromise toward what we're really trying to get to.

Last point. I don't want us to go beyond -- although we won't be voting on this, I do want, just for the record, to affirm that we are reprinting our recommendations from earlier based on a general conclusion that the Medicare program is overpaying, on average, home care providers, and I just think no one has said that yet, and I affirm that that is something that MedPAC, to the degree we can change that, should be trying to change that.

DR. HOADLEY: So, I, too, support the general notion of the recommendation. The thing that I've been trying to think about is the overlap or non-overlap between the kinds of cases that this program in the home health sector would address, or in the home health silo would address, versus the cases that would be coming out of the hospital perspective. So, to some degree, by the concepts of preventable readmissions, from the home health perspective, you're kind of excluding some -- you could be, again, it depends a lot on the details -- you could be excluding some of the ones that the hospital is sort of at fault for and vice-versa. You've got time periods that are different, so the hospital is concerned about things that happen within 30 days of the hospital discharge and here

you're talking about things that are going to happen much further out in time.

So, I don't think there's any problem with this in terms of the policy, but, I mean, to the extent that we're thinking about this as getting everybody looking at the same issues, in a broad sense, that's correct. In the sense of which exact cases and examples this applies to, it may actually be a fairly different set. And I don't know if we have anything data-wise that would help us think about how much or how little overlap there is between the sort of set of cases that this policy would address and the set of cases that the hospital readmission policy would address. So, it would be useful to sort of think about that or even just think about it more qualitatively. But that's the thing that's been kind of sticking in my head.

MR. HACKBARTH: Any comment on that, Evan?

MR. CHRISTMAN: Yeah. I think that that's an important question, and I really hope -- I'm digging a little deep into my knowledge of HRRP, and, hopefully, I don't make a mess.

But before I say that, Medicare has developed a measure of rehospitalization in home health that could sort

of serve as the engine for this. There are some tweaks we would want to make. But one thing that I don't think would have to change is sort of the definition of what is a potentially avoidable hospitalization, is tied to this AHRQ CCS system. I think they're moving in the same direction in terms of their definition -- in that definition.

As I recall, HRRP looks at readmissions for index admissions for six select conditions, and, you know, you could certainly start with those in home health. When we talked to home health practitioners, when they think of who should be in the denominator of this type of exercise, they've always pushed us for more. You know, they've said that this is a -- there's, of course, people you can't do it with, but, you know, I think we convened a technical panel three years ago and they pushed us heavily for more, and I think there are people who would say you could go far beyond these six for home health, but you could certainly include those six.

So, I think the opportunity for some alignment there is certainly clear, and in fact -- but I would hope that they would wind up with a hospitalization measure that was perhaps a little bit more expansive than the HRRP six.

DR. MARK MILLER: As a Commission, we talked about the next generation of the hospital readmissions penalty and came to consensus that what we were looking for was all condition potentially preventable, and I think that's what we would, at least, be our opening notion here on the home health side. If there needed to be a transition, fine, but with the notion being that you're headed to all condition potentially preventable.

I took your question just a little bit differently, and I want to make sure I understand it. So, let's pretend for a minute we were in an all condition world, so we have this big long list of conditions, and you're saying, well, what if home health is readmitting these cases but hospitals tend to be responsible for these cases, right? Is that kind of what you were saying?

DR. HOADLEY: Yeah.

DR. MARK MILLER: And at least one -- and do not take this the way it's going to sound, but --

MS. UCCELLO: Then don't say it that way.

[Laughter.]

DR. MARK MILLER: Well, then I guess I just have to stop, I mean.

[Laughter.]

DR. MARK MILLER: I mean, let's pretend they were, and only some overlap. But wouldn't you still want the signals to both sets of cases? That's why -- I was wondering where your -- what if you found if they were perfectly aligned or if you found them perfectly unaligned or very unaligned, would you be in a different place?

DR. HOADLEY: Yeah. No, I think --

DR. MARK MILLER: So I don't mean it to be argumentative --

DR. HOADLEY: No, the program makes sense under either way, but I think it's a matter of us sort of thinking about -- so, part of what Glenn said initially was we want everybody focusing on the same situations, and if a bunch of the reasons for hospital readmission is, you know, people that were maybe discharged a little too early or without some things happening, that's kind of not the home health agency's fault. If something's happening down the road, you know, 45 or 60 days after the hospital stay, that's still something we want to hold the home health agency responsible for, but that's no longer the hospital's issue.

And that's fine. If we get everybody all across

the spectrum dealt with, that's the best outcome, but it just sort of understanding the extent to which we're focusing on that same cluster of cases versus, you know, a bigger cluster here and a bigger cluster here with a little bit of overlap. You know, nothing wrong with that, just sort of understanding where we are.

DR. CHRISTIANSON: Well, I also agree with the draft recommendation, the direction it goes. I think, listening to the conversation -- I'm just about at the end of the comments here -- I think everybody is suggesting the devil really is going to be in the details here, and I actually think this is going to be fairly difficult to get right. So, maybe it was Mike that commented, having a certain amount of ambiguity in terms of the actual direction here, not being prescriptive in the direction, is probably the right place where we should be right now.

MR. GEORGE MILLER: Yes. I do support the direction of the draft recommendation. I just, since the devil is in the details, I'd like to ask you to consider one more detail, and that is because of -- the chapter was very well written -- still talking about the high rate of fraud and abuse, that we consider -- that the Secretary consider

putting a moratorium on those States with high use to try to address that issue, as well.

MR. HACKBARTH: So, Evan, remind me where we are on this. We made a recommendation of that sort, that the Secretary ought to have such authority. Congress did, in fact, give the Secretary the authority and she has exercised it in some instances. Take it from there.

MR. CHRISTMAN: Right. The PPACA included the ability for Medicare to declare a moratorium on the enrollment of new agencies, and at the end of this summer, CMS implemented that authority in two areas, and I believe it was sort of the Chicago metropolitan area and --

DR. NAYLOR: Miami.

MR. CHRISTMAN: -- Miami. Miami. And I would -- you know, I think we'd certainly agree that's a good start. I think we're sort of waiting to see if other areas get pulled in. CMS has been relatively slow to roll this authority out. I wonder if they're waiting to see what happens before they use it more broadly.

MR. HACKBARTH: Thank you, Evan. Good job.

We'll now have our public comment period, and let me just see how many people want to go to the microphone.

[Pause.]

So, what do we have, five there?

Okay, so let me just repeat the ground rules. Please begin by identifying yourself and your organization. You have two minutes. When the red light comes back on, that signifies the end of your two minutes.

Again, I want to remind people this isn't your best or your only opportunity to provide input on the work of the Commission. The best opportunity is to contact the staff. Second best is to write letters to Commissioners or to post information on our website.

So with that, you're up.

MS. UPCHURCH: Thank you. My name is Linda Upchurch and I work for NxStage Medical. We're a Massachusetts based device company and the leading innovator in the field of home hemodialysis.

We appreciate the opportunity to share observations, and particularly this has been a long day for you guys and I really appreciate your thoughtful consideration of everything brought before you.

Each of us here in line has a passion about a particular topic and you've been expected to summarize them

all, so thank you for that.

Rather than read extensive comments, I want to respond to some of the questions that you raised today. In 2012 and 2013 you appropriately focused on the benefits of home hemodialysis. That work has made a difference, so thank you for that.

Medicare, in the final rule for ESRD, just cited the work that MedPAC did in making some of the changes that they made. There's still a ways to go but it really makes a difference. So I encourage you, that your work does make a difference there.

It is important to look at both the dialysis and the physician fee schedules. You've worked to look at alignment across things in different areas today. That's an area that particularly can have impact in the home dialysis world.

Specifically of concern today, I heard a notion raised that home dialysis is uniformly cheaper to provide. I want to correct that because that is note the case. The data has shown repeatedly that that is not consistently the case. While it can be, in some circumstances, it is not uniform.

There was also a question raised about mortality and I think, George, that was you. A published article from the USRDS has demonstrated through extensive propensity matching of 17 characteristics, including whether or not they were listed for the transplant list or not, that there is a distinct and significant survival advantage for patients treated with home hemodialysis, as compared with patients treated in the center. There's also a transplant advantage, even for those who were not previously listed on the transplant.

So home dialysis can make a difference.

I also heard many questions about health care disparities so I want to point you -- and I'll be submitting it online. Avalere did a study showing that nationally black dialysis patients are 20 percent less likely than average to be receiving home hemodialysis. Hispanic patients, 37 percent less likely to receive home hemodialysis.

So again, there is work to be done.

Finally, just for perspective, I want to bring back Dana Kelley's comment. She reflected on the fact that the 20 percent mortality rate in the LTCHs is a reminder of

how very sick these LTCH patients are. For the dialysis world, that is a pretty typical mortality rate in dialysis. So these patients are treated in the outpatient setting on an ongoing basis but a 20 percent mortality rate is not uncommon in these patients.

So again, we will be submitting additional comments. We appreciate the work of staff.

MR. ELSWORTH: Thank you. Good afternoon, my name is Brian Elsworth and I'm representing myself today.

Two comments. One on the readmissions program for home health. I think that's a very laudable idea. I would very much echo the comment that was made about don't just focus on the top 20 percent. There's no reason to believe, at all, that an agency at the 50th percentile, 40th percentile, couldn't make a measurable impact on readmissions.

I would also encourage you to adopt a bonus framework. Home health agencies have a variety of tools like home telemonitoring and care transitions that are very highly effective, but they take resources, in some cases labor, in other cases technology, to implement.

But the good news is that they can make a

measurable impact on readmissions. So I would encourage you to adopt a bonus framework and to reach across the full spectrum, not just the top 20 percent.

The other comment I'd like to make is about the CARE tool. It has been a long time. I was in a meeting on September 11th, 2001 on this topic at HHS. One thing I would say to you is 15 years ago it was definitely a good idea to rationalize the assessment instruments. I think now it's going to be a lot harder because these instruments are so ingrained in the various silos.

That said, I would encourage you to think very carefully about what you would use a common assessment instrument for and put as much time and energy into that as you are on the technical exercise of actually harmonizing the instruments.

I think things like rationalizing the use of therapy in SNF and home health is a very worthwhile exercise, and do the conceptual homework on that as much as the technical homework on how to make a uniform assessment instrument.

Thank you very much.

MS. CEPRIANO: I'm shorter than the other

speakers.

I'm Cherilyn Cepriano. I'm the Executive Director Kidney Care Council of the Kidney Care Council. We represent the nation's dialysis providers.

I want to thank you for your time today on the ESRD PPS.

I first want to thank you for thinking broadly about this payment system. It is, indeed, a bundled payment system. As you might imagine, we were somewhat disappointed that the actual legislation focused only on one component, this one class of drug utilization, without calling specifically for a broader look at the bundle as it is working or not working.

And so we strongly encourage you to continue to encourage CMS to look at the bundle in its entirety as a bundle.

In addition, I appreciate that you focused on access. I want to encourage you to think about access not just as whether or not there's a facility open or closed. Access is also about to what services patients have access to.

What we are hearing from our providers is that

they will need to scale back those services. Nutritional programs, something we think improves quality of care. They might not be affordable if this $30 cut goes into effect, whether it's done over one year, two, three, or four. At the end of the day, what the Agency has proposed is that if this full $30 is taken out, a complex health care system that is life-sustaining that involves labor, drugs, supplies across the board will be compensated by Medicare at about $216. That is simply an unsustainable trajectory going forward.

Finally, I very much appreciate that as you look broadly at this system you, as our provider members do, look at things like access to capital, building, we know you're probably looking at stock markets, et cetera. But in addition to that, keep in mind that Medicare is the primary payer for dialysis patients. They represent north of 85 percent of all of our patients in our clinics. And of those, 45 percent or better are also Medicaid beneficiaries. Medicaid reimbursement has come down substantially.

Our ability to cross-subsidize what is a barely break even and now going negative compensation from Medicare is being challenged by erosions of commercial coverage as we

see changes and challenges that will limit our ability to receive reimbursement on the commercial side.

So we are very committed to providing quality care, to doing so, but we think we have a very challenging number of years ahead of us in the ESRD PPS.

We look forward to working with you and your staff to make sure that we can continue to provide quality care for our Medicare beneficiaries.

Thank you.

MS. BENNER: Good afternoon. My name is Mara Benner and I'm here representing the Partnership for Quality Home Health Care. We appreciate the opportunity to comment.

The Partnership is usually focused on helping to evolving the Medicare program, including home health services, and really trying to offer up substantive solutions. But unfortunately, today we are faced with the CMS final rule with rebasing and our concerns at this point for its impact to access to care as we go over the next for years.

Prior to its release, the Small Business Administration, as well as AARP and other significant stakeholders, recognize the concerns for this upcoming 14

percent reduction. Amazingly, CMS did not follow through with regulatory requirements to consider the four-year impact on both patients as well as on job loss and on the small businesses providing the home health care.

At the same time, in their final rule that was released November 22nd, they did state that they feel that approximately 40 percent -- that, again, is 40 percent -- of all home health agencies will face negative profit margins by 2017. Because we are primarily a Medicare funded provider, that means that many are likely to go out of business. Therefore, we are very concerned about access to care.

So we are currently asking that MedPAC take the opportunity now to fully analyze the impact of this regulation, especially on seniors and the ability for them to access care, as well as solo county providers and also on clinician loss.

So we'd appreciate the opportunity to work with the staff because we believe that the impact of this regulation will significantly impact access.

Thank you again.

MS. McCANN: Thank you. I'm Barbara McCann and I

represent Interim HealthCare, but I've also been on the OASIS Technical Advisory Panel on and off for 25 years.

I would like to say to you thank you for bringing up the idea of a standardized tool, but I want to ask you to think about doing it faster, please.

We do 75 items on every patient that comes through. If you're not short of breath when you're admitted, you will be by the time we get through the assessment.

There are probably 20 to 30 items that I'd be happy to provide that are an overlap between risk adjustment measures and HHRG. The other 50 are very special, but I can tell you that I think we'd be happy to give them up.

Why? Because I can tell you at tables from Connecticut to California right now, we are working on bundling, we are working with ACOs on cross process and we are right now creating our own instruments.

What an incredible waste of time and resource to do that. And we're doing it on top of our assessments. Give us something to work with earlier.

A second comment, coming from the OASIS perspective. The data that you looked at today on

functional improvement was not solely Medicare fee-for-service data. Because we're required to submit that dataset on Medicare Advantage, Medicaid beneficiaries and Managed Medicaid, that's a mix of everything. It's not the same as the pure original Medicare data that you usually see.

But that also says to you, as MedPAC, you have the ability to create analysis that looks at those measures by different payer types.

My caution is, as we look at 17 states going into dual eligibles, what are we going to lose about the information on those individuals when they all go together under a managed care practice in those individual states just at the moment that we're the kind of progress we're also making with Medicare Advantage plans around the country.

Thank you.

MS. GAGE: Hi, I'm Barbara Gage, Fellow from Brookings Institute and PI on the development of the CARE tool and the management of the post-acute care payment reform demonstration.

I just wanted to underscore the great work that the staff has done on these different issues.

The comment that you just heard was a comment that we heard very frequently as we traveled around the country to over 200 types of -- 200 providers, including the acute hospitals, the home health agencies, the SNFs, the rehab hospitals and the long-term care hospitals.

What they appreciated, particularly on home health and SNF, was the level of granularity. So I would also add to those comments about that impairment analysis on the OASIS is that with the items that are on the OASIS, you can't really measure mobility or self-care to the degree that the therapists typically do. And that's kind of the approach that we took with the CARE items, was to get down to the granularity of the type of professional that typically assesses whatever the issue is.

I'm happy to answer any questions or come back in the future and do so.

MR. DOMBY: Bill Domby with National Association for Homecare and Hospice.

If no one else is behind me, maybe I can end it on a very high note, from our end of it at least.

The Chairman's recommendation, you can expect our organization to provide full support for it. We think it's

been an overdue change in the payment model. We would recommend the model which both rewards and penalizes. We think there is strong data available already to use that and to grow from that model going forward and getting more sophisticated.

So thank you for that recommendation.

MR. HACKBARTH: Okay, we are adjourned until 8 a.m. tomorrow morning. See you all then.

[Whereupon, at 5:04 p.m., the meeting was recessed, to reconvene at 8:00 a.m. on Friday, December 13, 2013.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 13, 2013
8:00 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
MICHAEL CHERNEW, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
PETER W. BUTLER, MHSA
John B. CHRISTIANSON, PhD
ALICE COOMBS, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
GEORGE N. MILLER, JR., MHSA
MARY NAYLOR, PhD, RN, FAAN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
CORI UCCELLO, FSA, MAAA, MPP

AGENDA PAGE

P R O C E E D I N G S [8:00 a.m.]

MR. HACKBARTH: Okay. Good morning. Our first topic this morning is Medicare Advantage. Although there is no update recommendation for Medicare Advantage, each year by statute we are required to report on the status of the Medicare Advantage program.

DR. HARRISON: Good morning. This is going to be a very tightly packed session. I'm going to present analysis of current plan enrollment and the plan bids for 2014. Carlos will then update you on plan quality performance. Due to time constraints arising from our loss of the October meeting, this material will be compact. We will be happy to take your questions and requests and follow up in the January meeting when you will have the MA draft chapter to review.

Later in this session, Kim and I will present draft recommendations arising from last month's discussion on employer plan bids and payments and the inclusion of hospice in the MA benefit package.

In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries. Enrollment in HMO plans -- the largest plan type -- increased 10 percent to nearly 10

million enrollees. Local PPO enrollment grew at about the same rate to 3.3 million enrollees. Regional PPO enrollment increased about 16 percent, reversing a prior year decline. Heads up here because plans project a decrease again for 2014. Regional PPOs seem subject to large swings because there are only five plan sponsors and any action by one of them can have a large effect. Finally, enrollment in private fee-for-service plans decreased sharply, continuing the expected decline resulting from legislative changes back in 2008.

Currently, about 28 percent of Medicare beneficiaries are enrolled in MA plans, 30 percent in urban areas and 18 percent in rural areas.

The MA plan bids submitted to CMS project an increase in overall enrollment for 2014 of 3 to 5 percent, exclusively in HMOs and local PPOs.

Medicare beneficiaries have a large number of plans from which to choose. MA plans are available to almost all beneficiaries; 0.4 percent of beneficiaries do not have a plan available, which is unchanged from last year.

This table shows three changes for 2014 on the

last three lines:

Private fee-for-service availability continues to decline, consistent with expectations from past legislation: 53 percent of beneficiaries will have access to a private fee-for-service plan in 2014, down from 59 percent in 2013.

The number of average plan choices declined from 12 to 10 per county, largely because of declines in private fee-for-service plans.

Finally, fewer beneficiaries will have a zero premium plan with drugs available in 2014, declining from 86 percent to 84 percent. This is an indication that as benchmarks have tightened, plans may have less with which to provide extra benefits.

We estimate that 2014 MA benchmarks, bids, and payments -- including the quality bonuses -- will average 112 percent, 98 percent, and 106 percent of fee-for-service spending, respectively.

HMOs are bidding an average of 95 percent of fee-for-service; all other plan types average over 100 percent. And payments for all types are above fee-for-service. Also note that employer group plans are bidding 107 percent, and we will come back to that shortly.

One finding not on this page is that if there were no quality payments for 2014, MA plans would be paid at 103 percent of fee-for-service, assuming a 1.0 risk.

Now you may remember that last year we projected most of these numbers to be a couple of points lower. However, our estimates of 2013 fee-for-service spending were probably too high last year; and, therefore, our ratios were projected too low. Our takeaway from these new numbers is that plans in 2014 are bidding and will be paid about the same relative to fee-for-service as they were in 2013.

Carlos will now present the analysis of plan quality.

MR. ZARABOZO: Comparing last year's quality indicators to the most recent results, we see that the majority of measures remain stable, including intermediate outcome measures such as the control of blood pressure among patients with hypertension. Also remaining stable or unchanged were patient experience measures from beneficiary surveys where enrollees rate their health plans, and the plans' providers, in terms of ease of access to care, customer service, and the perceived level of care coordination.

There was improvement in a number of indicators, including process measures such as cancer screenings, as well as in hospital readmission rates, and Part D drug adherence measures.

Beginning with the year 2012, Medicare Advantage plans are eligible for the bonus payments that Scott mentioned.

The level of the bonus is based on a star rating on a scale of 1 to 5. The star rating is a rating of the plan's overall performance. The elements of the star rating include the kinds of quality indicators I just discussed, as well as contract performance measures, such as disenrollment rates and the number of complaints about a plan. Each measure has a weight assigned to it, with outcome measures given the greatest weight and process measures the least weight.

Under the statutory provisions originally authorizing bonus payments, only plans at 4 stars or higher are eligible for bonuses. Under a program-wide demonstration that continues through 2014, plans at 3 stars or higher receive bonuses. Both the Commission and the GAO have commented on the design and the cost of that

demonstration.

Plan star ratings are updated in October of each year in order to provide the most current information to beneficiaries participating in the October-to-December annual MA election period. However, the level of bonus payments for plans is based on the ratings available at the time that plans submit their bids for the coming year, which is in June.

In this table, we look at a fixed enrolled population -- which is MA enrollees as of September 2013, before the annual election period -- to show what proportion of enrollees are in the highest-rated plans based on the new star ratings released in October, compared to the status of those same plans and the same enrollees under the previous year's star ratings for the same plans. This table shows that a majority of MA plan enrollees are now in plans where the most current star rating is 4 stars or higher. In other words, a number of MA plans had improvements in their star measures that were sufficient to raise the plan's overall star rating and which puts plans in a position of being eligible for bonuses even under the statutory provisions regarding bonuses. So in 2015, assuming that the enrollment

distribution across plans is unchanged from September, 51 percent of plan enrollees will be in plans getting bonuses.

What we also show in this table is the effect of the difference between the statutory provisions regarding bonuses and the demonstration rules that determine which plans get bonuses. In 2014, only 5 percent of enrollees are in non-bonus plans, while under the statutory provisions, almost half of all enrollees would be in plans that are not eligible for bonuses.

DR. HARRISON: Now we are revisiting the two topics from last meeting: employer group bidding and the inclusion of the hospice benefit in the MA package. First we will go over the employer plan bidding issue.

Recall that we laid out last time how the employer group plans do not compete for enrollment through the bids they submit to CMS, and we showed how much higher the bids for these plans were relative to non-employer plan bids.

You have seen a version of this table last month, and we have updated it for 2014. The median employer plan bid is 99 percent of its benchmark, while the median non-employer plan bids 87 percent of its benchmark.

As a result of the bidding behavior, for 2014, the

employer group plans bid an average of 107 percent of fee-for-service spending and are paid about 109 percent of fee-for-service, while non-employer plans bid an average of 97 percent of fee-for-service and were paid about 106 percent.

So last time we discussed an option to base the payments for employer plans on the payments made to non-employer plans. The option would set each employer plan's bid at its individual benchmark times the national bid-to-benchmark ratio. The payment to the plan would then be its resulting bid plus the rebate based on its quality rating.

We spoke with several plans and organizations in the industry and got some feedback. Some pointed out that most of the enrollment in the employer market was in PPOs; whereas, most of the non-employer enrollment was in HMOs. You may remember a few slides ago that we showed that HMOs tend to be significantly lower than PPOs. Thus, we felt it would not be unreasonable to account for the difference and modified the option so that the policy could be implemented by plan type.

Under this modified option, which is presented in more detail in your meeting materials, HMOs and PPOs would use different bid-to-benchmark calculations.

So here is the Chairman's draft recommendation, which reads: The Congress should direct the Secretary to determine payments for employer group MA plans in a manner more consistent with the determination of payments for comparable non-employer plans.

One way to accomplish this is the modified option I just described. That formulation would accommodate the different benchmarks that the plans may face in local areas and acknowledge that the bids may be higher for PPOs than HMOs.

However, alternative options may also work, and under the wording of this draft recommendation, the Secretary could use other formulations she found preferable.

As for implications, we expect that the draft recommendation would reduce Medicare spending. Most employer group plans would be paid less by Medicare. Thus, plans would either charge employers more, make lower profits, or lower their costs. Some employers might choose to stop offering employer group MA plans.

So some beneficiaries may find that their former employers or unions would drop MA plan offerings or pass higher plan costs onto them. As a result, some employer

group plan enrollees might instead choose plans in the non-employer market or move to fee-for-service Medicare, sometimes with an employer-subsidized wrap-around plan.

Now Kim will discuss hospice in MA.

MS. NEUMAN: In November, we talked about the hospice carveout from Medicare Advantage and discussed the idea of including hospice within the MA benefits package. We'll continue that discussion today.

First, to follow up on a question from November, Alice, you asked about how diagnosis profile of the fee-for-service and Medicare Advantage hospice populations compared. We have included a chart in the mailing materials with that data, and it shows that the diagnosis profile of the two populations is generally similar.

As you know, hospice provides palliative and supportive services for beneficiaries with a life expectancy of six months or less who choose to enroll. When a beneficiary elects hospice, the beneficiary agrees to forgo curative care for their terminal condition.

Both beneficiaries in fee-for-service and Medicare Advantage can enroll in hospice. When a beneficiary in Medicare Advantage elects hospice, financial responsibility

for that beneficiary's care becomes split between Medicare fee-for-service and the MA plan. Fee-for-service pays the hospice provider a per diem for all care related to the terminal condition. Fee-for-service also pays other providers for any Part A or B services unrelated to the terminal condition. The MA-PD plans pays for any unrelated Part D drugs and supplemental benefits such as reduced cost sharing. With this structure, financial responsibility for care becomes fragmented for MA enrollees when they elect hospice; whereas, their care would otherwise be fully under the umbrella of the MA plan.

The hospice carveout also makes MA plans' responsibility for end-of-life care uneven across its enrollees. The MA plan has full financial responsibility for end-of-life care for some enrollees but not others depending on whether they elect hospice.

In contrast to MA, which does not have responsibility for hospice services, Medicare fee-for-service pays for hospice, and ACOs have financial accountability for hospice through their benchmarks. Also, most private insurers include hospice in their benefits package.

If the purpose of Medicare Advantage is to give a health plan financial responsibility and accountability for managing the care of an individual, and for that plan to do so in an integrated and coordinated fashion, it would make sense that the MA plan have responsibility for the full continuum of care, including hospice.

MA plans also have flexibility that the fee-for-service program does not; for example, the opportunity to offer supplemental benefits that are beyond what is covered by fee-for-service but that adds value to the beneficiary. Including hospice within Medicare Advantage would give plans the chance to offer concurrent hospice and conventional care if they wished to do so.

If hospice were included within Medicare, how might that work?

Well, first, the full hospice benefit would be included in the Medicare Advantage benefits package. That would mean the plan would be responsible for the full benefit as outlined in the Social Security Act; the plan could not pick and choose what services within the hospice benefit it would cover.

To reflect the MA plans' new responsibility for

this broader set of services, the government's capitation to the MA plan would increase for all MA enrollees. Different from the current system, the capitation would not change if the beneficiary elected hospice.

Now, this would be a change for MA plans and hospice providers, so there would need to be lead time to negotiate contracts and develop networks.

With that in mind, the Chairman has developed a draft recommendation, and it reads: The Congress should include the Medicare hospice benefit within the Medicare Advantage benefits package beginning 2017.

The effect of this draft recommendation on Medicare program spending is expected to be minimal. In terms of beneficiaries, we expect no adverse impact on beneficiary access to hospice care. Like other MA services, choice of providers may be more limited than fee-for-service. Some beneficiaries might obtain access to concurrent care, as plans would have the option to offer it as a supplemental benefit if they wished to do so. Plans also would have the option to charge cost sharing.

Jack, you asked about the financial effects on beneficiaries. It's hard to know for certain whether plans

would charge cost sharing; but if experience with home health is any guide, we see very few MA plans charge cost sharing for home health agencies in their network.

As far as the implications for plans and hospice providers, there would be administrative costs for plans and hospices related to contracting. Plans, though, would be better positioned to manage and coordinate end-of-life care for patients than they currently are. And this may give hospices opportunities to work with plans to participate in new models of care delivery.

In terms of quality and delivery system reform, this would promote integrated, coordinated care and would be a step toward synchronizing policy across Medicare systems.

So that concludes our presentation, and we look forward to your discussion and any questions.

MR. HACKBARTH: Okay. Thank you. Good job.

So Round 1 clarifying questions?

MR. GEORGE MILLER: Thank you. Good morning and great presentation. On Slide 6, please, I think, Carlos, you stated that there was a perception of care coordination. How do we measure or how do we determine what that care coordination was?

MR. ZARABOZO: That references to a particular CAHPS question that asks: Do you get information from your physician? When you go to the physician, are they aware of what your needs are? And so on. So that's the basis of that particular measure.

MR. GEORGE MILLER: Okay. Thank you.

DR. COOMBS: Did you say capitation rates would not increase?

MS. NEUMAN: Including hospice and MA, the capitation rates would increase across all enrollees. But the not increased part is that if somebody elects hospice, the capitation would be the same. The capitation wouldn't be affected by an individual beneficiary electing hospice.

MR. BUTLER: On Slide 14, at the bottom you contrast this to MA, in contrast to MA. The minimum required benefit package to be on the health exchange, does it include hospice benefit?

MS. NEUMAN: That's not outlined specifically in the minimum benefit structure, but if you look at the benchmarks --

MR. ZARABOZO: Benchmark plans.

MS. NEUMAN: Yeah, the benchmark plans across the

states, almost all of them have hospice.

MS. UCCELLO: So what responsibilities, if any, do hospices currently have for coordinating the care for the unrelated care?

MS. NEUMAN: So the hospice -- in the conditions of participation, the hospice is required to share information with the non-hospice providers, and I think the extent to which that works and sort of how you'd ideally like it to I think really varies from what I hear anecdotally.

MR. HACKBARTH: Any other clarifying questions?

DR. CHERNEW: Can I ask a question?

MR. HACKBARTH: Yeah.

DR. CHERNEW: I have a question on Slide 5. We were in this transition period. We were moving from the old system to the new system under the Affordable Care Act that was going to put the MA plans in quartiles and have them range from 115 percent to 95 percent of the fee-for-service for the benchmarks. There was a transition period for that?

DR. HARRISON: So counties that didn't have to move a lot have fully transitioned. That was a two-year transition. So it was '12 and '13.

DR. CHERNEW: Okay.

DR. HARRISON: Counties that had a medium amount to move had a four-year transition, so they're --

DR. CHERNEW: In the middle.

DR. HARRISON: -- 75 percent of the way there. And then the counties that had a lot to move are halfway towards where they're going to be.

DR. CHERNEW: So my question is: We were at like -- if I remember correctly, the top-line number of benchmarks to fee-for-service was like 113 percent a few years ago. We've been through this transition for a bunch, and now we're at 112 percent of --

DR. HARRISON: I remember 117 and 119 from years back.

DR. CHERNEW: Okay. So --

DR. HARRISON: I haven't looked at the right year.

DR. CHERNEW: So the point is, going to 112 actually does reflect a lot of this transition that's happened, because I think it's going to end up at like 103 or something like that, is what we projected,.

DR. HARRISON: Well, without quality, I think we're going to end up at 101.5

DR. CHERNEW: So it's quality that gives you this benchmark --

DR. HARRISON: The 112 includes quality.

DR. CHERNEW: That was my -- I understand now.

DR. HARRISON: If you took quality out right now, they're at about 106.5.

DR. CHERNEW: Now I understand. Thank you.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: Let's see. Mary, do you want to lead off Round 2?

DR. NAYLOR: Actually, may I lead with a question? The bonus system in the Affordable Care Act, how long will that be? Are there defined limits to its implementation?

MR. ZARABOZO: The duration, it's statutory.

DR. NAYLOR: I know it's statutory.

MR. ZARABOZO: Yeah, it's statutory and will continue --

DR. NAYLOR: Will continue indefinitely.

MR. ZARABOZO: Four stars and above, yes.

MR. HACKBARTH: And just as a reminder, in Round 2 I do want your reaction to the two draft recommendations.

DR. NAYLOR: So to the first recommendation, which I'll find pretty quickly, that the Congress should direct the Secretary -- yes, I support the direction of this recommendation. This is very consistent with all the principles, all the work that you've done beforehand, this great report and this set of principles around getting to alignment for payment that are as comparable. I was interested -- I probably should have clarified. Remind me of the estimates in terms of other than would reduce Medicare spending when we achieve this final transition, the estimates for that.

DR. HARRISON: Do you mean where the benchmarks end up?

DR. NAYLOR: Where we get to a system where the employer group plans are more consistently aligned with the non-employer.

DR. HARRISON: Well, they would end up as the non-employer, and the non-employer would end up with benchmarks at 101 percent plus quality in 2017.

DR. NAYLOR: Plus quality, okay. Thank you.

And then in terms of the hospice recommendation, I also support including the Medicare hospice benefit within

the Medicare Advantage benefits.

MR. ARMSTRONG: I also support both of these recommendations. Just one comment on the second. I think this is really an excellent advancement in the right direction, and predictably, I would say it seems like you're really dragging it out by targeting 2017 as an effective date. And the kind of issues around building relationships between plans and hospice providers and so forth I just don't think are as complicated as you describe them to be. And so I just -- I support this. I would pick up the pace a little bit if we could.

DR. HOADLEY: Yeah, I support the recommendations.

On Recommendation 1, I had sort of talked last month about the issue of the relatively few plans that are more locally based, where the employers are more locally based, and I like the fact that, you know, you're not trying to get so specific that it leaves some ability to look later. I know you have at least one line in the text that kind of points out that that could be an issue in some cases. I think it's probably a relatively small issue, but I think it's good to keep that flexibility for the Secretary to think through whether that's something that they need to

deal with.

On Recommendation 2, I'm struck by Scott's comment about sort of how long it takes to do this, and I guess maybe one question is: The bidding cycle and sort of even just separate from the issue of making relationships, you know, what's the timing for a bidding cycle to actually know how to formulate a bid? I can't remember how much in advance the bids go in.

DR. HARRISON: The bids will be in by June 1st for 2015.

DR. HOADLEY: '15. So, I mean, that's one part of what has to be, but it still might be that we could say 2016, even for --

MR. ZARABOZO: Also the risk adjustment system needs to be --

DR. HOADLEY: Adjusted?

MR. ZARABOZO: Changed.

DR. HOADLEY: And then I had one thought just on the more general questions. You may do this in the more detailed analysis that you do in the full chapter, but I don't know if you -- have you looked at, you know, with the overall growth of enrollment in MA over a period of years,

how much change there has been in sort of the demographic and other kinds -- geographic and mixes? And is there any thought that that shift in the enrollment base is having any effect on the quality score? So if you've got more people enrolled who are younger, say, is there any thought -- I mean, I know a lot of the quality scores have risk adjustments built in, but is that something that's likely to affect --

MR. ZARABOZO: It would be difficult to look at in the sense that the quality scores now matter so much, so any change -- I mean, everybody, all plans, I mean, it's in their interest to improve the quality scores.

DR. HOADLEY: Right.

MR. ZARABOZO: We could try to look at differences across time and across populations.

DR. HOADLEY: Anyway, thank you.

DR. CHRISTIANSON: So a general question, I guess, first. Is there anything in your general presentation about the trends in the MA program that would be predictive of issues that the Commission might want to or need to address in the future?

DR. HARRISON: Most of what we do quantitatively

and with trends you will have seen. There's some longer-range trends. Is there something specific you're thinking of?

DR. CHRISTIANSON: No. I mean, it's a lot of data, and I was just wondering. You're very close to the data. Are there things here that might raise any flags for you?

DR. HARRISON: Not at this time, I think.

DR. CHRISTIANSON: Okay. Not yet.

DR. MARK MILLER: The only thing I would say here is there was a period where we were looking very intensively at the data and the trends and felt that the payment system was way off track and made a series of recommendations that, again, as usual, were highly popular. And, you know, there has been change put into the system as a result of our recommendations. And the way I see our work now, at least in a couple of areas, is we're watching this transition, you know, to the lower benchmarks and trying to be very cognizant of any negative impacts there. There's also some of the same problems for the four quartiles of the way they've organized the counties that we've raised in the past. We continue to watch the quality stuff, and we make

recommendations -- or comments, for example, each year as they come along on how to work that. And the employer and the hospice piece were a couple of items that we've always had around but had bigger fish and didn't have the bandwidth really to go through.

But I think going forward it's monitoring the impacts of the benchmarks, looking at those seam issues, staying on top of the quality issues. And I think, you know, as the transition goes, we'll probably have to come back and then start thinking about these rates relative to ACOs and fee-for-service, some of the other stuff that we've been --

MR. HACKBARTH: That's the piece that I was going to add. So that would be the next major look at this, trying to establish the level playing field across fee-for-service ACOs and MA as we began to discuss at the last meeting.

There was a period of pretty intensive focus on MA some years ago, well in advance of the Affordable Care Act, where we made these really popular recommendations that are referred to. The Affordable Care Act moved in the general direction that we had been advocating, do exactly what we

had been advocating. It has been my judgment that even though the Affordable Care Act isn't the way I would write the MA payment policy, it doesn't make sense for us this soon after the act to sort of pick at it and say you ought to do this differently, you ought to do that differently. Let's, you know, allow it to run for a while, monitor what happens.

And now we'll shift our focus down the road to this level playing field issue across the different platforms -- MA, ACO, fee-for-service. So that's been my sense, Jon, of how to proceed.

DR. CHRISTIANSON: Thank you.

On the two recommendations, the first one seems, you know, eminently sensible, but I wonder, it also seems pretty easy to understand how the incentives don't work there. And I agree with allowing quite a bit of wiggle room in terms of trying to address it and change the incentives as in the recommendation. But I wonder if given that, in my view at least, it should be a pretty easily understood problem and there are solutions, or at least potential solutions, why we don't have kind of a target date for that like we do for the second recommendation. It seems to me

like it's something that wouldn't take that long to do, and I would encourage us to -- I'm sort of chiming in with Scott's usual comment here, saying I think we can move this along. It's been a problem for a while. Why not do something about it?

And then I support the second recommendation. I think that makes all the sense in the world.

MR. GEORGE MILLER: Yes, thank you. I support the Chairman's Draft Recommendation 1. As others have said, it makes perfect sense. And just to lend my voice to accelerating the pace that Scott and Jon illuminated on the second recommendation, No. 2. But I would like to ask a question in more detail on Slide 7, and I think the corresponding slide would be No. 8. That is, on No. 7, have we determined or have you determined in your analysis the difference in the five-star -- once you get above four and those who move to five, is there a discernible difference? And do you drive -- the plans are driven to a five-star significant enough or is there enough quality difference and the financial incentive difference that they want to stay at five-star? Or is there some that may be a five-star that say, well, you know, four stars is good enough or four and a

half stars is good enough? Is there enough incentive, enough built in in the cost difference so that a plan doesn't say, well, I was at five stars, it's not worth the extra effort, I'll just slide back to four stars?

MR. HACKBARTH: One thing to keep in mind, George, is that in addition to the payment difference, there is an enrollment difference, and I'll ask Scott to address this. Five-star plans and only five-star plans can enroll people at any time of the year.

MR. GEORGE MILLER: Yeah, I remember that.

MR. HACKBARTH: Scott, do you want to --

MR. GEORGE MILLER: So is that enough of a difference to drive --

MR. HACKBARTH: Here's the man who would know more about it.

MR. ARMSTRONG: Yeah, actually I think it's a reasonable question to ask. We do ask ourselves that. We are a five-star plan. But it's a lot to maintain five versus four and a half. Year-round marketing is an advantage. Frankly the brand and the pride that comes from it is pretty powerful, too.

MR. GEORGE MILLER: Thank you.

MR. GRADISON: I support both recommendations. I continue to be interested in gaining a better understanding of why this percentage participation is MA is growing, and in particular, anything you may be able to dredge up with regard to the demography, the people that are moving in. I'm especially interested in knowing whether a significant explanation for the percentage increase are people who are new to Medicare, and the reason I'm interested is just a hypothesis that folks may be more comfortable with MA if it looks more like what they've experienced prior to their Medicare eligibility, because I think that could have long-term implications in terms of options that may be wise to offer in the future, even beyond MA, that would provide a more seamless transition from pre-retirement to pre-Medicare eligibility into Medicare eligibility in terms of plan type.

Thank you.

MR. HACKBARTH: That's an interesting point, Bill. Somebody earlier raised a question about whether changes in the composition of enrollment influences satisfaction scores. It would be interesting to look at whether people who are enrolled in a managed care plan before Medicare eligibility have different satisfaction scores than

beneficiaries who had never experienced managed care enrolled for the first time. I suspect the answer is yes. But I don't know if it would be feasible to look at that.

DR. HARRISON: We can look at people who age into a given plan, so that, for example, they were a member of Group Health the preceding month as an active worker and continue under -- an early retiree continue under Medicare.

MR. HACKBARTH: Just to be clear, I wouldn't invest a huge amount of resources on it, but, you know, I suspect that future cohorts of Medicare beneficiaries, having become accustomed to managed care during their working lives, will have different attitudes, different propensity to enroll, and different levels of satisfaction than beneficiaries who never experienced managed care before.

DR. COOMBS: First, I support both recommendations.

Kim, I'm very grateful for you having done this graph because it was something that was in the back of my mind based on another hospice chapter that we did unrelated to MA plans. And the thing I was specifically interested in was the non-cancer diagnosis; and if they're comparable, I

think that this is an easy transition. So I speak in favor of that.

Thank you.

DR. NERENZ: I'm fine with the recommendations. I have a very general background question about the extent to which MA plans have flexibility in terms of the kind of payments they make to providers, the sort of covered services. For example, are they fully free to enter into bundled payment arrangements as opposed, for example, to being quite limited by the fee-for-service regulations? I realize that's a fairly amorphous question, but I'm going to get to something from that.

DR. HARRISON: They are free to set up their own payment arrangements. There are certainly medical groups that work with plans that get global capitation, and there's a lot of fee-for-service payment, and I think all kinds of arrangements in between.

DR. NERENZ: All right. So as a new for instance, an MA plan could contract with an ACO on some sort of agreed-on financial terms.

DR. HARRISON: I believe they are doing that.

DR. NERENZ: Okay. Then if we go to Slide 5,

every time we have this discussion, I'm interested in the right-hand column, and I'm trying to decide whether the fact that these are over 100, does that represent good value for the Medicare program and for the taxpayers? And I understand there's a quality component to that. I understand there's an added benefit component. But I still always wonder why aren't those numbers closer to 100. And if there is this flexibility and there has been this flexibility for a long time, I'm wondering, you know, why we don't see perhaps greater evidence at the aggregate level of some creativity that would ultimately lead to lower costs. So that's where this all goes.

DR. HARRISON: Well, the reason why things have been above one isn't necessarily the bid. Some plans can bid below, so their costs presumably are below.

DR. NERENZ: Understood, yeah.

DR. HARRISON: But the benchmarks had been so high that you were going to get a higher payment.

DR. NERENZ: And that was also another question, and I think Mike kind of got into that, because it is driven by the benchmarks, not strictly by the bids. And we've talked about that in the past, and we're, you know, trying

to drive that down. So, again, I'm not observing any acute specific problem, but still it's sort of a bottom-line question if you look at right-hand Slide 5. Is this good value or not good value?

DR. HARRISON: All right. So two things. One, if you got rid of the quality payments, the 106 would be 103. So there's not a lot we're playing with there.

Now, the beneficiaries do get extra benefits. The rebates give them extra benefits. What we've always objected to is that it's Medicare that's paying for these extra benefits instead of the beneficiaries.

DR. NERENZ: Understood [off microphone].

MR. HACKBARTH: Dave, my view has always been that we ought to pay the same amount, let the beneficiary choose, so it ought to be a financially neutral choice.

Now, you know, I could live with a system that said, well, if an MA plan has higher quality than fee-for-service, there could be an added increment for quality, just as we provide added payments for quality on the fee-for-service side. And if on average all MA plans had higher-than-average quality, then you could have 100-plus percent with the quality add-on. But that's not what's happening

here yet. This isn't purely quality. This is a function of quality and benchmarks that are too high.

DR. REDBERG: I support the Chairman's recommendations and would hope we could transition to them as soon as feasible to including the hospice in the MA plans.

My question -- well, it's not really a question, but I'm interested in the relationship of quality measures and beneficiary health, and I'm just wondering, you know, now that we have many more people in MA plans and more time, whether we could start at some point finding information that actually looks at, you know, rates of flu or cancer or diabetes or heart disease related to the quality ratings, the star ratings, to see whether we're really measuring what we hope we're measuring with the star ratings, which is that they're getting better care and, therefore, would have better outcomes.

DR. HALL: I'm in favor of both of the recommendations. Apropos of the star ratings, I think we may be into an era where we're seeing a ceiling effect with star ratings. I think anything below a three doesn't really count. But so now we're really talking about a three, a

four, or a five. Who's to say that five is the right level for quality? So I think that's another thing as we go forward we might want to keep track of.

If you go on Medicare.com and try to look up -- .gov, I'm sorry, and look up what are the distinctions between the various levels, it's not that easy. You really have to want to know, like you're preparing for a MedPAC meeting or something, to do this.

[Laughter.]

DR. HALL: A word about the hospice carveout and what we're trying to do about it. I think this is a momentous thing for us to be doing. I live in a community that has very, very high managed care penetrance in MA plans and also, I think, a relatively advanced sort of understanding of hospice benefits for a variety of reasons. And even where the deck is stacked in our favor, the confusion that results with families and people trying to take care of -- or take advantage of hospice benefits is really enormous. There's a lot of turnover in personnel that are taking care of them, and there is a lot of mis-billings. They just don't need this sort of thing. And so I think it would help very much if this were part of the MA

-- if it was more uniform in the MA plans versus fee-for-service. So I think we're making some great progress with both of these recommendations.

MR. HACKBARTH: Bill's initial comments about the stars raises a question for me, so, you know, we've got this star system. You know, within the levels there are measures of performance that aren't constant. They can be changed. Is there a systematic plan for how aggressive the targets should be to qualify for levels? How does CMS think about that systematically?

MR. ZARABOZO: There was a mention in the mailing material that the four-star threshold did not change this year, but CMS can change the four-star threshold and say, for example, plans have been performing at a very high level on this particular measure.

One thing that happens in that case is the measure is no longer used because all plans are performing at a high level. Or they could say we established a four-star threshold based on historical results; we now see that the results are coming in much better and, therefore, we're raising the cut point for what determines a four-star plan. So some plans might drop below the four-star level. So it

does vary from year to year.

MR. HACKBARTH: So have they articulated a standard that, you know, they're going to use a certain percentile of performance, you have got to exceed that percentile in order to qualify?

MR. ZARABOZO: Yeah, I think when they established the four stars, it was based on the percentile performance. But they're saying now, I think, that they're going to look at the four-star thresholds in the next round.

MR. HACKBARTH: Okay. Thanks.

DR. HALL: You know, I think it's a little bit like Lake Wobegon where all the children are above average. And I think probably there should be a star rating of seven or eight. There should be some reach goals, and at some point we might want to look about incentivizing institutions to get to a higher level than -- five is not perfection. It's just a metric.

DR. BAICKER: We have to fight grade inflation everywhere we see it.

[Laughter.]

DR. HALL: Harvard. Everything [off microphone].

DR. BAICKER: Yeah, I've heard.

So I support both recommendations. I think it's appropriate -- I think it's a great tactic to have the first one be broadly cast with then some examples of the specifics, because I do think there are a lot of -- the devil is always in the details, and the specifics about the way the benchmarks are set nationally versus regionally, thinking about breaking out the HMOs versus the PPOs, there are a lot of moving parts. But the examples will show that it's implementable and concrete, and the recommendation will give the flexibility to explore the details. So I think that's a great combination.

DR. CHERNEW: So I also support both recommendations, and let me just take a quick second to say what I think the tradeoffs are.

For the first one about MA, I think the basis issue, which you went over last month and again here, is that in the individual market, in order to give extra benefits, you have to bid below the benchmark and pay for those with the rebate, and the employer doesn't have to do that. And as we discussed last time, it's too hard to make the system symmetric because there's too many employer plans doing too many things. So basically, effectively, there's

essentially a tax if you're buying an MA plan sort of individually that the employer doesn't have to pay; the employer can get the whole benchmark.

And so I think in the end of the day, I find it compelling that we'd like those systems to be as comparable as we can make them, given administrative complaints. And so that's why I support the recommendation.

That said, you mentioned -- and you went through it relatively quickly on one of the slides -- the beneficiary perspective about employers dropping MA plans. I do think that that is a concern. So while I support the recommendation, it is a concern if we were driving too many beneficiaries away from things that we thought were particularly good or concern employers were dropping out of the MA market or things like that. I don't have any reason to believe those behavioral responses will be particularly large, and so in the end of the day, I don't think we can justify this asymmetric system between the employer and not. And so equalizing them I think is useful, which is why I support the recommendation. And I do like the generality of the way that it's set, the way that it's stated.

With regard to the hospice benefit, again, I'm

always in favor of consistency and simplicity, and it strikes me that this is moving in the right direction for that reason. And I do believe that there's some ability for MA plans to integrate this benefit and do good things. There's been some examples of some companies that I think have done good things around this benefit, and I think that's good.

The only pause that I have -- and, again, let me reiterate I support the recommendation -- is there is this concern about the price that MA plans have to pay. And so the tradeoff is between the efficiency that you get and the simplicity and the integration of the benefit with the potential that the MA plans are ending up having to pay more for the same benefit because they have to negotiate the rates as opposed to using what the Medicare hospice rates would be.

Again, in the end of the day, I come down supporting the recommendation because I think that simplicity and consistency dominates and allows the potential for efficiency. But I think we have to monitor as this works through the potential downside. So I support both the recommendations. Both of them have a little bit of

tradeoffs in my mind about what the risks are, but I think monitoring them going forward, the benefits of both outweigh the potential risks.

MR. HACKBARTH: Mike, on the second point, if I understand you correctly, you're saying MA plans may need to pay hospices more than Medicare rates. Is that --

DR. CHERNEW: Yes, they may have to do [off microphone].

MR. HACKBARTH: How is that different from any other provider?

DR. CHERNEW: Any other service -- no, I agree 100 percent. So for any other service, the tradeoff for MA is the efficiency of MA with the fact that they may have to pay for those services more than the Medicare rates. And so the MA program is basically a tradeoff between the efficiency of the plans versus you lose the price power. And so in the end of the day, consistency wins the day, but at the margin when you make this change, you would have to think about in this particular context how that was playing out.

DR. MARK MILLER: And at least in our conversations with both the hospice side of this discussion and the MA side of this discussion, those concerns were

expressed both ways: that the hospices came in and said, "We're going to get rates less than fee-for-service," and the MA plans came in and said, "We're going to have to pay rates above fee-for-service." And I suspect -- well, I suspect it will depend market by market and, you know, whether you have a large dominant hospice in any given market or whether --

DR. CHERNEW: And whether the recommendations on the hospice chapter, which we'll have, get followed, right? So when we think about the way that the -- I've got to keep my hand away from the mic. For certain services, the payment rates that the Medicare program pays to the providers are more generous than for other services, and so the potential for MA to undercut varies by the rate that we pay. If we were to lower the -- if the Congress were to lower the rates that the hospices cut, it's going to be harder for MA to pay under, or over.

DR. MARK MILLER: Understood [off microphone].

MR. HACKBARTH: Remind me, Scott, what the rules are about MA plans being able to require providers to accept fee-for-service rates. It used to be that they could do that at least in some circumstances. What's the status of

that now?

MR. ZARABOZO: That's for the out-of-plan services that they assume financial responsibility for. So if somebody goes to the emergency room, the liability of the plan is the Medicare rate.

MR. HACKBARTH: Yeah, but wasn't there -- maybe it was just sort of a private fee-for-service plan --

MR. ZARABOZO: Private fee-for-service paid Medicare rates, and there's a minor provision for the regional plans for essential hospitals to --

MR. HACKBARTH: Okay.

MR. BUTLER: First is just an observation on this Slide 5. You know, we spend a lot of energy understanding why these numbers are above 100 percent, and we've said it's benchmark driven, and it's the return of benefits for the excess, so there's some value there.

I'm kind of curious. We never show -- this is for the future, like medical loss ratios, and show in a fee-for-service plan how much of these percentages are tied up in administering the plan in the fee-for-service model versus the MA plan. And my guess is it's, what, 4 percent versus 15 percent? I'll throw out, you know, some kind of average.

And it will be a little -- another way to look at this.

Now, the difference, of course, could be both the amount of care as well as the prices that are paid by the MA plans. But it might be another lens over time that would help us better understand some of these comparisons.

So now back to the --

DR. MARK MILLER: Just to make sure I follow, you're almost saying if I had that information, but I also knew by plan type what the average MLR is, that would be helpful.

MR. BUTLER: It would be an interesting way to evaluate, you know, what these options are providing. I think a lot of people say, "Boy, 96 percent of the dollars are going to health care?" That's another way -- well, you understand the point.

MR. HACKBARTH: And we have those data from bids.

DR. HARRISON: Right, we have the projected values.

MR. BUTLER: So now back to the recommendations. I support both of them. I'm not sure why we don't do 2016 versus 2017. I'm sure ultimately the Chairman will respond in one way or another to that urging. It's not the biggest

deal in the recommendation.

But I would go back -- we kind of say, well, it makes sense to coordinate care. I think it's a little bit stronger than that. We probably should have had the hospice chapter first rather than following this discussion, because it highlights the emergence of the neurological diagnoses being so predominant. It also highlights the fact that, as we've said before, oversight and recertification is kind of an issue. You're not sure when you should be in or out of the hospice program. And if you have another set of eyes that are kind of coordinating this on behalf of the patient, it makes a lot more sense than kind of having these things separate. Hopefully people will end up in the right place at the right time, and we should spend far less time on the healthy 65-year-old and more on this particularly vulnerable part of life to kind of make sure that everybody's on the same page. So I think it's more than just kind of, well, that kind of makes sense. I think it's pretty essential.

I am sensitive to the hospice folks that say, hey, you know, this is the time that you need choice more than ever. But I would want to see some demonstration, not just concern that that may happen but demonstration in the

private plans that maybe it has happened in a way that, you know, would create some concerns. And I'm not sure there is that evidence. But I would be sensitive to that if that was available.

DR. SAMITT: So I support both recommendations as well. I want to direct my remarks at the imperative for the level playing field discussion between fee-for-service, ACO, and MA. And at the risk of disagreeing with the Chairman, I think that from my perspective -- huh?

MR. HACKBARTH: I said it won't be the first time [off microphone].

DR. SAMITT: Okay, it won't be the first time. So I would say that the imperative for the level playing field is not at the payment level; it's at the value level. So I think, you know, one of the things that we've been struggling with that we're unable to assess is what are the differences between service, access, quality, benefits between fee-for-service and ACO and Medicare Advantage? Because certainly if the Medicare Advantage model or the ACO model is in some way offering a higher level of quality, greater efficiency, better accessibility, there may need to actually be a differential payment if we find that that is

of value. So I think we just have to be careful not to swing the pendulum the other way in terms of creating equal payment when the two programs, as we study it, may not be of equal value to the beneficiary.

The second comment that I would make is about the star program. I'm a big fan of the star program. I think it continues to move us forward to better care at a lower cost. If I were to recommend any enhancements in the star program, I would say that we should be measuring star performance not just at the plan level but at the sub-plan level. For someone like Scott, it's one and the same, but there are several large MA plans that actually have sub-performance where perhaps more coordinated or integrated care models that are in that network are outperforming less coordinated models, and right now that difference gets masked. And I recognize I am beating my usual drum, which is getting at the sub-information that distinguishes performance within MA plans. But I think there would be merit to expanding the star program to rewarding sub-performance of quality within MA networks.

MR. HACKBARTH: I'm not sure we're that far apart, if at all, on the first point.

Let me just ask a question about the second. So in various contexts, we've noted that often MA contracts include, you know, large geographic areas and, you know, even different models of care. That choice resides in the hands of the plan on how they want to deal with CMS?

MR. ZARABOZO: That's correct. The star rating is at the contract level, and as we pointed out in other material, you have multi-state plans that get one-star rating across many different markets. And within California, for example, Northern and Southern California are under the same star rating, and those are very different markets.

MR. HACKBARTH: Has CMS ever looked at saying that we need to have contracts by market level or some other smaller unit?

MR. ZARABOZO: Well, the ratings used to be at the market level, at a smaller unit. And as we recommended when we did --

MR. HACKBARTH: Right.

MR. ZARABOZO: -- to do plan-level comparisons, they do, of course, have -- the special needs plans are separately reporting, so there's a subset of plans that are

separately reporting. But that is an issue that this is too broad, the unit of observation is too broad for the stars.

MR. HACKBARTH: Yeah. So it was, what, three or four years ago we did a mandated report on how you would have to redesign the system to be able to compare MA plans to fee-for-service in a more reliable way, and this was one of the recommendations.

What did CMS say in response to that specific recommendation about --

MR. ZARABOZO: The most recent thing that they've said is that it would be problematic to do so.

[Laughter.]

MR. ZARABOZO: Something to that effect.

DR. HALL: Just in terms of Craig's comments, most large insurers who have a pretty large book of business in MA also have data showing exactly what you're talking about. So they'll say, we've made substantial improvement, because now in 40 percent of our sites, we're operating at a five level. And then you say, well, and on the other side? Well, they're coming up.

So, I don't think that's public knowledge, but I'm sure that every insurer has that and then looks at that as

their own internal benchmark. But that could be obscured at the level that you're talking about, completely.

DR. MARK MILLER: [Off microphone.] I almost heard you saying an additional point. So, it's reported at the organization level. We've talked about having it at the plan. But I heard you say you wanted it even below the plan level. Was that correct --

DR. SAMITT: Yeah.

DR. MARK MILLER: -- or did I misunderstand?

DR. SAMITT: Yes. It's very much in line with what Bill's describing --

DR. MARK MILLER: Yeah. That's what I'm --

DR. SAMITT: -- that it's even within a plan, you'll find you have five-star performers and two-star performers and you mask, really, the ability to translate incentives for quality to those organizations when they're diluted within large networks.

DR. CHERNEW: I think -- so, I agree with that in a variety of ways, but ignoring any methodological or sample size issues, one of the other concerns is -- and I see this in -- if you read through the chapter, there's, like, there's the HOS measures, the HEDIS measures, there's the

CAHPS measures, there's tables that say, these ones got better, these ones were stable, these ones got worse, and then there's a discussion of them for one way or another.

Kate said something yesterday which I think is important and often not captured, which is there's a lot of noise around a lot of these things and I would be really hesitant to overreact to specific things, or if you started doing sub-measures, it might be that there's a good and a bad sub-plan. It might be that if you break things up enough, some are going to be good, some are not going to be good. You go two years down the line and they'll switch.

So, there's always this question about how you deal with the noise when you have multiple measures and finer cuts, so for whatever it's worth, I do think it's worth exploring when the plans have very different systems. There's, like, a more integrated and less integrated system. But if you allow too much flexibility about what the subgroup is, you run into complicated multiple comparison issues.

MR. HACKBARTH: Yeah. It's an important but really complex sort of issue to think through. There is that noise issue. But think of a large network plan, which

many of them are, and they encompass, you know, the vast majority of the providers in a given market area. And we know from other data that there's likely to be variation in the performance of the providers within that network, but they have chosen for their business reasons that they want a large, inclusive network.

Now, we tell the Medicare beneficiary that that's a four-star plan or a five-star plan or a three-star plan, whatever it is, knowing full well that the quality of care that the beneficiary gets depends not on the plan's star rating, actually, but which of the providers they choose within that all-inclusive network. That's where the rubber hits the road.

And so, in some ways, we could with the star system be sending signals that include a lot of noise, not just statistical noise --

DR. CHERNEW: Right. Right.

MR. HACKBARTH: -- but averaging performance kind of noise that doesn't help beneficiaries.

Herb.

MR. KUHN: The two recommendations, I support both, the first one, in terms of determination of payments

for employer group MA plans, and, of course, the inclusion of hospice, the second recommendation.

I would like to just ask one, maybe, question of Carlos, and per the slide that's up here, we've talked a lot today about the benchmarks and the payments relative to fee-for-service above the benchmarks. In the other payments issues we looked at yesterday, one of the metrics we looked at was margins, and we had a robust conversation about margins. Do we have any information in terms of general information about margins for MA plans? Is that something we could also look at in the future?

MR. ZARABOZO: I'm going to punt this to Scott, as prearranged.

[Laughter.]

DR. HARRISON: What we have -- so, the bids break down into medical costs, admin, and margin, but those are projected forward. What we don't really have is anything historical, like what's used -- we don't have cost reports. Now, we could present the projections, and we'll do that in January, if you'd like, but digging backwards is a little more challenging.

MR. HACKBARTH: Didn't GAO at one point several

years ago actually do a look-back and compare what was built into the bids with what they -- an estimate of what the actual was relative to the bid?

DR. HARRISON: Yeah. So, when you submit a bid, you're also supposed to build it up from past performance. I don't know how well that's audited, but there should be some historical stuff. I don't know whether we get that particular subset of data, but we could look into that, and it would be a few years back.

MR. HACKBARTH: Am I imagining the GAO study? Do you remember the one that I'm talking about?

DR. HARRISON: Yeah.

MR. HACKBARTH: And my broad recollection -- please feel free to say, no, you don't remember correctly -- but my recollection was that they said that the actual estimated profits were significantly higher than the margins that were built into the bid, is that --

DR. HARRISON: That may very well be true. Part of the problem, well, not problem, but part of the data issues may also be what gets counted as, like, Medicare allowed, like in the margins for --

MR. HACKBARTH: Yeah.

DR. HARRISON: -- some of the providers, and I don't know -- you know, if you're providing nurse hotlines, does that count as a Medicare-covered service --

MR. HACKBARTH: Yeah.

DR. HARRISON: -- and that kind of thing. So --

MR. HACKBARTH: So, if you would --

DR. HARRISON: We would have to take a little --

MR. HACKBARTH: Yeah. Just so I don't leave an inaccurate impression with people, would you just look up that GAO study and report back on what it actually said at the next meeting.

DR. HARRISON: Sure.

MR. HACKBARTH: I don't want to put out misinformation.

DR. MARK MILLER: Yeah, and I want to nail this down. So, we will report admin and margin in the January meeting --

DR. HARRISON: From the bids.

DR. MARK MILLER: Right, from the bids. That was the plan. We're going to start working on Peter's NLR thing, which is very similar to what we're talking about here, and we'll run the GAO thing down and so come back to

you with a specific number.

Does anybody want to pop off and say what the range is?

DR. HARRISON: In looking at the three-pronged breakdown of med, admin, and profit, I kind of remember that --

DR. MARK MILLER: I'll pop off. I think it ranges somewhere between, what, 12 and 15 percent for admin and profit?

DR. HARRISON: Admin and profit together, yeah.

DR. MARK MILLER: Now, you can't write that number down. We'll come back with a specific number, but I think that's the ballpark that we're talking about. Is that about right?

DR. HARRISON: That's about right, yeah.

DR. MARK MILLER: Okay.

MR. KUHN: [Off microphone.] Thank you.

MS. UCCELLO: I support both recommendations. I like the way the first one is framed more generally and I like the additional discussion about the separate ways to deal with the PPO and HMO plans.

I thought the quality section was well done,

Carlos, and I just want to confirm that I read this correctly, that it's just -- it's not clear that beneficiaries are moving from low-star plans to high-star plans.

MR. ZARABOZO: Right. That was the point. We're still looking at that.

MS. UCCELLO: Yeah. So, I think just understanding more, and I think that you guys are doing more work on this generally, about what factors play into beneficiaries' decisions on which plans to choose, I think is just important, kind of generally, to know.

MR. ZARABOZO: That's exactly what we're looking at, yeah.

MS. UCCELLO: Yeah.

MR. HACKBARTH: So, we're done for today. Thank you. Very good work. And we are ready to move on to hospice.

[Pause.]

MS. NEUMAN: So, now we're going to talk about hospice payment adequacy, and I'll start with some basic statistics for 2012.

In 2012, about 1,270,000 Medicare beneficiaries

used hospice, including more than 46 percent of beneficiaries who died that year. Over 3,700 hospice providers furnish care to Medicare beneficiaries, and Medicare paid those hospices about $15 billion.

While it's not the focus of our hospice payment adequacy discussion today, we also note that Medicare paid about $1 billion in 2012 to non-hospice providers for care provided to hospice enrollees unrelated to the terminal condition. More information on that topic is in the appendix of your mailing materials.

So, we've already talked about the hospice benefit in the prior session, so I'm just going to highlight one piece of background information on this first slide and that relates to the eligibility criteria. For a beneficiary to be eligible for hospice, they must have a life expectancy of six months or less if the disease runs its normal course. At the start of each hospice benefit period, a physician or physicians must certify that the beneficiary's life expectancy meets this criteria. There's no limit on how long a beneficiary can be in hospice as long as he or she continues to meet this eligibility criteria.

So, this next slide reviews the Commission's work

that led to recommendations in March 2009. We plan to reprint some of those recommendations in the upcoming March report, so I'll review this briefly.

In 2008 and 2009, the Commission looked at hospice in depth. Our analysis uncovered some trends. Since 2000, there had been substantial entry of for-profit hospices, increases in length of stay for patients with the longest stays, and higher lengths of stay among for-profit hospices than nonprofit hospices across all diagnoses. And this pattern of events suggested to us that there may be issues in the payment system that are creating opportunities for actors to pursue revenue generation strategies.

So, we took a look at the payment system and found that it doesn't align well with hospices' provision of care. Medicare generally makes a flat payment per day for hospice care, while hospices typically provide more services at the beginning of the episode and at the end of the episode, near the time of the patient's death. As a result, long hospice stays are generally more profitable than short stays.

In addition to issues with the structure of the payment system, we also uncovered issues with accountability of the benefit. We had information from a panel of hospice

physicians and administrators that suggested that the benefit needed stronger oversight. Panelists reported lax admission practices and recertification practices at some hospices, and some expressed concern about questionable financial arrangements between some hospices and some nursing homes.

So, to address these issues, in March 2009, the Commission made a series of recommendations to reform the payment system, to improve accountability, and to increase data reporting to better manage the benefit, and I'm going to highlight two of these recommendations where action has yet to be taken and where we plan to reprint the Commission's standing recommendation.

First is payment reform. The Commission recommended the payment system be changed to a U-shaped model, higher at the beginning and end, lower in the middle. Subsequent to this recommendation, Congress gave CMS the authority to revise the payment system as the Secretary determines appropriate in 2014 or later. CMS has been conducting research on payment reform, but to date has not made changes to the payment system, so we plan to reprint this recommendation.

The other recommendation I'll highlight relates to increasing accountability. The Commission recommended that the Secretary conduct focused medical review of all stays beyond 180 days for providers with unusually high shares of patients with very long stays. While PPACA included a provision for focused medical review, CMS has not implemented it, so we plan to reprint that recommendation, as well.

So, now we will look at our standard framework for payment adequacy. First, we have a chart showing growth in the supply of providers. Focusing on the green line, we see that the total number of hospice providers serving Medicare beneficiaries has been increasing for more than a decade. In 2012, the number of hospice providers continued to grow, up about 3.8 percent from the prior year.

Now, if we look at the other three lines in the chart, we see the trends in the number of providers by type of ownership. This shows that the growth in provider supply is being driven almost entirely by for-profit entry. The number of nonprofits and government providers have been stable or on a slight downward trend.

The next chart shows the increase in hospice use

among Medicare decedents. In 2012, 46.7 percent of decedents used hospice, up from 45.2 percent in 2011. Across a wide range of beneficiary characteristics -- age, race, urban/rural, gender, fee-for-service, managed care, dual and non-dual eligibles, hospice use among decedents increased between 2011 and 2012. Minorities and beneficiaries in rural areas continue to have lower hospice use than other beneficiaries, although hospice use is increasing for these groups, as well.

This next chart gives us a further picture of utilization growth. The number of hospice users grew to more than one-and-one-quarter million in 2012, a 4.5 percent increase from the prior year. Average length of stay among decedents also increased between 2011 and 2012, from 86 days to 88 days. Median length of stay was 18 days in 2012 and has been relatively stable at 17 or 18 days since 2000. Not shown in the chart, length of stay for the longest stays continues to increase. The 90th percentile in length of stay among decedents grew from 241 days in 2011 to 246 days in 2012.

As we've talked about previously, both very short stays and very long stays are a concern. With short stays,

there's the concern that the patient doesn't get all that hospice has to offer. And with very long stays, particularly when they make up an unusually large share of a provider's case load, there is concern that some providers may be seeking out patients likely to have long stays who may not meet the eligibility criteria.

As we noted earlier, inaccuracies in the current payment system make long stays more profitable than short stays, which makes the payment system vulnerable to patient selection. As shown on this slide, length of stay varies by observable patient characteristics, like diagnosis and patient location. This means that hospices that choose to do so have an opportunity to focus on more profitable patients. Consistent with that, we see for-profit providers having substantially longer lengths of stay than nonprofits, 105 days versus 69 days, on average.

And when we look at the margin figures later, embedded in those margins will be the effects of length of stay differences on providers' financial performance. Payment reform would lessen the variation in financial performance across providers.

So, next, on to quality. We currently lack

publicly reported data on hospice quality. Per PPACA, hospices began reporting quality measures in 2013, and if they fail to do so, they face a two percentage point reduction in their update for the subsequent fiscal year. In 2013, the vast majority of hospices reported quality data.

Two quality measures were initially adopted. One seeks to measure the effectiveness of pain management and a second was a structural measure to help CMS identify additional measures for the future. CMS will be replacing these two measures in the near future. Beginning July 2014, hospices will be required to submit quality data for seven process measures through a standardized instrument. For example, a couple of the process measures relate to screening and assessment of pain and assessment in treatment of shortness of breath.

In 2015, hospices will also be required to participate in an experience of care survey. The survey will be sent to the bereaved family members or the informal caregivers of hospice decedents. Public reporting of data from these initiatives is not expected before 2017.

So, now, access to capital. Hospice is less

capital intensive than some other Medicare sectors. Overall, access to capital appears adequate. We continue to see strong growth in the number of for-profit freestanding providers, which suggests adequate access to capital for these groups. We also see for-profit chains engaged in acquisition of providers and we see interest in investment in the sector by private equity firms.

For nonprofit freestanding providers, less information is available on access to capital, which may be more limited. Provider-based hospices have access to capital through their parent providers, and as we've heard in other sessions, home health agencies and hospitals appear to have adequate access to capital.

So, this brings us to Medicare margins. We estimate in 2011 that the Medicare margin is 8.7 percent, up from 7.4 percent in 2010. A couple notes on how we calculate margins. This is the same as we do every year. We assume overpayments are fully returned to the government, and we exclude non-reimbursable costs, which means we exclude bereavement costs and the non-reimbursable portion of volunteer costs. If those costs were included in our margins, it would reduce our margin estimates by 1.4

percentage points and 0.3 percentage points, respectively.

Next, we have margins by category of hospice provider. As we have seen in prior years, freestanding hospices have strong margins, 11.8 percent. Provider-based hospices have lower margins, and this is partly a reflection of their higher indirect costs, which are likely inflated due to the allocation of overhead from the parent provider. If provider-based hospices have the same share of indirect costs as freestanding hospices, their margins would be substantially higher and the aggregate Medicare margin across all providers, which we currently estimate at 8.7 percent, would be up to 1.9 percentage points higher.

We also see from this chart that for-profit hospices have a higher margin than nonprofits, 14.5 percent versus 2.5 percent. However, when we look at freestanding providers whose costs are not affected by the allocation of overhead, the nonprofit margin is 6.4 percent.

These next two charts show two phenomenon we've seen before. On the left, you see that hospice margins increase as average length of stay increases. You can see that margins increase for each quintile of length of stay until the margin dips slightly in the highest length of stay

quintile, and that dip occurs because some of the hospices with the longest stays who are in that quintile exceed the Medicare payment cap and we assume they return the overpayments to the government. Without that cap, the margin in that group would be much higher.

On the right, we see that hospices with more patients in nursing facilities have higher margins. As you'll recall, in our June 2013 report, we discussed reasons hospices with more patients in nursing facilities may have higher margins, including potentially longer stays, economies from treating patients in a centralized location, and overlapping responsibilities between nursing facilities and hospice staff. In the June report, we estimated that a three to five percent reduction in payments in the nursing facility setting might be warranted due to the overlapping responsibility between the hospice and the nursing facility.

So, next, we have our 2014 margin projection. To make this projection, we start with the 2011 margin and we take into account the market basket updates, including the productivity and other legislated adjustments, the phase-out of the wage index budget neutrality adjustment and other wage index changes. We also assume cost growth higher than

the historical rate for 2013 and 2014 due to some new administrative requirements. Putting that all together, we project a margin of 7.8 percent for 2014. If the sequester was in effect in 2014, the margin would be about two percentage points lower.

Finally, one policy of note for 2015 is that the phase-out of the wage index budget neutrality adjustment will reduce payments in 2015 by an additional 0.6 percentage points.

To summarize, indicators of access to care are favorable. The supply of providers continues to grow. The number of hospice users has increased, and average length of stay has increased. Quality data are unavailable. Access to capital appears adequate. The 2011 margin is 8.7 percent and the 2014 projected margin is 7.8 percent.

So, that brings us to the Chairman's draft recommendation, which reads, the Congress should eliminate the update to the hospice payment rates for fiscal year 2015.

The implications of this recommendation are a decrease in spending relative to the statutory update.

In terms of beneficiaries and providers, no

adverse impact on beneficiaries is expected, nor do we expect any effect on providers' willingness or ability to care for Medicare beneficiaries.

So, that concludes our presentation.

MR. HACKBARTH: Thanks, Kim and Sara. Good work.

For the audience, let me just remind you that we consider draft recommendations in December. All the final votes will occur in January.

And our approach to considering update recommendations is that we assume that the existing base rates ought to continue to the year in question, in this case, fiscal year 2015, unless there is evidence -- convincing evidence -- that they should either go up or down from the current level. So, we begin at zero update, if you will, and then look for evidence to warrant either an increase or a decrease.

We make our recommendations off the base rate. If the sequester means that the actual rates paid are lower than our recommendation, then that indicates that we oppose the sequester. And for this year, the sequester is set to the side. And we adopted that approach when the sequester first went into effect because the sequester was purportedly

temporary and there were indications that Congress was eager to replace it with other measures. As time has gone by and the sequester has stayed in place, that assumption looks ever more problematic. So, next year when we consider our process for the update recommendations, we will rethink -- think again about how to incorporate the sequester into our analysis and recommendations.

So, round one clarifying questions. Bill Gradison, then Bill Hall, Dave, and Rita. Anybody over here? Bill.

MR. GRADISON: Thank you. I'd like to draw your attention to page five of the material you sent out ahead of time. Right in the middle, it has this sentence which, frankly, I just don't understand, and I wonder if you can help me understand it. It says, "An additional reduction to the market basket update of 0.3 percent was required in fiscal years 2013 and 2014 and possibly in fiscal years 2015 through 2019 if certain targets for health insurance coverage among the working-age population are met."

I don't understand the connection between the two, which is a policy issue, I guess, but can you help me understand the best you understand it?

MS. NEUMAN: So, there was a provision in PPACA that said that in 2013, there is a legislated 0.3 reduction. And then in 2014 through 2019, we look at the rate of uninsurance among the working-age population compared to CBO projections, and if it's within a certain distance, there's an additional 0.3 reduction. And so in 2014, that threshold was hit and that additional, that 0.3, was taken. So, it's likely that the additional 0.3 would be taken in 2015, as well.

It's hard to speak to the exact rationale for that policy, so I'll --

MR. GRADISON: Yeah, I had a little trouble with that, too. I'm not fighting with the Congress, but I just couldn't quite understand why they took it out on hospice, or maybe they've done it on other parts of the program, too, with the same rationale, based upon actual reductions in the uninsured rate. I don't know.

MS. NEUMAN: Yeah. I mean, you can speculate that maybe the idea is that if there are more people covered, they can -- and not uninsured -- they could bear more of a reduction on the Medicare side. You know, that may be a rationale that was put in place.

MR. HACKBARTH: But was this adjustment unique to hospice?

MS. NEUMAN: This, as it is currently structured, is unique to hospice. I think in the hospital side, there is something --

MR. HACKBARTH: Yeah. Conceptually, there are some things on the hospital side that may be roughly analogous, but this is interesting.

MR. GRADISON: Thank you.

MR. HACKBARTH: Let's see. Let's just go down the row. Then I have Dave and then Rita and Bill Hall.

DR. NERENZ: Just a clarification on the terminology, freestanding, home health, hospital-based. This refers to the organizational structure as opposed to the physical location of services, is that correct?

MS. NEUMAN: It refers to the organizational structure. So, specifically, it refers to the type of cost report they submit.

DR. NERENZ: Okay. Just so, for instance, a hospital-based hospice may actually provide care entirely in patients' homes, not physically in a hospital --

MS. NEUMAN: Exactly.

DR. NERENZ: -- or even, theoretically, the other way around.

MS. NEUMAN: Exactly, and another really common one is all of these types of providers likely provide some care in nursing facilities, even though many of them are hospital-based or home health-based or freestanding. So it does not correlate with where the care is necessarily provided.

DR. NERENZ: All right. Thank you. Thank you.

DR. REDBERG: On Slide 15, when you were talking about the calculation of margins, you mentioned that the highest one dropped because of the assumption that the overpayment was returned. Does that actually occur, do you know?

MS. NEUMAN: So, we don't have data on the success rate in getting the overpayments back. There is -- I think a conservative statement would be there is likely some slippage, at a minimum. We have, you know, some provider closures, other issues. So, I can't quantify how much, but 100 percent is probably not likely.

DR. HALL: In the -- on page seven of the material you sent us, you made reference to the 2013 report that

described a U-shaped curve for costs. So, does that factor into our recommendation at this point? How do we compensate for the fact that with payment decreasing according to length of stay, that the costs are going to go up for a number of people at the end of life, the very end of life?

MS. NEUMAN: So, the U-shaped recommendation would have the payments higher at the beginning, lower in the middle, and then higher at the last seven days of life.

DR. HALL: So, how do you predict that? That's pretty good --

MS. NEUMAN: How do you predict --

DR. HALL: Well, I mean, that's sort of soothsaying. I predict you're going to die in seven days.

MS. NEUMAN: Oh, it's --

DR. MARK MILLER: You don't. When it turns out that those were the seven days, the reimbursement goes to the hospice.

DR. HALL: Retrospectively?

DR. MARK MILLER: Yeah.

DR. HALL: Okay. Thank you. That helps.

MR. HACKBARTH: Could you just remind everybody what the status is of our recommendation on moving to a U-

shaped system?

MS. NEUMAN: So, we made the recommendation in 2009 and we have been reprinting that recommendation. The Secretary does have the authority to change the payment system and CMS has been conducting research, but they have yet to make a change. So, it's unclear when or exactly what the structure of a change would be.

MR. HACKBARTH: Okay. Jon, did you have your hand up?

DR. CHRISTIANSON: [Off microphone.] Next round.

MR. HACKBARTH: Okay. Mary.

DR. NAYLOR: So, two questions, briefly. Have we ever used any kind of payment incentive to encourage enrollment into hospice? So, we're watching pretty slow growth, modest growth over the last several years. Or, alternatively, to move a medial length of stay, 17, 18 days, to higher? So, have we ever in a prior proposal made any recommendations to promote better engagement, earlier use of the service?

MS. NEUMAN: I don't think we've made a formal recommendation. I think a lot of the things that the Commission is interested in, like shared decision making and

ACOs, that those kinds of structures, which think about the patient more holistically in their overall needs, could have the potential to lengthen those shorter stays. But we haven't formally made a recommendation that goes at it directly.

MR. HACKBARTH: Do you have a particular idea --

DR. NAYLOR: I mean, in addition -- into an update -- I guess the formal recommendation would be, I would love to see us move in the direction of creating through payment incentives for organizations to actively engage, and there have been in the recent IOM reports, for example, on cancer, that very -- that was a number one investment, which is to say to really make sure that people understand their options, that they have information on costs and benefits from different services in a very timely fashion. So, in other words, and it -- because we continue to see a pattern --

MR. HACKBARTH: All right.

DR. NAYLOR: -- of just very incremental use of a very good service --

MR. HACKBARTH: Yeah.

DR. NAYLOR: -- when targeted to the right

populations.

MR. HACKBARTH: So, the key would be to reward the engagement as opposed to the outcome. You wouldn't want to say, oh, you get more money if more patients end up in hospice, because what we want to do is have the patient know they have a choice.

DR. NAYLOR: Exactly. Exactly. But the other part of this is, and so it's a little different, is whether or not payment could ever get us to a point where we incent organizations, once people have made those decisions and it's their choice and their preference and their value, to get earlier introduction into a service. A median length of stay of 17 to 18 days, and you're still seeing people three or four days, I mean, a high proportion, very late in the game. So, whether or not that might also be a strategy.

MR. HACKBARTH: Any other round one?

Okay. Bill, do you want to kick off round two.

DR. HALL: So, I support the recommendation for no update, and I guess I just have, I think, two comments.

One is, I think -- this is still a form of care that's an evolution, tremendous evolution. The last decade was fantastic in terms of -- if you compare our statistics

now with where they were in 2000, the acceptance of hospice is considerably higher. And also, there's age creep going in here, as well.

Since the for-profit sector is involved quite a bit, I would worry that if we didn't show that we have surveillance over margins -- I know that Mike doesn't like margins, but -- I think it could adversely affect the growth of the entire movement. That curve that you showed was very impressive. So, I think we're acting responsibly in this way and I don't think anyone could say that we are denigrating hospice by doing this. In fact, we're just keeping the market open, I think, for further evolution.

And I think as we follow this along, I would suggest that we need to pay close attention to the changing demography. We often think of cancer as the big killer here, and in many ways, it's much easier to define things for cancer in terms of expectation of how long people are going to live, what are the strategies for pain control. But I think what we're seeing is an evolution of neurologic disease and just sort of non-specific frailty, and this population is probably going to require a different kind of a look-see, not today, but at some point in the future. But

I think we're on the right track here with hospice.

DR. REDBERG: I support the recommendation of the Chairman, and I also wanted to agree with Mary and encourage us to have more end-of-life discussions -- encourage more end-of-life discussions or planning discussions because I do think a lot more beneficiaries would be informed and perhaps would be choosing hospice. Certainly, we know that more people are dying in ICUs than would ever -- I mean, when you poll, almost everyone wants to die at home in a setting where they are not hooked up to a lot of tubes and IVs, and yet many of our beneficiaries are, we know, dying and a lot of our efforts are in those last few weeks of life, which is okay if people are choosing that, but I think a lot of people are not having an informed choice.

And I also think it's not just patients, it's physicians. A lot of physicians are not really aware. I mean, certainly in my own specialty in cardiology, we have a lot of heart failure patients who are -- it's quite a terminal disease once you're in end-stage heart failure, and yet a lot of those patients don't have end-of-life discussions.

We just published an article recently in JAMA

Internal Medicine on ICD deactivation, showing that a lot of patients have not, even when they have the defibrillators implanted, don't have an understanding or a discussion of deactivation at end-of-life. And so I think it requires sort of a change in our physician and medical education as well as in encouraging shared decision making so that we really do have a better informed and more people able to understand what the hospice alternative is, to encourage it.

MR. HACKBARTH: Kim, do you know if any of the existing patient satisfaction instruments used by Medicare, CAHPS, et cetera, include questions asking beneficiaries whether they have been advised about end-of-life choices? Is that something we collect data on anywhere?

MS. NEUMAN: I'd need to get back to you on that. There is some shared decisionmaking type questions, but it's focused on end of life?

DR. SOKOLOVSKY: [off microphone].

MS. NEUMAN: Yeah. So as Joan is saying, there are kind of shared decisionmaking questions but not focused specifically on end of life. But that's not to say that you couldn't try to have some kind of CAHPS thing that sort of did a special look at folks at the end of life.

MR. HACKBARTH: Okay.

DR. NERENZ: Yeah, I think the adequacy indicators of various types support the direction of the recommendation. I'm fine with that. Here's another place, though, I want to bring up this point about the different types of programs and how the margins vary, if we could go to Slide 14. Here's perhaps even one of the more extreme examples of hospital based being at least apparently more expensive than others.

You discuss this on page 30 in the chapter, and I'm asking maybe in the finalization of this in January, if you have more detail or more examples, even specific case examples, of how this cost allocation gets done, I would find it very interesting, because, you know, I appreciate the concept but it's not yet tangible how this works. I'm trying to distinguish, for example, in my mind the idea that a hospital has a fixed set of overhead costs that it has some flexibility of allocating, and so we see them allocated in different ways. And the text implies that some of that allocation, I'll just call it inaccurate, meaning that it's a big central cost that has to be allocated somewhere, but it doesn't necessarily reside strictly, say, in this program

or in some other program.

Or it could be that every single one of these hospital-based programs is truly more expensive because of sort of the truly related set of overhead expenses. And I really would like to know how that works. So if based on the cost reports you could show us a little more what that cost allocation is -- what are its elements? What's being put in here? -- I'd like to know that.

MS. NEUMAN: So structurally the way the cost report works is that you have the hospital, and let's just use their A&G, for example, they allocate that down to their different lines of service. Then the hospice provider itself has its own A&G line, which then also gets allocated obviously just to the hospice. And so just the structure of the cost report creates --

DR. NERENZ: I'm sorry. A&G?

MS. NEUMAN: General and administration. So, yeah, thank you. Anyhow, it gets -- it's structurally set up in a way that there's these two allocations happening. Capital the same thing. And so when you talk to cost report experts, they'll tell you the way it's set up, there is going to be some extra money that's getting allocated over

to the hospice that probably isn't really the hospice's costs.

MR. HACKBARTH: Dave, in your comment you mentioned several possible different explanations for why the hospitals have higher costs and lower margins, not just here but sort of regularly. One is accounting and allocation of overhead costs. Second is that potentially their costs actually are higher. And a third is patients are different in the hospital-based providers. So there may be some other categories, but I think those are the three big ones. And I think the answer to this question, which I know is one that you've been thinking a lot about, it's all of the above or it can be all of the above.

And so, Kim, just to mention the allocation issue, in some cases hospitals may actually have higher-cost personnel because they have union labor, for example, that, you know, a free-standing provider may not. And in some instances that may be part of what's going on.

In other cases we have evidence that, in fact, the patients are not accurately paid for, like hospital-based SNFs. We've said that case mix system is not well designed. It underpays systematically for certain types of patients,

and as Peter noted yesterday, our estimate is that payments would increase by 27 percent or some such number for hospital-based SNFs if our case mix system was used.

So, you know, depending on the service and the institution, it can be allocation, it can be difference in actual costs, or it could be differences in patients. There isn't one single explanation for this phenomenon.

DR. NERENZ: Right, and that still leads me to always be curious about the underlying details, because it seemed like one of the major charges to us is to determine whether payments are adequate. And I look at that chart, and I say, well, they certainly seem to be adequate for free-standing. I don't know if they're adequate for hospital based. The numbers suggest they are not. But then it depends on all these -- the sausage making. How does that cost number ultimately get derived?

MR. HACKBARTH: I didn't intend for my answer to sound like, "Go away, Dave." You know, I've just answered your question. I'm trying to say that it is complicated. But on this last issue, you know, the notion that we should pay higher for a hospital-based providers because they have higher costs is something that, in fact, you know, we have a

pretty strong principle against because it violates the efficient provider concept. If there are other providers that, for whatever reason, can provide the same service to the same patients at a lower cost, we shouldn't pay more to some providers just because their costs are higher.

DR. NERENZ: And I would say I'm not opposed to that. I'm not trying to push in a different direction. Actually what this brings to mind is even sort of a bigger-picture strategic issue that in a number of times we've made positive statements about the general concept of system integration, that we favor that, we think it's a good idea. I think we have generally been agnostic about the organizational forms through which that occurs. But outside of our discussions, there are questions about, you know, Should hospital be the centerpiece around which one builds a system? If its fundamental costs are essentially higher, as evidenced here, one might then wonder whether that really is the preferred model. It is not our business to encourage one or the other, but we look at numbers like this, and the question arises. And that's, I guess, my observation.

DR. CHRISTIANSON: It looks like from your charts the government and other -- or the nonprofit hospices have

been slowly declining in number, but pretty stable. What about hospital owned? Is there exit from the industry through hospital? That would be an indication that there may be an issue.

MS. NEUMAN: There's a small -- we can see it here -- oh, actually, no, we can't. Let's see. It's in the paper. There is some decline in hospital based, and there's, I think, two components to it. Some are having financial issues and closing. Others are being bought out and becoming part of free-standing entities. So there's two things going on there.

MR. BUTLER: I was going to make this in my comments, but because you brought it up, I'll make it now. So sometimes I'm protective of the hospital-based services getting short shrift. I'm not sure that that's the case in hospice. So let's go back to the corporate allocation. There are several reasons why -- there are two reasons why it could be higher. One is that, as you point out, the allocation of the G&A -- you're forced to allocate some to the hospice that maybe isn't -- that really isn't true. Of course, that means that the others are understated; you know, somebody is -- we have our margins incorrect somewhere

else. But that would be one reason.

Another reason is that actually the people in legal, the people in finance, and the people that are -- they're actually spending time on this. It is not the wrong allocation. It's a lot more expensive to run a small hospital-based SNF given the corporate people that we get involved in these free-standing ones, which is probably the case, I think.

And then the third reason could be, as we always like to focus on, are their patients different? Is there a severity issue? And there could be in the sense that the U-shape pricing, my guess is that the hospital-based ones are picking up the end-of-life ones that are going from the -- you know, if you had the repricing, it might help the hospital-based ones. But we don't know if that's the case or not.

MS. NEUMAN: We have estimated the effect of the U-shape, and it would increase payments to hospital-based providers because they have shorter stays, so that would help

MR. HACKBARTH: This is sort of analog to the SNF thing where we think the payment system --

MR. BUTLER: And, therefore, their margins may, you know, look a lot different if we implemented that pricing difference.

DR. COOMBS: So I think when we look at the hospital, if we were to break it down, you probably would see a difference in the disease processes within the hospital-based hospice. And that may be partly because of just the location in terms of being able to transfer patients from ICUs who have gotten termination of care for various reasons, and that may be an issue there. I don't know whether or not you had a chance to look at that, because I think that's the first thing that crossed my mind in terms of why the margins for those patients with hospital based is different.

MS. NEUMAN: So the hospital based have shorter stays, and length of stay is correlated with disease. So it may be that there's a different disease profile. It may also be that they're just getting the shorter patients within each disease category. That is something we could look at and get back to you on.

DR. COOMBS: And I've been impressed that many of the patients that I come across -- and we do terminal

extubations -- they've never had a discussion, absolutely no discussion. They've been in the health care system for -- some of us have admitted them multiple times to the ICU, and I feel there's this burden to get things squared away for the acute process, but once they get squared away, there's not an impetus to discuss the end-of-life topics that need to be covered in terms of what's done for patients. So I think the shared decisionmaking is really an important piece of this, and it almost needs to be in that recommendation in tandem with -- and I support the recommendation -- the primary recommendation.

On page 15 of the circulated material, there was the comment that there was no correlation, no relationship between supply of hospice and the utilization of hospice. But I have a different kind of question, and that has to do with geographic regulations and use of hospice in terms of utilization correlated with states that have different kinds of approaches to end of life, and that being either an enhancer of the discussion and an enhancer of the process. There might be lessons learned from states that have a very advanced kind of discussion around end of life and some of the other policies that may exist that may promote earlier

discussion where there's a culture where hospice can prevail in terms of being able to be maximized and appropriately utilized.

MR. HACKBARTH: Right, and I think you've reported previously on variation, regional variation, state-level variation, in use of hospice, and it's fairly significant, isn't it?

MS. NEUMAN: Yeah, it is fairly significant, and a host of factors could account for that. I was wondering, Alice, if you are thinking of things like states that have the most post kind of thing, or what are you --

DR. COOMBS: So one state might -- you can go backwards, if you want, or you can go forward. You can look at one of the states that you're very familiar with and look at their utility and actually look at what's their length of stay in hospice. I mean, if they're really good at predicting who needs hospice and, you know, their decedent rate is on par with what might be expected, you might have some lessons learned just from the environment that's created by that kind of policy.

DR. MARK MILLER: Alice, did you comment on the recommendation?

DR. COOMBS: Yes, I did [off microphone].

DR. MARK MILLER: And you were?

DR. COOMBS: I support it [off microphone].

DR. MARK MILLER: Okay. I'm sorry. I just missed it. I'm trying to keep track of everyone.

MR. GRADISON: I also support the recommendation.

With regard to a couple of these points, with regard to cost accounting, I have a hunch that the internal cost accounting that institutions do is not necessarily the same as what they're required to do for their reporting to CMS. I mean, cost accounting as a management tool is to help you make some internal decisions rather than to meet a governmental requirement. If you take these numbers too seriously, you have to ask why do any hospitals continue to have hospital-based SNFs or hospital-based hospices? And there are a number of answers, but one of them has to do with the allocation of overhead costs, and another one has to do with the difference between the contributions to overhead, which gets down to marginal cost, and the consideration of what percentage of the full cost you are getting reimbursed. And it's certainly worthwhile to continue to provide a service that continues to make a

contribution to overhead, even though on these reports it might show minus 15 percent or something like that.

With regard to the more fundamental questions that have been raised about the use of hospice, like many of you I've followed this for a long time, actually, in my case something over 30 years, and I think it's remarkable that we're up to 48 percent. Many of the challenges that were there at the very beginning still exist: understandable reluctance of physicians to have conversations about end of life is near or it's coming or it's six months or something of that kind. It's not as bad -- people are learning and getting more comfortable with that. But at the outset, that was one of the great difficulties, understandably, because at the risk of gross unfairness or overstatement, death is defeat for many people in this profession. It's not the outcome obviously they want, and sitting down and talking about it is not the easiest conversation in the world.

If you break down the participation in hospice by condition, I think it's quite remarkable. Cancer, I mean, I'm not sure how much further -- we can go further, yes, Bill, but with cancer, we're really up high in terms of percentage of people dying with cancer who have had some

hospice care? Were they early enough? No. Understandably. I think that's a very real question, as Mary has raised.

I'm a great hospice supporter, as I guess all of us are, but I keep coming back to a phrase which helps me to be a little more understanding of why this process is so slow, which is where there's life there's hope, and I think there's some degree of truth to that even under the most dire circumstances.

MR. GEORGE MILLER: Thank you. I'm in support of the recommendation. Just one comment about the cost reporting. Peter is exactly correct, although Bill has just pointed out an interesting comment about the methodology, and I think it's true, there is some concern. We do share our costs. There's some concern whether it's accurately reflective of the actual cost, the allocation to things like the SNF, the hospice. But we also are required, because we have those departments, to do some things that other free-standing organizations are not required to do.

Now, does it cover all the cost? I would not suggest that that's the case. But we do have some of the legal responsibility, and we've got to have our folks go through things that a free-standing organization does not

have to do. So it's certainly worth looking at. I would not disagree with that.

But what I would like to add to the conversation, just emphasize though that I think hospice is a very important benefit. If we looked at the total spend of the Medicare program and, like we did yesterday, we're able to link the hospice benefit across silos into other services and make that at least educational aware of this alternative, we may be able to lower the spend in those other areas, just like we talked about moving from MA to fee-for-service and ACOs, particularly with the mortality rates in LTCHs and dialysis, educating the physicians and the Medicare beneficiaries about some measures they're made aware of, and education I feel is the link. In spite of what Bill said about end of life, it is coming, and we have to be adult about it and have to have the conversation. And palliative care, as Rita talked about, is a better alternative than wasting away in an LTCH or some ICU with tubes coming out of every orifice. And, again, I emphasize death is coming.

DR. CHRISTIANSON: Thanks, George.

[Laughter.]

DR. CHRISTIANSON: I thought I had something important to say, but I don't know anymore.

I support the recommendation. I think, in fact, given the margins in the industry, it's probably on the generous side, if anything. Maybe it's on the generous side because we say we're not taking into account sequestration, but we are. And the margins would drop 2 percentage point if sequestration continues, so that makes me feel better about the recommendation, I guess.

I wonder, not being on the Commission, again, very long, we've known since 2008 that there's this payment incentive, made a recommendation in 2009, I think we restated -- did you restate the recommendation? You didn't restate it this time, and is that because CMS is, as Kim said, working on it? I didn't quite understand where they were or what they were doing, but there may be some advantage to keeping the spotlight on this payment reform issue.

MR. HACKBARTH: So I can't remember. It has been awhile since I read the chapter. Do we have a text box in the chapter restating the U-shaped recommendation?

MS. NEUMAN: Right.

MR. HACKBARTH: Yeah.

DR. CHRISTIANSON: That's not something you're asking us to do here? It wasn't part of your recommendation?

MR. HACKBARTH: My current thinking, Jon -- and I'm open to suggestions about this -- is that when we have a prior recommendation that, you know, we stand by, rather than re-voting we rerun them and we try to do so in a visibly prominent way, put them in a text box where they stand out, and that's the way we sort of, you know, hit the nail on the head again. If we start down the path of re-voting some things and not others, I'll need to figure out some decision rules about, you know, what qualifies for that and what doesn't.

DR. CHRISTIANSON: I understand that. Thank you. I am dismayed that it takes so long to get something --

MR. HACKBARTH: Yeah. On your initial point about the comparatively high margins, often what we've done in the past is link significant changes in payment levels to payment reform. So the update is about the payment level, and the U-shaped distribution in this case is about how to reform the distribution of payments. And often I have been

-- I won't use "we." I have been reluctant to say let's start actually cutting rates below the prevailing level until we get the distribution of dollars right, because if you start cutting the rates and you haven't improved the distribution, then sometimes the institutions that you most care about are really going to take it in the air, and it will be less painful for the ones who we think are overpaid on a distributive basis.

So I like to -- let's get the system fixed first, and that creates a solid foundation for saying, okay, now let's find the right level of rates

DR. CHRISTIANSON: So that's reasonable. Another view on that it has been taking a long time to get the system fixed, in my view, and putting more pressure on that process could occur by cutting the rates. And I'm a little bit reassured by Kim's response in terms of the hospitals having negative margins, but not exiting the industry in droves. We know from the MA experience that providers and plans will respond pretty quickly to payment changes that they feel actually have a negative impact on their bottom lines.

So I support the recommendation, and I wish we

were a little more aggressive.

DR. HOADLEY: I, too, support the recommendation and actually am very sympathetic with this last back-and-forth as part of the logic that goes on, including the notion about the old recommendation. And, you know, it would be nice if we knew there was some technical issue we could help sort of go to. If it's just, you know, one of those things that there's some reluctance or just some overload of a lot of things going on, you know, it would be nice to understand more about that. But sometimes we just don't. So I think reprinting it is probably our best step at this point.

The only other thing I was going to comment on, in looking at Slide 10 and sort of thinking about some of these differences in average length of stay but similarly some of the things you've done in more detail in the chapter on the long stays and things, it's trying to think about, you know, how do we better understand these. And, you know, you look at something like diagnosis and you're thinking, okay, but that may be very logical given clinical differences in those kinds of cases. Some of the other ones maybe not so much or are explained by some of the other reasons that people have

brought up in terms of the hospital based or things.

My first instinct was to say can we compare these numbers with anything else, like private sector experience, but in the end it just seems like the patient base is so different in an under-65 population that that may be not very helpful, probably not very helpful, although maybe within diagnosis there is some ability, although even then, you know, the difference of a cancer patient who's dealing with this at age 45 versus a cancer patient at age 80 that's dealing with this, very, very different circumstances.

So I think that's not a helpful suggestion, but I just sort of say it to think about whether there's any way to compare and think about these issues of whether there are aspects of the payment system that are driving differences inappropriately as opposed to things that are real and should be driving differences.

MR. ARMSTRONG: I don't have anything more to add. I do support the recommendation. Jon represented a point of view around whether, you know, zero increase was going low enough, but given the subsequent conversation, I think this makes sense.

DR. NAYLOR: I also support the recommendation and

encourage the continued work of the Commission that Kim and Sara and others have led around thinking about palliative and concurrent care as potentially one strategy to promote earlier entrance, reasonable entrance into hospice, to think about nursing homes and the relationship with hospice, and especially to think about opportunities for beneficiary informed decisionmaking.

MS. UCCELLO: I support the recommendation, and I share the frustration of the U-shaped curve not being implemented yet. But we have -- Kim, remind me, we did provide additional technical assistance on how that could be done in the June report, right, providing some examples of ways --

MS. NEUMAN: Right. Yeah, we did. We provided an illustrative example of a type of payment system you could implement with existing data. I will say one thing about the timing. PPACA limited the Secretary in terms of being able to implement payment reform no sooner than 2014. So this was the first year the Secretary has declined to make a change. She hasn't had the authority up until 2014.

MS. UCCELLO: Okay. Well, thank you for that clarification. So given that that time is coming then, do

we anticipate that she will move? Or is there more that we need to do on some of this technical assistance side?

DR. MARK MILLER: Want me to take it, Kim? I can tell Kim is getting uncomfortable, so I will say the things.

Despite the clarification that you just had on the timing, I will speak only for myself. I am concerned about the momentum here. I think CMS has a lot to do and there are some issues with this, but by and large, I think it can move forward faster than it appears to be happening in the background. And I don't tend to be highly critical of CMS' efforts. I think it's very hard for a Secretary to come forward and do something that has distributional impacts. And it's very hard for an industry to get behind something that has distributional impacts because it splinters people.

And, Jon, to your point, what starts to happen is when the Congress says, well, in the absence of anything else, I'm going to sequester or I'm just going to start cutting rates, people start to then turn around and look at these kinds of proposals because now they realize that everybody is going to take it.

So I think there is more. I think we could certainly write the chapter to be back to the urgency point

that we were saying at the time, in addition to reprinting the former recommendations.

MR. HACKBARTH: So, Mark, it wasn't clear to me, and maybe it was intentional that it wasn't clear, how much of this is workload at CMS versus how much is policy opposition or reluctance to do the necessary redistribution?

DR. MARK MILLER: Now, I wish Kim had taken the question. I don't know why I got in front of her.

[Laughter.]

DR. MARK MILLER: So, I mean, my own view of this is -- and Kim, you really should speak openly if you disagree -- is the technology needed to do it, I think, is available. You can move ahead and do this. And certainly within a couple of years, you can. So, that's one point.

They do have a lot going on. I don't think it is insignificant, the workload that is piled onto CMS on a regular basis.

The point I was making is I don't feel the momentum out of the agency, and so that even, you know, if there was a forward motion, here's a plan and here's what we're thinking of, it would still take a few years to kind of do it and do it in a rational way. And at least in my

sense, I don't feel that. But, Kim, you should respond or not as you see fit, because I buried myself.

MR. HACKBARTH: So, one other question, Mark, and I'm trying to explore Jon's point. So, you said that there are cases where a cut in the rates has prompted an industry to support reform in the distribution that previously it had not.

DR. MARK MILLER: I'll give you a very recent one. The home health industry has stood pretty firm for many years, resisting any kinds of cuts. The cuts have now started to become more serious and the Congress continues to look pretty seriously at them and they've come forward with a proposal that very much targets episode caps that has a highly distributional effect on the industry, and that's something that, I think, a few years ago, they would have never come forward with.

I'm not saying these are good policies, but I'm saying that they begin to look at things like that. I also think, to their credit, both home health and the skilled nursing facilities associations have tried to put forward things on readmission rates and other types of proposals. Again, I want to say this carefully. They aren't always

designed the way I think we would do them, but I think some of those conversations wouldn't have even occurred three, five years ago. Glenn, you may have other views.

MR. HACKBARTH: Well, on the home health example, and I may not have this right, so correct me if I'm wrong, but, basically, what they said, well, we don't like rebasing, so let's take this really extreme group of outliers and take them out and shoot them and leave the rest of us alone.

DR. MARK MILLER: Okay. Move to strike --

[Discussion off microphone.]

DR. CHERNEW: Yeah, exactly. That --

DR. MARK MILLER: Slow down there. I was worried I was getting myself in trouble.

[Discussion and laughter off microphone.]

MR. HACKBARTH: [Off microphone.] We covered that adequately.

DR. MARK MILLER: Send your cards and letters to me.

[Laughter.]

MR. GEORGE MILLER: [Off microphone.] recommendation.

MR. KUHN: I support the recommendation.

DR. SAMITT: I support the recommendation, as well.

MR. BUTLER: So, I support the recommendation and I support the stating some urgency. And I don't think it's inappropriate even, Glenn, to state the philosophy that you just stated, and that is that we're -- no, not the death panel part.

[Discussion and laughter off microphone.]

MR. BUTLER: No, the fact that you don't want to harm -- by an across-the-board reduction, you don't want to harm the ones that are victims of a poor pricing model now. I think you can -- why not just openly say that? I think it probably applies to the IRF issue coming up and a number of others. Because to just say, you know, you're making too much money in this sector, let's cut it down, then it gets -- we're driven just by margin, and that's not the message -- music to your ears, right, Mike? Okay. So, I won't --

But let me go back, if I can just one more time, to the hospital-based side. I think, Bill, if you look at the for-profit sector versus the nonprofit in hospital-based, it's very different answers. But getting back to

Scott's point yesterday about nonprofits kind of targeting, in general, a lower operating margin being enough to kind of fulfill their mission, they tolerate and say, well, this is consistent with our mission. We don't have to have everything make money. Whereas the for-profits -- and I'm not criticizing them -- they're kind of saying, you're trying to maximize the return. So, they sharpen their pencils a little bit more and say, this is just not a business that's paying for itself. So I think there's a little bit of that.

And I would also say that hospitals of all kinds, I think, but I know particularly us, have really ramped up -- you know, the hospitals' programs which started for one reason are now really involved in intensive care, really involved in palliative care, really are dialoging much more in ways that didn't occur before. And it affects not only the hospice interface, but LTCHs and things like that. And all this is, I think, a very positive direction that things are headed.

Now, back to the recommendation, which I support. I do think, and I'll reiterate, this is very much like home health. It's very price sensitive, very -- for-profit is

where the growth is, and whatever the pricing is, it's likely to be responded to pretty quickly and we shouldn't forget that.

The only thing I think we might be missing on the pricing recommendations, and maybe I'm just -- now my memory is slipping a little -- the institutional settings, like SNFs, where it looks like there's kind of -- it's either cheaper to do it there because you have a critical mass of patients or, in fact, they're duplicative services that are sometimes provided by a SNF. Sometimes, I wonder if there's a pricing opportunity to kind of reduce pricing when the hospice care is in an institutional setting versus a home care setting just because it's a different cost structure, and that might be a more accurate pricing of the services.

MR. HACKBARTH: Remind me, Kim, did we make a formal recommendation on that at the same time as we did the U-shaped, or separately from the --

MS. NEUMAN: You mean the nursing facility issue?

MR. HACKBARTH: Yes.

MS. NEUMAN: No. We just outlined it in the June report.

MR. HACKBARTH: Okay. So, that's something that

we may want to come back and make a separate formal recommendation on to complement. That would be true even if there was a U-shaped distribution in the payments, that we'd want to do that, as well.

MR. BUTLER: Yeah. I just think, fundamentally, the cost of --

MR. HACKBARTH: Yeah.

MR. BUTLER: -- doing it is probably less, to do it in those settings.

MR. HACKBARTH: Yeah.

DR. MARK MILLER: And I just want to say -- I'm really sorry to interrupt, Mike -- even though we didn't make a formal recommendation on it, we had a fairly strong discussion of this in the chapter and it has been noted in some of our conversations with the Hill staff. So, it's not a completely blank signal at this point on that.

DR. CHERNEW: I support the recommendation, and let me say the challenge in this industry is there's both under- and overuse and we struggle with how to deal with that. The U-shaped recommendation, I think, is one way to try and deal with that, but unfortunately, our concern about overuse pushes us to some of the administrative things that

we also have recommended in the past and I think there's this constant tension.

My concern is that we think about this as hospice as opposed to end-of-life, which segments the way we think about the patient. It moves us away from the patient towards the provider, which I don't think is particularly a good thing, and I think that manifests itself in a variety of ways. For example, I'm less concerned about quality measures of hospice, comparing one hospice to another, and more concerned about quality measures of people at end-of-life. So, I would rather the survey all decedents, not just the ones that ended up in hospice, because I think there's a lot of care that probably shouldn't be delivered to people that never got into hospice in the first place, and I think understanding that process matters.

Similarly, this tension of the level of profitability is complicated, because on one hand, I understand this tension. There's a lot of entry. It's profitable by the margin. We should lower the price more generally. I agree with that by nature.

On the other hand, there's a part of me, frankly, that likes this being profitable because I think it will

encourage groups to come in and provide more and deal with some of the underuse, and I have a nagging sense that, at least if well targeted, and that's a big "if," from an overall program perspective, a rise in hospice spending might not be the worst thing in the world. It's an area where, again, if done well, we could get lower spending and better outcomes in a difficult sort of stage of life.

And so it's, as Peter foretold that I would say, I'm not simply looking at the -- my mind doesn't simply look at the margin and say, oh, they're making a lot of money. Let's get them down. I think, well, there's a reason why it might be beneficial to have an incentive for entry in this area, but we do have to work on the targeting. I think some of the recommendations that we've made continue to do that, so I support the recommendation.

DR. BAICKER: I support the recommendation.

MR. HACKBARTH: Okay. Thank you very much, Kim and Sara.

So, moving on to our last item, inpatient rehab facilities.

[Pause.]

MS. SADOWNIK: Okay. Last but not least, in this

presentation we will discuss the adequacy of Medicare payments to inpatient rehabilitation facilities, or IRFs. I will present data on indicators of payment adequacy and then review a Chairman's draft recommendation for payment rates for fiscal year 2015.

IRFs provide patients with intensive rehabilitation services, such as physical and occupational therapy and rehabilitation nursing. In 2012, 1,166 IRFs treated 373,000 fee-for-service cases. IRFs may be specialized units within an acute-care hospital, or they may be free-standing hospitals. Hospital-based IRFs represent 80 percent of facilities, but they account for only 55 percent of Medicare IRF discharges. Relatively few Medicare beneficiaries use IRFs because patients must be able to tolerate the intensive therapy. Nevertheless, Medicare fee-for-service is the principal payer for IRF services, accounting for 60 percent of total cases in 2012 and over $6.7 billion in spending. Since 2002, IRFs have been paid on a per discharge basis where rates vary primarily based on patients' condition, comorbidities, and level of functional impairment.

IRF patients must be able to tolerate and

reasonably be expected to benefit from three hours of therapy per day for at least five days per week, and they must require therapy in at least two disciplines.

For facilities to qualify as IRFs, they must meet certain criteria. In addition to meeting the Medicare conditions of participation for acute-care hospitals, IRFs must have a medical director of rehabilitation, have a preadmission screening process for patients, and use a coordinated interdisciplinary team approach led by a rehabilitation physician, among other criteria.

In addition, IRFs must meet a compliance threshold which stipulates that no fewer than 60 percent of all patients have at least one of 13 conditions. CMS developed the compliance threshold to ensure that this intensive, costly setting predominantly treated only the most clinically appropriate cases. Trends in volume and patient mix have been sensitive to policy changes in compliance criteria. When CMS renewed enforcement of the compliance threshold in 2004, patient volume declined substantially, and we saw a large shift in the discharge destinations of cases that did not count towards the compliance threshold, especially major joint replacements; hospital discharges

shifted away from IRFs for these cases and to home health agencies and SNFs. In 2007, the compliance threshold was capped at 60 percent, and the industry began to stabilize.

We will use the same framework to analyze payment adequacy for IRFs as for the other sectors.

Let's start with access. With respect to supply, there were 1,166 IRFs in 2012. The total number of IRFs stayed relatively stable between 2011 and 2012, the first year since 2005 that the number of facilities has not declined. The number of free-standing facilities continued to increase, while hospital-based IRFs continued to leave the market, although the decline in 2012 was smaller than in recent years. While free-standing facilities make up only 20 percent of IRF facilities, they represent 45 percent of IRF discharges due to higher average bed size per facility and higher average occupancy rates. The majority of free-standing IRFs are for-profit, while the majority of hospital-based IRFs are nonprofit. Overall, for-profit facilities continue to enter the market, with a particularly large increase in 2012.

Occupancy rates represent another measure of IRFs' capacity to serve patients. Occupancy rates decreased

slightly in 2012 to 62.8 percent. Since 2008, when the industry began to stabilize, occupancy rates have fluctuated slightly, increasing in some years and decreasing in others, but changing by less than one percentage point overall from 2008 to 2012. Occupancy rates were higher in free-standing IRFs than in hospital-based IRFs and higher for IRFs in urban areas than those in rural areas. Trends in IRF supply and relatively low occupancy rates suggest that capacity is adequate to handle current demand.

Now that we've reviewed capacity, let's turn to trends in volume and payment. The total number of cases grew half a percent from 2011 to 2012, to 373,000 cases. While the total number of fee-for-service cases increased, the number of unique fee-for-service IRF patients per 10,000 fee-for-service beneficiaries declined to 92.4 in 2012. This measure has fluctuated in recent years, but the proportion in 2012 is similar to that in 2008, suggesting relative stability in IRF use compared to other rehabilitation alternatives.

Fee-for-service spending totaled an estimated $6.72 billion in 2012, an increase of 4 percent from 2011. This increase reflects growth in number of cases and in

payment per case, which increased by 3.4 percent in 2012. Factors that impact the growth in payment per case include a 1.8 percent update to the base rates in 2012, a 0.4 percent increase in outlier payments, and about a 1 percent increase in patient severity.

Access to capital is another measure of payment adequacy. Hospital-based units have access to capital through their parent institution. As we heard during the inpatient hospital presentation yesterday, hospitals have overall maintained adequate levels of access to capital. While we see an industry focus overall on shifting spending to outpatient, rather than inpatient, capacity, we also see that a small number of new hospital-based IRFs continue to enter the market. You might have seen in the news, for example, that competitor hospitals UCLA and Cedars Sinai are partnering to open a new 138-bed facility, which will be operated by the for-profit provider Select Medical.

As for free-standing IRFs, we are able to review access to capital for one major chain, which represents about half of free-standing IRFs. Continued acquisitions and construction of new IRFs, lower costs of borrowing, and implementation of several shareholder-friendly initiatives

reflect very good access to capital and positive financial health. Besides this chain, most other free-standing facilities are independent or smaller chains with only a few providers, and it is less clear how much access to capital these providers have.

Turning to quality of care, we evaluated outcomes on two functional measures that are important to beneficiaries: the amount of functional improvement, or FIM gain, and discharge to the community. We see an increase in both measures from 2011 to 2012, about a 3 percent increase in FIM gain and about a 1 percent increase in rates of discharge to the community. In previous work, we have looked at industry performance on a broader set of measures over earlier years and found improvement in quality of care, controlling for changes in the patient population over time.

I will now review IRF margins. Overall, Medicare margins were 11.1 percent in 2012, up from 9.8 percent in 2011. Margins in free-standing facilities far exceed those of hospital-based IRFs. Free-standing IRFs had margins of almost 24 percent in 2012. They represent about 45 percent of Medicare spending. In contrast, hospital-based IRFs had margins of 0.8 percent. Hospital-based facilities that were

for-profit had higher average margins than hospital-based facilities that were nonprofit.

As context for discussing possible explanations for differences in margins between hospital-based and free-standing IRFs, recall that although hospital-based IRFs constitute 80 percent of all IRF facilities, they account for only 55 percent of Medicare discharges. Therefore, 45 percent of Medicare IRF discharges are in free-standing facilities that have an average of 24 percent margins.

Free-standing IRFs have lower costs than hospital-based IRFs, which is impacted by volume and by demonstrated ability to constrain cost growth. Hospital-based IRFs tend to have fewer beds and lower occupancy rates, which keep them from fully capitalizing on the economies of scale of the more efficient free-standing facilities. With respect to constraining cost growth, among hospital-based IRFs, both direct and indirect costs were higher than in free-standing IRFs. In 2010, direct costs per case were 30 percent higher in hospital-based IRFs and indirect costs per case -- which include administration, capital, and general overhead -- were 11 percent higher.

In addition, overall Medicare margins are about

two percentage points higher for acute-care hospitals that have an IRF unit than for those without an IRF. Hospitals have multiple lines of business, and these data suggest that IRF units may be able to make positive financial contributions to their parent hospital.

This year, we examined the performance of relatively efficient IRFs compared to other IRFs. We identified relatively efficient IRFs by examining cost and quality -- defined as risk-adjusted outcomes on FIM gain and discharge to the community -- for a three year period. We classified IRFs as relatively efficient if they were consistently in the top third on at least one of these measures in each of the three years and never in the bottom third on any measure. In 2010, about 17 percent of facilities met these criteria for relative efficiency.

The analysis indicates that relatively efficient IRFs can have relatively low costs and provide above-average quality. Relatively efficient IRFs had costs per discharge that were 28 percent lower. With respect to quality, relatively efficient IRFs had FIM gain scores that were 5 points higher and had rates of patient discharge to the community that were 6 percentage points higher. Efficient

providers had patients with higher case mix and longer lengths of stay, but lower average costs per day.

The difference in margins between relatively efficient providers and all other providers was very wide, a median 24.8 percent versus negative 3 percent. Efficient providers were disproportionately free-standing. However, hospital-based IRFs that were relatively efficient were able to achieve healthy margins of 13 percent. Among free-standing IRFs, average providers can achieve healthy margins, but relatively efficient providers can earn substantial profits, with Medicare margins of over 27 percent.

As we have seen, aggregate Medicare margins for IRFs in 2012 were 11.1 percent. To project the aggregate Medicare margin for 2014, we modeled the policy changes driving payment rates for 2013 and 2014. We project that Medicare margins for 2014 will be 13.1 percent. If a sequester is in effect for the full year of 2014, the projected margin would be about two percentage points lower. To the extent that IRFs restrain their cost growth, the 2014 margin could be higher than we have projected.

In summary, our indicators of Medicare payment

adequacy for IRFs are positive. The supply of IRFs is relatively stable, volume has increased, and excess capacity in occupancy rates remain, suggesting that capacity remains adequate to meet demand. Margins average 24 percent for the sector of the industry that tends to operate more efficiently. Finally, overall quality of care continues to increase slightly, and access to capital appears adequate for both hospital-based and free-standing IRFs. We project that 2014 aggregate Medicare margins will be approximately 13.1 percent.

The Chairman's draft recommendation for your review is: The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2015.

On the basis of our analysis, we believe that IRFs could absorb cost increases and continue to provide care with no update to the 2014 payment rate. We estimate that this recommendation will decrease federal program spending relative to current law. We do not expect this recommendation to have adverse impacts on Medicare beneficiaries. This recommendation may increase the financial pressure on providers, but overall we expect a

minimal effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries.

This concludes the presentation, and we welcome any questions.

MR. HACKBARTH: Okay. Thank you. Good job.

So let me make a comment before we start Round 1, and I'm reflecting on the conversation that we just had about hospice and margins and links to payment reform. But I'm also thinking some about our LTCH conversation yesterday. So here, Sara, would you put up the slide with the projected margins? There we go.

So we've got, shall we say, substantial projected margins here, and this comes in the wake of implementation of rules that were designed to limit the number of Medicare patients going to these higher-cost facilities and move them elsewhere. And my vague recollection of that was that when those rules were implemented, there was a temporary decline in margins, probably because fewer patients were coming in, but now the margins have popped back up and are at a high level.

To the best of my recollection, we have no pending unimplemented reforms on the table about improving the case

mix system or anything for IRFs, so in that sense it's unlike hospice. We've got these high margins.

As I say, in some ways this sort of links back to our conversation about LTCH where we would be saying, you know, we want fewer patients using that high-cost facility, and here we have a case study of one type of institutional provider that responded to a similar, obviously not identical, set of signals.

So, you know, if I'm Jon, I would make the point again: "Hey, this number zero is too generous, and none of your reasons, Glenn, that you gave 15 minutes ago apply." And I'll have to think about how I would reply to Jon when he says that.

So let me just -- Mark, could you just talk a little bit about it? Am I making some legitimate connections? Is there an analogy here, at least a broad one, to what we've been talking about with LTCHs? What was the experience when we tightened up the criteria and the volume fell and now the industry has responded to that change in incentives? Elaborate on that history.

DR. MARK MILLER: The very specific comment that came up yesterday -- and I can't remember who I was having

the exchange with -- is we were saying there's five-some-odd billion dollars in LTCH; if you say I'm going to pay PPS rates for what we think are more PPS-like cases in LTCH, $2 billion leaves that pool; and if there's no response, then, of course, their margins would fall rapidly. And the question is, you know, will they respond? And they could respond by being more focused on the complex cases or respond by saying I'll continue to take the PPS cases, but I'll be, you know, more efficient about it.

In this instance, it was not dissimilar at all. There was a change in the criteria of patients who could go into an IRF, and it was a 75 but then it became a 60 percent rule, and it said, you know, no more than 60 -- you know, 60 percent of your cases can be of a certain composition.

The big condition that I recall being affected was the joint replacement, and at that point in time, there were a lot of joint replacements going to the IRFs that people, including some clinicians that we talked to, felt like could be dealt with in less intense settings.

So the enforcement occurred, and the kinds of reactions that I recall are things like there was a drop in occupancy rates, there were drops in volumes. The margins,

you know, went from yay to yay, and yay in this instance I think means the six to eight range, is what I recall, although I'm not sure I can dredge that up.

MS. SADOWNIK: In 2004, when compliance was enforced with the rule at that point, they were about 17 percent, and then they dropped overall.

DR. MARK MILLER: Yeah, but --

MR. HACKBARTH: But how low did it go?

DR. MARK MILLER: But the range, I think, was still in the six to eight --

MS. SADOWNIK: Yeah, the lowest industry-wide was 8.4 in 2009. But free-standings have rebounded further and higher earlier than that.

DR. MARK MILLER: Right, and that's what I recall, sort of it got compressed and now it's moved back up.

They have changed their mix of cases. They've moved out of the joint replacements and gone into things like stroke, brain injury, a couple other things I can't remember offhand. But we started to see growth there, and so they -- and then I remember multiple conversations with them about talking about how long it was going to take them to respond with their costs, but it did appear that many of

the actors were responding with their cost structures, either by beds being taken off line or changing their mix of patients and, therefore, the staff needed to deal with those specific sets of cases.

So my sense is, yeah, a couple of years of sort of re-finding their way, but then it now appears that there seems to be some rebounding that's occurring. Any other trend or anything that I missed in that recollection?

MS. SADOWNIK: No. I think you hit all the high points. Once the compliance threshold was enforced, it --

DR. MARK MILLER: I should say two other things. We also tracked the data to where people went, and so those joint replacements did arrive in SNF and home health settings in ways that were anticipated, at least by some of the clinicians. And there was some reduction in supply, but not gigantic, as I recall.

MS. SADOWNIK: There was a contraction in all measures -- in supply and beds and occupancy rate.

DR. MARK MILLER: Right.

MS. SADOWNIK: And the free-standing, especially the for-profits, began to rebound around 2007, and free-standing not-for-profits a few years after that, maybe 2009,

2010, and now we're starting to see rebounding among hospital-based for-profits as well.

MR. HACKBARTH: Thank you. That's helpful.

Round 1 clarifying questions?

MR. GEORGE MILLER: Thank you. In the reading, I always appreciate the demographic information, and I was struck by the fact that Hispanics only use 4 percent -- the population, only 4 percent of Hispanics are in IRFs, although with the map you can see they're in states that have large Hispanic populations. Is there a reason for that? Do we understand why that's so low?

MS. SADOWNIK: Research suggests two reasons that seem the two biggest contributing factors. One is lower rates of joint replacements among Hispanic populations in general, and the second is that among Hispanic patients with that condition, higher rates of going home as opposed to any PAC use.

DR. MARK MILLER: One thing that was [off microphone] striking to me, George, in the conversations when all this compliance discussion was going on -- and I'm not going to say that this is the norm across the country, but we ran across clinicians who were saying, you know, with

a joint replacement -- and I don't mean in extremely complex and if the patient had other chronic conditions, but, you know, a relatively straightforward joint replacement, there were clinicians who were arguing that if you did work with the patient before they did the surgery, had the surgery, then brought them out, you could handle almost all of this on a home health type of basis. So when she says home, it could be that they're arriving -- you know, going home and then doing home therapy and then outpatient therapy to rebound from their --

MR. GEORGE MILLER: But why would Hispanics be so much different than the general population? That's my only question.

DR. MARK MILLER: I don't know [off microphone].

MR. GEORGE MILLER: Okay.

MR. HACKBARTH: Alice, you had a clarifying question [off microphone].

DR. COOMBS: So I was curious. There's not information about readmission to acute-care hospitals in this chapter. I was just wondering if you could comment.

MS. SADOWNIK: Sure. We did not -- we looked at a more limited set of quality measures this year and

prioritized ones that we thought would be of greatest importance to beneficiaries and aligned those with the efficient provider analysis. But generally we find that among IRF patients, you know, about 70 percent are discharged home, about 10 percent go to a SNF, about 10 percent are discharged directly back to an acute-care hospital. And then in terms of 30-day readmissions, we found in previous research about 12 percent are readmitted within 30 days after discharge home.

DR. COOMBS: Still clarifying, one question I had, because you --

MR. HACKBARTH: [Off microphone.]

[Laughter.]

DR. COOMBS: Well, one question I had, because you said six days earlier for the free-standing, and I was wondering if that resulted in an increased admission rate with the data that you have. Maybe you can get back with us at some point, just correlating the free-standing versus...

MS. SADOWNIK: For the efficient providers?

DR. COOMBS: Yes.

MS. SADOWNIK: Do you mean six percent -- rates of discharge to the community that were six percentage points

higher.

DR. COOMBS: Six [off microphone].

MS. SADOWNIK: Yeah.

DR. CHERNEW: So there's a discussion in the mailing materials about the case mix group, which is like their DRGs or some version of that. Could you help me understand a little more how that relates to the DRGs? I'm just confused when you talk about certain things that I think in my mind are DRG-like, like knees and hips. But that doesn't seem how they're paid. They're paid according to this other thing that's discussed in the chapter called case mix groups, which relates to therapy needs and stuff.

MS. SADOWNIK: Right, exactly.

DR. CHERNEW: Surely that's not exactly.

[Laughter.]

MS. SADOWNIK: Yeah, moving on, next question. So, right, patients have the DRG that they had -- the majority of patients --

DR. CHERNEW: When they were in the hospital, wherever it was.

MS. SADOWNIK: -- that came from the hospital. Right. So they're in the hospital. They have a DRG. Let's

say they had a DRG for some --

DR. CHERNEW: Knee.

MS. SADOWNIK: Knee. So when they arrive at the IRF, they are coded into a completely different system, which may be broader in some cases or it may be more narrow in others. And there's sort of a hierarchy of classifications, so they have a more specific impairment group code. Then those are aggregated into larger case mix groups that are in some cases very --

DR. CHERNEW: And so if they -- you said in the chapter that, like, 30 percent of places or 31 percent of places don't even have an IRF, and many of the people even in those also go to SNFs and home care, which was the discussion you just had. But if they go to one of those other sites, they get coded into a completely different set of bins that's not -- so unlike the LTCHs where you had sort of a similar set of coding and you could just say, oh, it's higher here or there, here the actual underlying coding system they're getting put into is just completely different, so it's much harder to compare, I guess.

MS. SADOWNIK: Correct.

DR. CHERNEW: Okay.

MS. SADOWNIK: Right, which is why for --

DR. CHERNEW: I understand now [off microphone].

MS. SADOWNIK: -- making those types of comparisons, it's best to look at the DRG and where did those patients go as opposed to --

DR. MARK MILLER: And there is something that you just said that confused me. LTCH doesn't have a standardized assessment instrument. The thing I wanted you to say in response to his question is: When they show up at an IRF, there is an assessment instrument that uses functional status to put patients into groups and then --

MS. SADOWNIK: Not quite. So they are put into impairment groups on the basis of their clinical condition, which eventually feeds into the case mix group, and separately their functional status is assessed with, in the IRFs it's the FIM tool. And that functional status within a CMG drives the payment level. So you may have, let's say, stroke, CMGs for stroke, but there may be a bunch -- there are a bunch of levels based on their functional impairment.

DR. MARK MILLER: And that's where I was going, is you end up with something that's diagnosis like and functional status like to end up at a set payment.

MS. SADOWNIK: Correct.

DR. MARK MILLER: And that's why it has some relationship to DRG, which is very much diagnosis based, and then some functional piece. But the diagnosis can change when they go into the IRF.

MS. SADOWNIK: It can, but the payment is based on their initial diagnosis.

MR. LISK: The initial diagnosis is still based on the IRF diagnosis.

MS. SADOWNIK: Right.

MR. LISK: So you can have somebody who went into the hospital, they may have gone into the hospital for, let's say, a heart bypass operation, but they stroked out during the bypass operation. And so then they're actually treated -- the DRG in the hospital is for bypass, but the case mix group is going to be stroke in the CMG. So just to say that it doesn't always correspond one to one.

DR. MARK MILLER: That's what I was trying to get at [off microphone].

DR. CHERNEW: I understand a little bit better, but not quite better. It might not be that there's even a stroke thing. I was trying to figure out if there is, say,

a stroke CMG, or is it more just a severity and so it might not correspond at all, where in the LTCH I thought there was a correspondence between the words they had in an acute-care hospital and the words they had in the LTCH. But this might be an offline --

MS. SADOWNIK: No, you're right. There's a stroke--

DR. CHERNEW: -- level of clarification that I need.

DR. MARK MILLER: Actually you are right. I do now see what you're saying [off microphone].

MS. SADOWNIK: Overall I would say that the -- so the payment is based on -- payment buckets are based both on diagnosis and functional impairment. So there are a number of CMG categories for stroke, and those vary by functional level.

DR. CHERNEW: The reason I was asking, besides just general confusion, was there's a cross-sector pricing sense of things that happens sometimes, and it wasn't clear that that concept even really made sense here because the bundles were so different.

MR. BUTLER: I have two questions. The first

relates to geographic distribution. You have in the materials that you sent out the Dartmouth Atlas, like, picture of where these facilities are located. Either -- and I'm focusing on the freestanding for-profit institutions -- either the existing set of these institutions or the growth skewed geographically compared to where the inpatient rehab facilities are overall.

MS. SADOWNIK: I'm not sure of the geographic distribution of those facility types. I can get back to you on that. Overall, so 30 percent of beneficiaries live in a county that has a freestanding IRF and 61 percent live in a county that has a hospital-based IRF. But I can get back to you on the geographic distribution of that.

MR. BUTLER: The second relates to the -- you referenced the UCLA-Cedars Sinai together building a new facility with a for-profit company. Do you know the ownership? Is UCLA and Cedars Sinai putting in money and owning, or are they just asking -- and just asking the company to manage, or what's the relationship?

MS. SADOWNIK: Well, we are -- we have spent some time internally trying to figure that out. So, first of all, those two facilities, their joint ventures would

actually probably be a freestanding one in this case because they're opening it in a separate freestanding location.

And as for the management or operation being by Select, I think we're not -- we're not actually sure if that would necessarily connote that it would be a for-profit -- be classified as a for-profit facility or not, so --

MR. BUTLER: I'm trying to get at whether they're looking at this as a return on an investment in a fee-for-service world or, in fact, coordinating care in an ACO world, and I suspect it's more of the fee-for-service world approach. But, you know, it kind of says something about what motivates these things being built, and --

MS. SADOWNIK: Well, I think in this case --

MR. BUTLER: -- and maybe some of each.

MS. SADOWNIK: Right. And in this case, actually, both of those facilities, both UCLA and Cedars, have their own IRFs currently, very small, you know, a very small number of beds in each that are full to capacity, so the idea is to create a much bigger one together.

MR. LISK: But, both of those --

MR. BUTLER: They may want to backfill with other inpatient beds, for that matter, too.

MS. SADOWNIK: Right.

MR. LISK: Both those hospitals have actually very high occupancy, have high occupancy rates, so they may be wanting those beds actually for acute care, too.

MR. HACKBARTH: Other round one questions?

Let's see. George, do you want to lead round two.

MR. GEORGE MILLER: I support the recommendation, and like we said in all other silos, that moving it in the direction that we're going, I think, is positive. And again, I'd like to, as my previous comments, link all of these across all sectors, as well, so that we move from a silo model to a more robust continuum of care.

DR. CHRISTIANSON: Yeah. I support the recommendation. It's hardly necessary for me to say anything else, Glenn, but I will.

[Laughter.]

DR. CHRISTIANSON: You know, it's not news that Medicare is going to be under incredible pressure to control its costs, both for demographics and debt reduction reasons, and probably the inclination will be to do it in a kind of heavy-handed cutting across everybody in the same way. So, I think we need to take advantage of every opportunity that

we have to sort of show that there are wiser ways to control costs, and when there are opportunities to be more aggressive, we should do that.

DR. HOADLEY: So, I support the recommendation and could even be sympathetic to going lower.

The only comment I make will sort of mirror the first comment I made yesterday morning on sort of how we measure access, and this strikes me as one of those sectors where we don't have direct measures of access, as was said, and if we had a situation where, because of ACOs or whatever, we saw a significant shift out of these facilities into home health or wherever else, I keep trying to think about what that would mean for how we would interpret access measures, if there's a risk that we would somehow say, oh, there's an access problem because of that decline in volume. And I think some of the things you've got on here, like occupancy rate, are good ways that would still show up. There's plenty of space left in the hospitals that are open.

But it's just something as a thought exercise, and maybe at some point in the retreat or something we should think about how we're going to view access in these sectors where lower use may actually be interpreted as a good

result.

MR. HACKBARTH: As we go around, I'd welcome reactions to Jon's proposal that we should go lower.

MR. ARMSTRONG: Yeah. So, very specifically, then, I would say I think we don't go far enough. I think we should go lower with our recommended price. Again, it probably doesn't need to be said, but the frustration is we're setting a price for a service that's really inside of a system that we're trying to rationalize, and to me, the chapter does a nice job in offering a glimpse at a comparison to the MA plans' utilization of IRFs and how quite dramatically different that is when you actually have a system that's trying to rationally use this service in the context of the other alternatives. I think it just amplifies the importance of continuing that work.

In the meantime, we need to set these rates, and like I said, I would go further than the zero percent change.

DR. NAYLOR: So, I support the direction of the proposed update, and I'm trying to separate what we know about the service and how it's currently being implemented. I think for the population, which is so vastly different

than the LTCH -- I mean, this is a group of people who have a set of problems who can benefit from three hours of intensive services five days a week in 13 days and we are seeing pretty good outcomes from that, and using robust measures. The functional independence measures is a very robust measure.

So, I'm trying to separate that from how it's currently in the system and wanting to say, we don't want to lose that opportunity for that kind of service to be available because it could, in a person's trajectory, dramatically facilitate their rehabilitation. So, 80 percent of the people right now are in low caseloads. They don't have lots of other chronic conditions. They are people that can really benefit from intensive rehab services.

That said, it is of concern that the hospital-based rehab, about a 60 percent occupancy rate right now, and so we're not maximizing on that. It's higher in freestanding.

So, I am not sure that I want to go lower right now based on, I think, the opportunity -- I support the recommendation as stated, but based on the opportunity, and

here's a great example where the CARE tool could help us, because we could know whether or not making a 13-day investment gets you to a better yield in the long term, prevents rehospitalizations, and gets people back to work more quickly. So, I'm just -- I'm concerned about going too low to disincent the service.

MS. UCCELLO: I would be supportive of Jon's preference for a lower update. I think, and building on what Scott said, the mailing material had some information about how IRF usage differs by fee-for-service and MA. It was, like, MA plans are much more selective on who they send there. And so I think the compliance rate is too blunt of an instrument on trying to do this.

So, then, kind of echoing Mary, the need more for the CARE tool, the need for us to continue exploring these bundling of the acute and post-acute services is where we need to kind of continue on this. But the top line here, though, is I would be willing to go lower.

MR. KUHN: I support the recommendation that's presented, probably not in the space yet where I support a lower update. I would like to see kind of a more refined proposal than just going on a straight across-the-board

reduction.

DR. SAMITT: I support the recommendation. I could also be convinced to consider a lower update yet. You know, I think that, clearly, from the MA example that Mary described, that there is more scrutiny in alternative models to really look at appropriateness of IRF versus other care models and we would not want incentives to proliferate the less-efficient models. And so I certainly could support a lower update.

The one area of concern that I have are the very narrow margins that exist in certain hospital settings, especially not-for-profit hospitals, and whether there are some markets, geographies, areas of the country that will be severely negatively affected by lower updates where beneficiaries would benefit from IRF facilities, especially in a hospital. We wouldn't want closures in hospitals where there really isn't another for-profit or freestanding alternative. So, that would be the only area of concern that I would have.

MR. BUTLER: Okay. I wouldn't support going lower, but I would support the recommendation as is and I'll make a couple comments.

If you could put Slide 7 on. So, this shows -- I think this is very different from home health and hospice. If you go back even four more years, in our material, it shows the spending was $6.58 billion in 2004, actually higher than in 2008. So, unlike these other sectors, this spending has not grown -- you know, again, Mike, bottom lines isn't the only thing. This has kind of been contained, and it's been contained through the criteria used to admit patients, by pricing, and so forth.

So, I don't think it's kind of out of control in the same way that maybe some other sectors are, and I think that there is still opportunity to influence through pricing more specifically in criteria as opposed to kind of just simply lowering the rates, despite the obviously very high margins in some of these institutions.

Also, the cost of entry is so much higher, that despite some references to some new freestanding facilities, there's not like there's hundreds of them popping up. So, I feel a little differently.

I also would cite, and I don't have the numbers, but I believe the readmission rates from rehab versus SNF as trade-offs, the rehab units do significantly better. I'd

like to surface those. And if that's the case, there is a real financial benefit, and I think is partly, Mary, what you cite. The required therapy in these facilities is significant and I think it does make a difference. That doesn't mean that I'm not sensitive to the high returns that particularly the freestanding for-profits have, but I, at this time, would support just leaving things flat.

DR. CHERNEW: Yeah. So, I support the recommendation and I haven't come to a decision about how I would feel about being more aggressive, but I would say part of the reason is I'm not sure what happens to these patients when they don't go to the IRFs. There's a section in the chapter about quality that basically says it's about the same when they go, and there's a section about MA comparison to fee-for-service which says that the MA plans use them less. I'm not sure if they're under-using in MA or overusing in fee-for-service. So, I'm uncertain, frankly, about, for example, financially, is it way more expensive if the same person goes to an IRF? I know there's places in the country where there are no IRFs, so those patients get treated in other settings, and I'm not sure how it plays out.

My sense is that we're in a reasonably stable place, which is why I support the recommendation, and I understand the comments around the table about why it looks like it's conceivable we could go a tad lower, and I'm not inherently opposed to that, but I haven't thought through it well enough and I haven't thought through how to think about this in a patient-centric as opposed to site-centric way, and that's what's sort of causing the pause that I've been trying to figure out.

DR. BAICKER: I support the recommendation. I'd be open to thinking about lower. I, I think like Mike, was struck by the MA versus fee-for-service comparison in the chapter, which I thought was somewhat telling about potential opportunities for reducing use and changing the mix of patients in the fee-for-service group. More information about how the patients in fee-for-service look relative to the MA patients in the areas where there are IRFs, so that you're doing as much of an apples-to-apples comparison, might be helpful in supporting what the alternatives might look like for those patients and might be good input into a discussion about even lower. But I'm certainly supportive of the recommendation as it stands.

DR. HALL: I support the recommendation as it stands and I would need to see a lot more data to want to inflict even a lower update at this point. It's a system that seems to be working pretty well. It has promise. And I think this does send a message to the industry. I'll leave it at that.

DR. REDBERG: I support the recommendation as it stands. Like Mary, I do have some concerns. I think there's a lot of good that comes out of these inpatient rehab facilities that it really is a focused service that our beneficiaries benefit from.

I was struck by the geographic distribution, which looked a lot like the LTCH geographic distribution. Some of it certainly is the population centers, but that concentration in Texas and Louisiana that you see out of proportion to the population there is striking. But, still, I would support the recommendation as it stands.

DR. NERENZ: I would support the recommendation for reasons others have already stated.

DR. COOMBS: As well.

MR. GRADISON: I do, also.

MR. HACKBARTH: So, all three of you, let me ask

you a question. Does that mean you would prefer not to go lower? You like the current recommendation?

DR. NERENZ: At this instance, that would be accurate, although I'd certainly be open to discussion about going lower. But it reflects this balance, and others have used the Goldilocks analogy. It seems to have the right feel of, at the same time, being cautious with Medicare spending but also not disrupting a program that seems to be effective and, as Peter said, not running out of control. But I would be open to that discussion if you wanted to go that way.

DR. COOMBS: So, I was thinking about the notion of a maldistribution of IRFs in certain areas in conjunction with some providers who are hospital-based in certain areas and what that would mean to them. Giving a negative update could be anywhere from a minus-three to a minus-four, depending on what it was with the sequester in hand, so that was the other consideration that I had.

MR. GRADISON: I could be -- I can move in that direction. I'm not quite there now. And it has nothing to do with being considered Scrooge at this time of year.

[Laughter.]

DR. COOMBS: I did have one other question. Is it possible to get that titrated information regarding -- I think Peter talked about the readmissions -- but to get it in the freestanding versus the hospital-based at some point?

MS. SADOWNIK: Sure. That's something we can work on.

MR. HACKBARTH: Yeah. Okay. So, on the issue of whether to go lower, there seems to be some division of opinion. Let me think some more about that and talk to you between now and the January meeting.

I'm of two minds on this. On the one hand, some of the patterns -- could you put up the Slide 10, Sara, please. So, we have this difference in profitability of for-profit versus nonprofit, freestanding versus hospital-based, which is not unusual. This is a pattern frequently repeated. You know, it's always a signal to me, you know, what's going on here? Let's try to understand what might be the explanation.

Put up Slide 12 now. Here, we get a little bit different picture. We see even among the hospital-based that we have some that have substantial positive margins, which suggests it can be done. And we have some for-profit

hospital-based that are doing pretty well. You know, the not-for-profit versus for-profit seems to be the most persistent pattern.

But, again, we see that in acute care hospitals, as well. So, I look at acute care hospitals and we have efficient provider margins that are negative, overall average margins -- the average overall margin that's projected to be double-digit negative, and some not-for-profit/for-profit issues in there. We say we can live with that. We may want to increase the update a little bit above current law, but it's not going to make those negative margins go away.

And here, we're saying, oh, we see some of those not-for-profit/for-profit patterns. We're reluctant to cut an average margin that's double-digit. I'm not entirely comfortable that we're being consistent there.

And just for the record -- one last point, Mary, and then I'll call on you --

DR. NAYLOR: [Off microphone.]

MR. HACKBARTH: Okay. I'll get to you in just a second.

I do want to emphasize that I think IRFs do a lot

of really good, important work for patients, and I feel the same thing about home health agencies and I feel the same way about acute care hospitals. I think IRFs doing their job really well may save some spending elsewhere, like on readmissions.

Having said all that, I'm not sure how that justifies paying -- overpaying for each unit of service provided. I don't think if we reduce the payment rate, they're going to stop doing good things for patients. And if we have access problems like Craig identified, the solution for that is in holding up double-digit average margins for all IRFs across the country. It's if we have access problems in particular places, we need to address those more specifically.

So, there are some things about the patterns that make me a little bit uneasy. On the other hand, I'm really eager that we be consistent and fair across the different provider groups in how we treat them, and I need to sort of sort through in my own mind where to go with those conflicting feelings.

Mary.

DR. NAYLOR: I was just doing a quick -- back to

when you were talking about the margin difference, and I said it has to do with how we look at margins in the context of payment adequacy overall.

MR. HACKBARTH: You know, on that point, you know, I think that a negative margin is not necessarily conclusive proof that we're not paying adequately. I think it's a little more difficult to argue that a double-digit margin is not evidence that we aren't overpaying. And so some cases, I think, the margin numbers really could lead you to a strong conclusion.

Mike.

DR. CHERNEW: No, I mean, I agree with that. I think it depends on what you think the alternative to IRF was and what the cost is in the IRF versus not. So, if you said that this is a high-cost sector making a large margin, you would really have to convince me that the quality was a lot better. So, some of it is do you go in -- and I say the chapter clearly doesn't do that. The chapter has a clear tone that the quality is about the same across all of these settings, making you wonder, why would you certainly pay more in this setting versus another one, and why would you pay this much in this setting given the sense of margin?

And I agree with that completely.

But, if you told me that this was a low-cost setting and they were making a lot of margins because they were really efficient relative to some other setting, I would be more tolerant of a high margin, and I just don't think that's the particular case here, but --

MR. HACKBARTH: And so in that latter case, the question that I would ask, if we cut the margin from 12 percent to eight percent, would the IRFs stop doing those good things --

DR. CHERNEW: Yeah. Absolutely.

MR. HACKBARTH: -- that we saw the lower total cost? I think probably no, but -- Mary.

DR. NAYLOR: I just wanted to, also, because this could be very helpful, so I read the quality differently, meaning I saw pretty good improvements in quality. The analysis around comparison of SNF, IRF, and home health was based on the CARE assessment, which was largely an assessment to develop the reliability and validity of the CARE tool and, oh, by the way, to take a look at what we were seeing. So, I think your point is a really good one. It has a lot to do with what we see as the evidence here

about vast improvements in quality and we may be interpreting that differently.

DR. CHERNEW: Right. So, Sara, what's your take on the quality across sectors?

MS. SADOWNIK: I think you summarized the findings of the CARE tool accurately, and there was other research that had been done prior to that, to a common assessment tool being developed, that did not -- that found that they were not able to make a definitive statement because of some difficulties in comparing patients across settings, and in terms of IRF patients, some questions about whether there are variables that can't -- that are harder to measure, like aptitude for doing that intensive regimen. So, overall, I think those are the points, that evidence has been either not conclusive of differences, or not differences, or finding similar short-term outcomes across different PAC settings with the CARE tool.

MR. HACKBARTH: One last thought on this, and I apologize for sort of rambling on, but this is part of my process of rethinking before I talk to you about the final recommendation.

You know, I try to imagine myself in Scott's

position. So, if I'm running an organization like Scott's I might think very differently about how I pay for home health or an IRF provider than I do in the Medicare siloed system. So, if I'm Scott and I'm dealing with a really high quality home health agency that I've selected, or an IRF that I've selected, and I know that they're doing a great job for my patients, and if I pay them a little bit more, they say they're going to invest in new technology or they're going to expand their operations, I might be inclined to say, yeah, that's a good investment for me to make because it'll pay dividends in the future.

In Medicare, where you've got this siloed, unintegrated system, you can't strike that bargain. Oh, I'll pay you a little bit more and allow you to have a higher profit on this year's business because it'll come back to me in some way in the future, or for my patients in the future. You know, it just goes out through the silos, and in some cases, there may be a future dividend. In other cases, it's going to shareholders or wherever.

And so long as we're thinking about Medicare in an unstructured, unmanaged system, you know, the margins -- high margins, unfortunately, become a focal point.

DR. CHERNEW: [Off microphone.]

MR. ARMSTRONG: So, just to continue, if I were me --

[Laughter.]

MR. ARMSTRONG: -- I would think about how I organize that, as you just described, and I would be willing to pay a premium relative to what I would pay for alternative services. But I would still work very hard to avoid contributing to 11 to 13 percent margins. That's too high.

MR. GEORGE MILLER: Yeah --

MR. HACKBARTH: Okay. Oh, George, I'm sorry.

MR. GEORGE MILLER: Yeah. If we look back historically, many of these services were in the hospital and they got spun out because others could do them better, notwithstanding that. But a health care delivery system that had all of those components before they were stripped out is complicated and it is very difficult to figure out the right cost. So, I think this discussion is a natural evolution of what has happened over time.

I'm struck by -- this conversation, I think, is appropriate and well meaning, and just the converse, though,

doesn't happen with many other services. We don't see a freestanding diabetes center. We don't see a freestanding emergency room center. So, these things are naturally because the reimbursement structure -- although you don't want to talk about margins, they drive this type of independent structure that doesn't need all of the complexities of a hospital and its costs as multilayers that add on additional costs.

So, as we strip these things out appropriately, and you have people like Scott see how to buy these services, in my mind, you've got to take consideration where they originally came from and what's a better way to price them. But the fundamental basis of health care in America right now is -- for the most part has been -- let me put it that way -- has been the hospital because of this complexity. They can take care of a wide variety and range of health care needs in a setting that provides both inpatient, outpatient, ICU services that may or may not be appropriately priced. But as you take each one of these out, we figure out the right prices at the right time for these. So, I just wanted to say that for just saying it, then, so -- to reflect on that, yeah.

MR. HACKBARTH: Thank you, Sara and Craig.

We'll now have our public comment period.

[No response.]

MR. HACKBARTH: Seeing nobody step to the microphone, we are adjourned until January. See you all then.

[Whereupon, at 11:20 a.m., the meeting was adjourned.]