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 18, 2014
9:16 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
FRANCIS “JAY” CROSSON, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, RN, FAAN
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA

AGENDA PAGE

P R O C E E D I N G S [9:16 a.m.]

MR. HACKBARTH: Okay. Good morning. We still have a few Commissioners filing back in, but I do want to get started. We're behind schedule already. And I apologize to people in the audience for the late start. We have things that we need to do in Executive Session before the public meeting, and we've got a number of Commissioners who fly in from the west coast. And so when we start at, say, 8 o'clock, it's 5:00 a.m. on their body clocks, and I don't have the heart to start before 8:00 a.m. for them. So that's the reason we sometimes get off to a little bit of a late start.

As people no doubt know, this is the meeting when we begin our consideration of our update recommendations for the various Medicare payment systems. Today I will offer draft recommendations for the nine different Medicare payment systems. Those are draft recommendations. The final votes on our recommendations will occur in January. The draft recommendations may or may not be changed. It depends on what happens during our discussion today and then in subsequent conversations I have with individual Commissioners between now and the January meeting.

The short version is that the draft recommendations I'm offering today as a group are the same as the recommendations we made last year, and the reason for that is that, in my judgment, the conditions are pretty similar to what they were last year. Again, that could change based on our conversations over the next few days.

In addition to the update recommendations, we will consider a few other draft recommendations that are not for payment updates but deal with other matters.

In formulating our payment update recommendations for the Congress, we use what we refer to as a payment adequacy framework that includes the following factors: beneficiary access to care, quality of care, volume of services being provided, access to capital, and financial performance as measured by the Medicare margin -- that is, the margin the providers get, financial margin they get on Medicare patients.

Our practice is to start with zero. By that I mean we presume no increase or decrease in the base payment rate. We use our payment adequacy framework to determine whether a change in the rate is appropriate.

By law, by the statute that governs MedPAC's work,

we are to recommend Medicare payment rates that are consistent with the efficient delivery of services, so you will hear us make frequent mention to efficient provider analysis.

In recent years, a fact of life, of course, for providers serving Medicare beneficiaries has been the sequester, which reduces Medicare payments with an across-the-board reduction of 2 percent. The effect of that, of course, is to affect revenues to providers and their financial performance. And, of course, that is not lost on us.

As staff move through the presentations today and tomorrow, the margin information they produce and show on slides will include the effect of the sequester. I would point out, however, that the sequester is not a Medicare law. It is outside the Medicare statute. It applies across the board, not just to Medicare but to a host of other domestic programs and to the Defense Department budget as well.

Our statutory charge, MedPAC's statutory charge, is to recommend Medicare payment rates, and one way to think about that assignment is that each year before the beginning

of a new fiscal year, CMS produces in the Federal Register a detailed final regulation that, among many other things, lays out the base payment rates in dollars and cents for each of the Medicare payment systems. What we are doing is recommending how that dollar-and-cent value ought to change for each of the different provider groups. That is our statutory assignment.

To the extent that Congress, by means of the sequester or any other means, produces a payment rate that is different than that dollar value that we recommend, we disagree with it. It's Congress' decision, but we are on record as disagreeing with it.

With specific regard to the sequester which cuts payments across the board, it has been our view, continues to be our view that if Congress wishes to save money in the Medicare program, it is better to achieve that through more targeted means. We don't think that the savings opportunities are spread across Medicare evenly 2 percent in every provider group. We think there are greater opportunities in some areas than others, and that is the best way to achieve Medicare savings consistent with access for Medicare beneficiaries to high-quality care.

For several Medicare provider groups, specifically physicians, home health agencies, and skilled nursing facilities, this past year we recommended package recommendations that included multiple elements and included multiple-year transitions. Last year the way we handled those recommendations was to rerun the package recommendation but not revote it. I am recommending that we continue to do that same thing this year for physicians, home health agencies, and skilled nursing facilities.

Last year we also recommended a package for hospitals that included the acute-care hospital inpatient and outpatient update, a change in outpatient payment rates for specified APCs, a change in LTCH payment rates, and an increase in acute-care hospital outlier payments as a package. My inclination with that package is to do with it as we have done with physicians and home health agencies and skilled nursing facilities, which is to rerun that package without a separate vote, but that is an issue that we will be discussing as a Commission today and when I talk to individual Commissioners between now and January.

Just a few final thoughts about the payment adequacy framework that we use. It's a multipart framework.

It does not produce a single right answer as to what the update should be. It is not arithmetic. This is a judgment made on the basis of multiple considerations. Indeed, I say if it was arithmetic, then Congress wouldn't need MedPAC. They created MedPAC because they knew it was a matter of judgment, and they wanted people to come to a table and bring a variety of different perspectives and offer the best advice that we can.

For my part, the elements of the payment adequacy framework that are most important are access for Medicare beneficiaries and quality of care for Medicare beneficiaries. The Medicare program was created to serve Medicare beneficiaries, to assure them access to high-quality care. The Medicare program was not created for health care providers. Health care providers are a means to the end, not the end in themselves.

Also important to me is the fiscal burden of the Medicare program on taxpayers, and, frankly, I'm particularly worried about young taxpayers, many of whom are struggling themselves to pay for their own health insurance coverage and save money to send their kids to college and the like.

Medicare's design, created back in 1965, an open-ended entitlement, free choice of provider, with beneficiaries having -- most beneficiaries having much of their out-of-pocket payments at the point of service covered either through public programs like Medicaid or receiving implicit subsidies for private coverage, as we outlined in our benefit restructuring report several years ago, means that we've got an open-ended, fee-for-service, free choice of provider, often first dollar insurance program for seniors, a package that isn't available to most other Americans these days. And so I'm worried about the cost of that structure.

As Medicare currently works, update factors, the work that we're embarked on the next couple days, is one of the few levers available to control the cost of that Medicare program, that structure that I referred to. There's lots of talk about creating new mechanisms, whether through payment reform or benefit restructuring or premium support or other things. But right now those are at best working on the margin. As in the case of payment reform, they are not the heart of the Medicare program. Right now payment rates, payment updates per unit of service, are the

principal mechanism for controlling the cost of the Medicare program. And that's the mind-set I have when I approach the work over the next couple days.

So that's a bit of context for our work. We begin this morning with the hospital inpatient and outpatient update and discussion of payment adequacy. Craig?

MR. LISK: Good morning. This session will address issues regarding Medicare payments to hospitals. First, we will discuss whether payments are currently adequate. Then you will discuss the Chairman's draft recommendation for updating payment rates for 2016.

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 provider and for relatively efficient providers.

We have a lot to cover today, so we will move fairly quickly. More detailed information is contained in

your mailing materials.

In 2013 Medicare paid hospitals roughly $167 billion for inpatient and outpatient services for Medicare fee-for-service beneficiaries. This represents a 1 percent increase in spending per beneficiary.

Total spending growth per capita was relatively low between 2012 and 2013 due to declines in inpatient volume being offset by increases in outpatient service use as well as restrained payment rate increases.

As we discussed in November, access to care is good, and we do not see any near-term issues that would affect beneficiaries' access to care. We will not cover all of that information again but will take any questions you may have.

We do see a reduced demand for inpatient services but increased use of outpatient services. In most markets we find an excess supply of hospital beds with occupancy rates declining. However, there is regional variation in bed capacity and use, which we discuss in more detail in your chapter.

Access to capital is also good for most hospitals. Interest rates are low and bond ratings are stable, and the

strong growth in stock prices we have seen over the past two years shows access to the equity markets is also good.

We assess the quality of inpatient hospital care by analyzing recent trends in several clinical outcome measures, including in-hospital and 30-day mortality rates, patient safety indicators such as rates of health care-associated infections and post-surgical complications, and 30-day readmission rates.

In this year's analysis, we find that hospitals' overall performance on all of these measures either improved by a statistically significant degree or was stable from 2010 to 2013, the most recent year for which we have claims data.

We would point out that the decline in readmission rates has occurred concurrent with the implementation of the readmission penalty in 2012.

We also continue to see hospital cost growth is down from historical averages. This is due first to hospital input price inflation, which is the cost of inputs used to provide a fixed basket of hospital services, slowing from 3.7 percent to 2.2 percent in the current period and is no longer growing faster than economy-wide inflation.

Second, historically we have seen hospital costs increasing more than a percentage point faster than input price inflation, hospital input price inflation, the result of more inputs being used per service, but now we see costs growing close to hospital input price inflation.

So let's move on to discuss the implications for margins.

A margin is calculated as payments minus costs divided by payments and is based on Medicare allowable costs. In 2012 and 2013, Medicare inpatient and outpatient margins both declined, but the overall Medicare margin has remained steady at minus 5.4 percent, mostly due to increases in Medicare HIT payments hospitals have received.

The inpatient and outpatient margins would have held relatively steady, though, between 2012 and 2013 but for the sequester which was in effect for half of the year. The overall Medicare margin would have been a percentage point higher if the sequester had not been in effect.

Our next slide shows how the overall Medicare margin differs across hospital groups. The average overall Medicare margin for rural hospitals was a positive 0.2 percent in 2013, which is six percentage points above the

margin for urban hospitals. Much of this difference is due to the low volume adjustment and proportionally higher HIT payments rural hospitals receive, many rural hospitals receive.

For-profit hospitals had the highest overall Medicare margin at a positive 1.2 percent in 2013. We think this higher margin is due to a combination of factors, with for-profit hospitals having a lower cost structure and a tendency to provide more profitable services.

While Medicare margins continue to be negative, all-payer margins are at a record high, as you can see here with the yellow line, where they rose to 7.2 percent in 2013. Other total hospital financial indicators stayed strong in 2013, as shown by the operating margin -- the green dashed line -- and the EBITA, which is a cash flow measure -- the top line.

This slide highlights the divergence in margins discussed in your mailing material. The divergence reflects a constraint in Medicare payment rates in contrast to rapid growth in private insurance payment of between 5 and 7 percent, which have allowed total all-payer profits to rise.

DR. STENSLAND: Next we're going to discuss our

forecast of the overall Medicare margin for 2015, which is the current policy year.

We estimate that overall Medicare margins will decline from about negative 5.4 percent in 2013 to about negative 9 percent in 2015.

So why do we expect this decline in margins?

The updates for 2014 and 2015 will push revenues up, and we expect to continue to see an increase in case mix. However, we expect cost growth to continue in the 2 to 3 percent range, which will roughly offset the growth in payment rates and case mix growth. So margins would be flat if that was all that was happening.

However, there have been some policy changes over the past two years. The sequester, the DSH payment reductions, the HIT payment reductions, and penalties for poor performance on hospital readmissions and hospital-acquired conditions will all reduce aggregate payments. The net effect is an expected decline in margins of almost 4 percent to negative 9 percent. Now, this would be about negative 2 percent if the sequester is repealed.

So when you see the negative 9 percent margin, a question would be: Do hospitals still have a financial

incentive to see Medicare patients? And I think the answer is yes. As we discussed in September, between 10 and 30 percent of hospitals' costs are fixed. So Medicare payments, even with the negative 9 percent margin, are more than covering the marginal cost of care for the average hospital. That's a long way to say that hospitals still have a financial incentive to see Medicare patients when the average margin is negative 9 percent.

Craig and I have talked about margins for the average hospital. A key question is whether Medicare margins are also negative for relatively efficient hospitals. To address this issue, we investigate whether there are a set of hospitals that perform relatively well on quality and cost measures. We deem these hospitals our set of relatively efficient hospitals.

To determine who is relatively efficient, we use the same criteria we've used for the last couple years. I will not go into them in detail, but hospitals are categorized as relatively efficient if they perform well on mortality or standardized costs and did not perform poorly on mortality, readmissions, or standardized patient costs in 2010, 2011, or 2012.

So, after we identify the group of historically efficient hospitals, we then look to the next year and see, well, how did they do in 2013? Here are the results.

We ended up with a group of 266 hospitals that have historically been relatively efficient providers for three straight years. This group of 266 hospitals represents about 13 percent of all the IPPS hospitals that had usable data for all four years in this analysis.

Now, if we look at the first column, we see that the historically efficient hospitals had 16 percent lower mortality, on average, while keeping their costs ten percent lower than the national median. The lower costs allow these hospitals to generate a positive Medicare margin in 2013, with a median margin of about two percent. Now, we're still computing the differences in readmission rates for 2013, but historically, the relatively efficient group has also done better on the readmissions.

It's important to remember that when we talk about efficiency, we're talking about quality and cost. Craig mentioned earlier that for-profit hospitals tend to have lower costs. And, while there are some good for-profit hospitals and they make it into our relatively efficient

group, for-profit hospitals are actually under-represented in our efficient group due to being less likely to perform well on mortality and readmission measures. And, I just mention this to emphasize the fact that quality is a key part of our measure of efficiency, which differs from how some other people talk about efficiency.

And, the bottom line from this analysis, the take-away point is that it is possible to constrain your costs and still provide relatively good quality care at a general hospital.

So, now, let's move to our summary of the payment adequacy results. First, access to care is good. Access to capital is adequate, although there are a few providers that have had some financial problems and have had downgrades, in part associated with their reduction in volume. Quality is improving. Margins continue to be low for the average provider, negative 5.4 percent. However, relatively efficient providers were able to make a slight profit on their Medicare patients in 2013.

However, as we discussed last year, there are payment policy changes scheduled to take place in 2015 that would reduce payment rate to hospitals. And, if current law

holds, we would expect negative margins in 2015, possibly even for the relatively efficient hospitals. Margins are expected to be negative, but as I said, hospitals will still have a financial incentive to see Medicare patients because the revenue they receive from each Medicare case will still be more than the marginal cost of providing care to that case.

So, now, I want to discuss last year's recommendation before I present the Chairman's draft recommendation.

As you may recall, there were three parts to last year's recommendation. Before we made the recommendation, we looked at the payment adequacy indicators last year and they were essentially all the same as they are this year. The trends, the quality trends, the margin trends, all those trajectories were basically the same last year as they are this year.

And, the package of recommendations that we discussed had the three objectives. First, there was a 3.5 percent update recommendation. Second, the Commission decided that payment rates should be equal or close to equal in hospital outpatient departments and physician offices for

55 outpatient services. And, third, the Commission decided that payments to long-term care hospitals and acute care hospitals should be similar when they provide similar services, and I will briefly recap those two site-neutral aspects of last year's recommendation package.

So, this slide discusses the part of last year's recommendation that reduced differences in rates between hospital outpatient departments and physician offices. As we said, higher rates in hospitals encourage hospitals to convert physician offices to outpatient departments and to shift volume of services to the higher cost outpatient setting.

For example, we see this happening in the data. In 2013, we saw seven percent growth in echocardiograms in hospitals and we see and eight percent decline in echocardiograms in physician offices, which are paid roughly half the rate that hospitals are.

To eliminate the incentive to shift volume to higher-cost sites, we recommended bringing payments for 66 services provided in hospitals to rates closer to those paid in physician offices. For example, the Medicare program would bring rates for echocardiograms that are provided in

an outpatient department to a rate that's equal to that in physician offices.

The list of 66 services was limited. It was limited to those that are frequently provided in physician offices, so we know it's safe to do. They were cases where patients' severity was similar between the physician office and the hospital. And, in addition, to protect hospitals' emergency department stand-by capacity, the list of services did not include any services that are frequently provided on an emergency basis.

Now, the financial impact of this policy was to reduce payments to hospitals. The reduction to the hospitals would be about $1.44 billion, and what that consists of is about $1.2 billion reduction in Medicare program payments. So, that would be reduction in the payments from the taxpayer. Beneficiaries would save roughly $240 million in coinsurance, and that's because the coinsurance is much higher when you go to the outpatient department because that base rate is higher. When we bring that base rate down, the beneficiaries' coinsurance goes down and that's how they save the $240 million.

Now, we'll talk a little bit about last year's

LTCH recommendation. Now, the third part of this package was to move rates to long-term care hospitals and acute care hospitals to more of a similar level when they treat similar patients, and exactly what that meant in the recommendation was that the higher LTCH rates would be limited to the most medically complex or chronically critically ill patients. These are patients that have long ICU stays before being admitted to the LTCH or that required prolonged mechanical ventilation. Many current LTCH patients don't meet this CCI definition. These non-CCI cases would receive traditional acute care hospital rates.

Now, the savings from lowering the LTCH payments for the non-CCI cases would then be used to fund additional payments to acute care hospitals that care for the most difficult CCI cases in the acute care setting, and this would help level the playing field in markets with and without LTCHs.

The end result by bringing payments down at LTCHs for the non-CCI cases and bringing payments up at acute care hospitals when they treat the most difficult cases would be to have the payment rates depend more on how severely ill the patient is and depend less on where the patient goes for

their care.

And, now, I'll read the Chairman's draft recommendation. 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; lets LTCHs base payment rates for non-CCI cases equal those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for CCI cases in IPPS hospitals. The change should be phased in over a three-year period from 2016 to 2018. Increased payment rates for acute care hospital inpatient and outpatient prospective payment systems in 2016 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

Now, the rationale behind the package was two-fold. First, there was a need to reduce incentives to shift care to higher-cost sites. The recommendation would correct for this difference in payments across sites in three ways: First, it would align outpatient rates with physician office rates for selected services, bringing down LTCH rates for less critically ill patients, and bring up acute care

hospital rates for the most critically ill patients that spend long times in their ICUs. Finally, the recommendation would give an update above current law. Given the payment adequacy indicators from last year and the other changes that are part of the package recommendation, the Commission decided last year that an update above current law was warranted.

So, the package has a combination of impacts on the hospital, and I'll run through at least the financial impacts here. First, the site-neutral policy of moving certain outpatient rates toward the level of physician offices will reduce hospital payment rates. Second, the reduction in long-term care hospital payments and taking those funds to provide additional outlier payments to general acute care hospitals would increase payments at acute care hospitals. Finally, the update would increase payments to acute care hospitals over current law. Now, the net increase in payments of 2.5 percent in 2016 would be about 2.25 percent over current law.

And, now, we'll open it up for comments and questions.

MR. HACKBARTH: Okay. Thank you all.

So, what I'm going to propose is that we try doing three rounds. One is clarifying questions, strictly defined, and forgive me if I interrupt you in the midst of a question and deem it not sufficiently narrow to be a clarifying question. So, clarifying questions are, again, Table X, what does the third row mean, that sort of thing, very specific, concrete questions.

Then, what I'd like to do is have a second round that may be a little bit more free flowing. As somebody raises an issue, see if there's somebody else that wants to build on that or go in a new direction.

And, then, conclude with a very quick, like, one minute each, round, what's your current thinking about the draft recommendation. I'm not asking for a final position, but I'm generally comfortable, or I would like to see this part changed, that sort of directional feedback so that we can move from this conversation towards our final recommendations in January.

To be able to do that across all of these different payment sectors is going to require a lot of discipline in terms of very -- following the structure for the comment period and being very disciplined in your

formulation of what you want to talk about, so I ask for your help in that.

So, let's start with the round one clarifying questions. Any clarifying questions? And, we'll start with Mary and then go down the row.

DR. NAYLOR: Thank you. Slide 6. I'm wondering if you could comment on disentangling the quality data for inpatient versus outpatient. So, these improvements, I think, are --

DR. STENSLAND: Yeah. Most of our measures are actually inpatient measures. So, this is within the stay or 30 days after the stay. We don't have as many good measures on outcomes on the outpatient side.

DR. NAYLOR: Great. And, then, Slide 13. Can you estimate -- thank you for the implications of the policy changes for next years. Can you estimate what the overall margin would be for relatively efficient hospitals given those changes?

DR. STENSLAND: The -- right now, we've projected for a 2015 -- you're suggesting a 2015 margin?

DR. NAYLOR: Twenty-fifteen margin.

DR. STENSLAND: Yeah. So, we have a 2015 margin

projection of negative nine percent, and the relatively efficient hospitals will do better, but they might not do well enough to be above zero. It is a significant possibility that they'll be slightly negative -- not dramatically negative, but slightly negative in all probability.

DR. NAYLOR: Close to the two percent that you estimated in terms of legal changes --

DR. STENSLAND: Umm -- two percent --

MR. HACKBARTH: So, I think I'm with Mary on this. So, that's the current law projection for 2015. That does not include the effect of our package --

DR. STENSLAND: Correct.

MR. HACKBARTH: -- which you said would increase payments above current law.

DR. STENSLAND: Right. So, there's -- it might get somewhat confusing, but we have a projection for 2015, and that is the negative nine percent and maybe a slightly negative margin for the relatively efficient providers in 2015. Then, there is the update recommendation which we have for 2016, and then that will -- there'll be a separate -- that would have different implications for what the

margin would be in 2016, if that makes sense.

MR. HACKBARTH: Okay. Clarifying questions, moving on around here --

DR. REDBERG: We can stay on Slide 13. I just wanted to know, you did have some comments in the mailing materials on what distinguished the relatively efficient hospitals, like large nonprofits and lower mortality rates. Were there any other identifying features you could comment on, because it would be interesting to know what makes some hospitals more efficient and how we can encourage that.

DR. STENSLAND: The -- we had some more detail on this in our 2011 chapters, but they weren't big effects. So, I think the major effects are large hospitals tend to do better on mortality, and then that gets them more likely to be in the efficient group. You have some hospitals that tend to be in areas where, for whatever reason, Medicare payments are relatively low. So, we adjust this by the MedPAC wage index, like, what the wages are in the general market. So, if you happen to be in a market, for whatever reason, you're not very advantaged by the Medicare payment system, you tend to constrain your costs more, everybody in the market. And, so, you tend to be a little bit more

likely to be in this group.

MR. GRADISON: This question has to do with the basic data that you use in calculating -- in identifying institutions, hospitals that are efficient with regard to both quality and cost. Are those basic data all publicly available, the basic data itself?

DR. STENSLAND: Yes. The basic data is all coming off of the combination of Medicare claims and Medicare cost reports.

MR. GRADISON: Thank you.

DR. CROSSON: You know, this is a little bit to Rita's question. One of the things that struck me in the text was the relative change in staffing mix that had occurred between 2008 and 2013 with a decline in LPNs and LVNs of 31 percent and an increase in registered nurses. With respect to what Rita just asked, is that across the board or is that -- do you know, perhaps not, whether that differs between for-profit and not-for-profit hospitals or between efficient hospitals and the other hospitals?

MR. GAUMER: Yeah. That is across the board. So, we didn't have a breakdown of the for-profit and the nonprofit.

MS. BUTO: Yeah. I was wondering whether you've got or could break down -- this is Slide 13 -- the 266 relatively efficient hospitals by geography or region, large and small, for-profit, not-for-profit, and the reason is just to get a sense of whether we have a good distribution of those efficient hospitals across the country and what the impact might be regionally.

DR. STENSLAND: You get a pretty good spread across all of the country. You have about 14 percent or so of the nonprofits are in there, maybe six percent of the for-profits, so you get some from both of those two categories. And, in terms of the big and the small, you do end up with a lot more larger hospitals, and you have some rural hospitals in there, but probably fewer rural hospitals, in part just because there is some correlation between the volume of cases and some of the risk-adjusted outcome measures, like mortality.

DR. SAMITT: Same line of questioning. Have we looked at the efficient hospitals and compared them to the ACO program to see if any of these, or a majority of them, also are pursuing the ACO pathway?

DR. STENSLAND: I haven't done that, but that's a

good idea.

MR. HACKBARTH: Okay. Clarifying questions on this side. Warner, Alice, and Jack.

MR. THOMAS: Did you, in your projection of the profitability or subsidy of the hospitals, did you take into consideration the reduction and/or elimination of the HIT payments in the future?

DR. STENSLAND: So, a lot of the drop that we saw in our projection, from negative 5.4 to negative nine, basically, the update and case mix growth basically offsets -- is offset by cost growth. So, then, the real decline that we see there is pretty much due to the decline in HIT payments, the decline in DSH payments, and some of the documentation and coding adjustments that are in current law. So, those factors, exactly what you're talking about, is what's driving the decline.

MR. THOMAS: And, do we anticipate that would continue to increase, because the payments will continue to decline going forward?

DR. STENSLAND: The magnitude of the decline -- you know, the HIT payments went up, and that's part of what kept the margins level up through 2013, and now they're

going to start to go down, and I don't remember exactly when they end -- I think it's about 2017 or 2018 where the HIT payments end altogether. So, you're going to have this declining for the next couple years of HIT and declining for the next couple years of DSH and then it'll level off on both of those.

MR. THOMAS: And, on page 16, with the 66 APCs, you indicate Medicare paid $1.2 billion more. Is that net of the reduction in the payments for physician services?

DR. STENSLAND: Yes, that is the net amount.

MR. THOMAS: Okay.

DR. COOMBS: So, do you know the overlap with the for-profits and the academic institutions? Is there a significant overlap?

MR. LISK: The for-profits, there's only a small number of, let's say, major teaching academic, major teaching for-profits. They are different from -- their characteristics in terms of margins are different from the other for-profits.

DR. COOMBS: Did you notice a trend with efficiency with that combination?

DR. STENSLAND: No. We didn't look at that, and I

think the numbers are so small, I would be worried about drawing too much of a conclusion. If we have two or three -- if the expectation is only to have two, it's hard to draw too many conclusions.

DR. COOMBS: And then one other question regarding the academic institutions. If it were not for IME, what would the margins look like? Do we have an idea of what that contribution would be?

MR. LISK: Saying what the margin would be without the IME, I would have to make that calculation. It would be a fair bit lower because the IME is a fair bit of their payments. They would be below other -- they would be below other hospitals if the IME wasn't there.

MR. HACKBARTH: So we could come back with that.

Jack.

DR. HOADLEY: On Slide 11 where you talk about the DSH reductions, presumably -- this is the DSH reductions from the ACA that you are talking about here in the changing of the formula. Presumably, for some of the hospitals, especially in like Medicaid expansion states, they are replacing a lot of uncompensated care with new, but that is going to not show up on the Medicare margin side. That's

going to show up on the total margin side. Do we have any sense of how to quantify what's going on?

DR. STENSLAND: A total margin side?

DR. HOADLEY: Yeah.

DR. STENSLAND: Well, so far, through 2014, at least the data that's showing up through the Census and what the for-profit big systems are reporting is that they're actually doing quite well through 2014.

Now, their Medicare profitability is going down because the DSH payments are going down, but their amount of uncompensated care dramatically went down. So, on net, they're actually doing better, which implies it was kind of a good deal for them, that tradeoff.

DR. HOADLEY: But it's also part of what creates that spread between the Medicare margin and the total margin. Okay.

MR. HACKBARTH: I want to go back to the earlier question about for-profits and the efficient provider calculation.

So, if you put up Slide 9, we show for-profits having significantly higher margins than not-for-profits, which I assume means also all of the things equal lower cost

per case. I'm inferring from that -- and I think I heard you say that the for-profits are slightly underrepresented in the efficient provider group relative to not-for-profits, and I am inferring that that's because of the quality test in the efficient provider calculation. Is that right?

DR. STENSLAND: Correct.

MR. HACKBARTH: Okay. So that's Round 1. Let's go to Round 2 for which we have 15 minutes, and what I'd like to do is see a show of hands of people who have things they would like to talk about in Round 2. How many have I got? I've got Bill and Craig, Warner -- okay. So we've got about 5, and we've got 15 minutes.

What we'll do is the process we've used in recent meetings. We will have Bill go first, and then we'll see if anybody wants to build on that. And then we'll proceed down our list. Keep in mind 15 minutes is all we've got for this.

Bill.

MR. GRADISON: I think we should make public the list of 266 hospitals that meet these tests, either in an appendix to our report or online. I think it would foster some healthy competition, and there's so many other

assessments of quality and good hospitals and other hospitals out there. I think that since we are relying upon one which I learned a few moments ago is based entirely on public information, people on the outside shouldn't have to work through those numbers on their own to see who is on the list, which they could do, because it's based upon information that is out in a public domain.

MR. HACKBARTH: We will try to deal with that later on.

Is there anybody that has a comment related to that, that they want to offer or build on Bill's?

Craig.

DR. SAMITT: So my question is specifically about 66 APCs and the consistency of that number over time. So I would imagine that we would see an evolution of an ongoing shift of services in physician offices to HOPDs. So how often should we be reevaluating that 66 in any annual recommendation to determine whether that number should be larger or smaller, potentially?

DR. MILLER: I don't think Jeff or I know, and I think it's probably, if you think about the Commission's work, every few years, you might want to take a look at

this.

There will be some awkwardness in doing this. One of the criteria is that it's done the majority of the time in the physician's office. If a lot of this continues, that criteria becomes something of a question and almost countercyclical to the point of the site-neutral payment. Scott pointed this out a couple times when we were going through our deliberations. It probably should be looked at every few years.

MR. HACKBARTH: Pick up with Craig's? Rita.

DR. REDBERG: Just related to that, I think it would also be great if, at some point, we could begin to incorporate criteria for appropriate use of those, because those common APCs include a lot of tests, not just that their prices are different, but how -- I mean, echocardiograms, for example, are estimated. Some percentage are considered unnecessary or inappropriate in that they didn't lead to any particular change in management, benefit, and outcomes, or were repeated too quickly.

MR. HACKBARTH: Anybody else on the topic of how we determine what's in the APC group, the site-neutral

payments?

Warner.

MR. THOMAS: I just have a question about that. How did we determine the payment adequacy for the 66 APCs that the physician office payment was adequate? How did we determine that?

DR. STENSLAND: I think that was based on the premise that physicians are willing to provide these services in their office. They are willing to set up the echocardiograms and have the Medicare beneficiaries come in and do it, and so -- because we don't have costs and revenue data from the physician offices, we have to go by their willingness to provide the services.

MR. THOMAS: But there is a reason that physicians are transferring to hospitals. I mean, they're probably not just doing it because it's something they feel like doing. My guess is there's probably some financial pressures that cause that. Wouldn't you think? Would you think that's part of what's driving some of that?

DR. STENSLAND: That's part of the -- I think that was part of the rationale behind the recommendation, and you all correct me, but the general idea that if the hospital

can make more off the service than the physician is making more off the service, well, then the physician does have an incentive to sell their practice to the hospital, and the hospital can generate more money.

They can do exactly what they were doing before, but maybe they can generate more income, so they can get a bigger salary from the hospital than they could make on their own because the hospital gets paid more than they do, even if it's the same machine in the same building with the same patient and everything else is the same, and whether -- the concern is that if we make that shift and there might actually be some inefficiencies caused by that shift, because sometimes the hospitals say, "Well, our overhead structure is higher." I think George Miller would say we have to change the ceiling height and do all these things to make it a part of a hospital. And so we would hate to see all that extra waste go into converting some office building into a hospital when really the only purpose of doing that is to get the higher payment that then can kind of be shared by the physician in the hospital.

MR. THOMAS: Okay. Thank you.

DR. COOMBS: I think it's complex. On initial

blush, I was thinking that maybe some regions might have benchmarks in terms of certain APCs being performed preferentially, and I think there might be drivers in communities regionally that may predict that 80 percent of this APC is going to be in a physician's office.

So I guess maybe a wish list, three or four years down the line, might be to look at a population health indicator where APCs are best handled in terms of quality, some quality benchmarks that are attained.

I only say that in the sense that if you had 90 percent of echoes in one region that's done and it's done fairly well, it would indicate that in terms of quality, there is no delta, but there is great, tremendous savings in terms of preferentially being performed in the physician offices. You might say in certain regions that if you know something like that, it may give your surveillance to see that there's something else at work in that community in terms of the shifts that occur because of market power, if you will.

So I was just thinking, down the road, we might think about percentages of those APCs in one entity versus the other.

MR. HACKBARTH: Okay. So we have eight minutes left in this segment. I'm sensing it's time to move beyond how we determine the APCs, unless there is somebody who really has an urge to address that, and open up to other comments.

Mary.

DR. NAYLOR: So we have been -- in the past, explored looking at this and separating inpatient from hospital outpatient because -- as a possibility in thinking about updates, and I would say that not this year, but we should really think about this because we are watching, as your beautiful report suggests, a 17 percent decline over seven years, and use of inpatient, a 33 percent increase during that same period, with cost sharing going to beneficiaries, very little quality data, not employment data as much as we need.

So there is, I think, a real opportunity and need to think about at least unbundling as we look at access, volume, and quality -- and margins, how it is that we should be doing updates.

And the second piece, unrelated, is that as we think about the impact of policy changes on updates and

including -- on the one hand, we're saying, we do not want to reward poor performers, hospital reduction, readmission, or hospital-acquired infections, and the policies associated with that. So I just wonder -- and that is what I was raising earlier. Page 34, 35. You are thinking about what could change. I am wondering whether or not we should even include those factors because those policies are intended to try to raise performance, and whether in calculating what margins might be next year, we should at least separate those intended to eliminate poor performance versus those that are going to affect all hospitals.

DR. MILLER: I just wanted to get in a clarification here. So your point is, if some of the reason that the margins deteriorated is because of readmission penalties, then we just put it back in with the update, you're sort of saying maybe there's not a pure logic to that.

DR. NAYLOR: Exactly.

DR. MILLER: Got it. I just want to make sure that I followed it.

MR. HACKBARTH: Okay. I know Scott wanted in here. Who else has a Round 2 comment that they want to

make?

Scott.

MR. ARMSTRONG: Just briefly -- and I know it's probably not a surprise to you, but I found really interesting some of the reference in this chapter to more population statistics, the days per thousand or the cost per beneficiary of hospital services. I know we are looking at a package of per-unit prices, but we should be looking at, ultimately, the fact that we are spending a total dollar amount on hospital-based services that, at least in my view, is too much.

I just wonder if there is more we would learn if we knew more about perhaps some correlations between those efficient hospitals and markets in the country that have relatively low utilization or relatively low cost per beneficiary or if there's just more that we could learn about best practices and so forth, not just relative to margins or hospital-specific quality, but relative more to regional variation in overall outcomes.

MR. HACKBARTH: Last call for Round 2, questions or comments.

[No response.]

MR. HACKBARTH: Okay. Let's move to Round 3, and what I'd ask is just a very concise statement of your current thinking about the draft recommendation. You are not bound by what you say now, but I want to get a sense of where people are and what issues we need to work through in the next month, starting with Craig, and we'll come around this way.

DR. SAMITT: So I'm comfortable with the recommendations, as drafted.

I would also say that I am comfortable with Bill Gradison's recommendation about publicly revealing these efficient hospitals. Transparency of comparative performance is a motivator for both providers and beneficiaries, and I would be in support of that notion.

MS. BUTO: I agree with that, and I would add Mary's point of -- and I really like the idea of making public, the list of efficient hospitals. I do have some questions about where those are and do we have a good representative sample, but I like Mary's point about separating out the motivators to improve quality from the update and not mixing those together necessarily. So I can support the recommendation.

MR. GRADISON: I can support it as well. I would only add that I think of it as a package and would be very reluctant to see pieces of it changed in any major way.

DR. REDBERG: I can also support the recommendation as a package, and I also support Bill's suggestion to make the names of the relatively efficient hospitals as an appendix public as well as Mary's recommendation.

DR. CROSSON: Yeah. I support the recommendation, set of recommendations as well.

I have one question in terms of what Mary was saying. I thought, Mary, you were saying, suggesting that in the future, we unbundle inpatient and outpatient and analyze those separately and bring forward separate updates. Is that not what you said?

DR. NAYLOR: We have discussed that as a possibility, and I think as the gap is growing between inpatient and outpatient, we should continue to explore that, and one way to do it is to disentangle our assessment of factors related to access, quality, et cetera, to get us to a better sense of what we should do.

DR. CROSSON: So I would support that.

MR. HACKBARTH: Jeff, do you want to comment on doing inpatient and outpatient separately?

DR. STENSLAND: Historically, we have tried to package the inpatient and outpatient together, and part of our concern, at least on the margin metrics, is that performance on one might affect your performance on the other. And we have this general overall margin which includes not only inpatient and outpatient, but also things like SNF, whatever you make or lose on your graduate medical education, your home health agency. Maybe you have an IRF in the hospital.

For example, one of our concerns has been that we see big negative margins on people's SNFs, when it's a hospital-based SNF, but the hospital-based SNF might actually help your inpatient margin, because if you have a hospital-based SNF, maybe you'd discharge the person a little sooner because they are just kind of going to the next floor, and you're comfortable doing that, and so you have a shorter length of stay. So there's kind of this interrelatedness of the costs and the margins between the different sectors, and so if we pull them out -- we do present separate inpatient and outpatient margins now, but

we emphasize the aggregate margin because of this interdependence. Of course, it's all your call.

DR. NAYLOR: I just want to anticipate Scott's comment that we need to pull it all together, but I support the package of recommendations.

MR. HACKBARTH: Scott.

MR. ARMSTRONG: So I have supported this before. I would only support this as a package, as it's been said.

I have to say this seems, at a time when hospitals are making stronger margins than they have in a long time, difficult for me to come around to this.

I can see a path to supporting this, but both given the strong margins and view that the Medicare program overall is spending more than it should be on hospital-based services, I just think to make our payment decisions for this sector the highest increases of any sector at a time when we're seeing these kind of all-payer margins will just be a tough one for me to swallow.

DR. CHRISTIANSON: I also support the recommendation, but I'd also like to say that I think the difference in the payment rates for the 66 APCs that you have identified for physician offices and hospital

outpatient settings really isn't defensible, and I think it's a bad use of taxpayer dollars. I think it is an unwarranted expenditure of beneficiary dollars. I think it has to stop.

I think, parenthetically, it also artificially rewards the consolidation activity we see at the community level, and as you have pointed out many times in your presentations, this gets translated into more bargaining power in the private sector, which increases the cost structure of these organizations, which makes Medicare margins look worse over time than they would be if we weren't artificially -- Medicare wasn't artificially rewarding consolidation.

So I know this is part of a package, but I am just saying that my enthusiasm for the package is greater seeing this component as being part of it, because I just think this is something that really needs to be addressed.

DR. HOADLEY: As many have already said, the notion of these together in a package is one of the parts that's appealing about it. I like what Jon said in terms of the importance of that, but I also like what Scott said in terms of the -- my point about the DSH is some of the

dropping-Medicare-margin is contributing to the increase through the kind of weird dynamics of how DSHs and uncompensated care is changing to the overall margins, and so I take that, at the very least, to say, even though the Medicare margin is down, projected to be down, we are not saying, "Oh. Well, we should take the update even higher." So I think that's part of where the compromise kind of works out, and so, in the end, I think it is a reasonable thing. But, like Scott, I think we have to think about that, that level.

DR. COOMBS: I support the recommendations, and I would say that I think going forward, the impact of the APC growth as it relates to hospitals acquiring physician practices will be something that will be uncharted territory, and unless we get our arms around that in a way in which we can actually tease out what happens with this transfer of these procedures into hospitals, I think that's a piece that is an open window, and we will have on control over the cost if we don't have some way of actually studying that and saying that these are the things that we think should be done in this venue versus that venue.

And I think it's very complex because, as you go

from one geographic region, whether it's rural, urban, there is going to be a tendency for things to happen in an HOPD versus as a physician office, but if you set a benchmark that this is a procedure that should happen in this entity unless there are these exceptions, I think going forward, that will be something that will be helpful to clinicians as well as health care providers and delivery systems as a whole. And I just think that it's an open territory where we need to get our hands around.

MR. THOMAS: Yeah. I could certainly support the recommendation with a couple of comments.

I agree with Jon's point on the site-neutral. I would ask that there be a consideration for a comment around the regulation that goes with these types of procedures in a hospital setting versus a physician setting. So I think if we are going to have a different payment, then the regulation ought to be considered as well as part of that situation.

I also think we just need to -- I understand Scott's point around the hospital margin situation, but I think we also understand that some of this has been buoyed by the HIT payments, and that if we see the efficient

providers go negative, I think it's just something we've got to be mindful as we look at this going forward.

And then one last consideration would be to -- I think we should show the update factor kind of net of the other deducts, so that we kind of show a net impact of what the update factor looks like. I think that would show more clarity and transparency when we report the update factor.

MR. HACKBARTH: Just say more about what you mean about that.

MR. THOMAS: So I think if you look in the presentation at the end, it shows the update factor net of other components that are deducts. I think it is helpful to make sure in the recommendation that that's clear. I mean, the update factor is higher than current law, but there is also deducts that have an impact on that, that I think we just ought to be clear in the recommendation, so it shows a net number at the end of the day.

MR. HACKBARTH: Okay. So I just want to make sure I've got you here.

Put up Slide 18, please. This is the draft recommendation, and the last bullet addresses the update for the inpatient/outpatient payment systems.

MR. THOMAS: On Slide 20 where it shows the net increase and payments at the end of the day is 2.55, just making sure we're clear that that's in the recommendation.

MR. HACKBARTH: Oh, you want to make sure that last bullet --

MR. THOMAS: Yes, the last bullet there.

MR. HACKBARTH: -- is in the plan, that that would be --

DR. MILLER: Oh, it will.

MR. THOMAS: Okay.

MR. HACKBARTH: Okay. Thanks, Warner.

MR. THOMAS: I'm new at this. My first --

DR. MILLER: No problem.

MR. HACKBARTH: Good point.

Kate.

DR. BAICKER: I am also supportive of the recommendations, reiterating the importance of viewing them as a package.

In terms of thinking about then inpatient versus outpatient, the emphasis that we've had over the past several years about paying the same amount for the same patient getting the same procedure in different settings

definitely speaks to the wedges that we're seeing in some of the settings and that the recommendations are addressing.

I think the chapter is appropriately nuanced about what we can learn from margins and what we can't necessarily learn from margins, and I share the concern that pulling apart different units of the hospital in the margins analysis will be potentially misleading, given their common fixed cost and cost structure. And we want to be careful in that regard, but that doesn't take away from the importance of site-neutral payments that I think the recommendations advance.

MR. KUHN: So this one is a bit of a challenge because, as we've heard from others, the relevance of the margins. It is kind of a tough conversation, because you look at these margins, but yet we continue to see excess capacity, excess to capital. So it makes for an interesting and a difficult conversation.

But we also heard some interesting things here today as well. Last year, margins were negative 5.4, projected to be negative 9.0. And for the first time ever, we're seeing the most efficient providers or the most efficient hospitals have a negative margin. We've never

seen that before.

And not necessarily to be Johnny Raincloud here for a minute, but I just saw a Reuters report yesterday that said all three credit ratings have a negative outlook for hospitals for next year, and I don't know if we've ever seen that with all three coming out like that.

So, having said that, I like the recommendations overall. I think they work, and I particularly like the fact of the update. That gives us, as Warner and others have pointed out, the net 2.55. I think updates need to be sufficient for at least the efficient providers to be able to cover their costs. They have to be, I think, in a position where they can earn a profit to reinvest as part of the process to continue to serve Medicare beneficiaries, so I think that higher update makes sense to me.

Also, I think it's important -- and it has been in the chapter as well -- and make sure we continue to highlight the uncertainty in the marketplace and the unevenness of coverage with so many states still not doing expansion of coverage and the yet-to-be-determined Supreme Court decision on what will happen with the marketplace. So those have to be issues that are at least highlighted and

recognized.

DR. HALL: So I support the roundtable discussion. I think this is the end of it, and I think in my mind, this is one of the more well-vetted concepts that we put together in the last couple of years.

I particularly like bullet point number 3, the third line. The word "concurrent," I think really tells exactly what it is that we're doing, that we're making some recommendations in terms of updates for inpatient care that does have some uncomfortableness in the group.

But I think the concurrency with the change in outpatients really puts it together for me. So I'm very supportive.

MR. HACKBARTH: So we have five minutes, which I want to use to -- I won't go around the table, but my inclination is -- since this is a packaged recommendation that includes a multiyear transition, my inclination would be to rerun it in our report but not have the separate vote in January; in other words, handle it as we have handled our other package recommendations with a multiyear component, namely physicians, skilled nursing facilities, and home health agencies.

Anybody want to comment on that, either for or against?

Kate.

DR. BAICKER: That was for.

MR. GRADISON: Yeah, a question.

MR. HACKBARTH: For. Kate is for. Okay.

MR. GRADISON: The 3.25, that's new. I don't quite -- maybe I don't understand what you just said, but this isn't identical to what we said, is it? Is it?

MR. HACKBARTH: It is.

MR. GRADISON: Is it to the 3.25?

DR. STENSLAND: Yep.

MR. GRADISON: Is that exactly --

DR. STENSLAND: Exactly the same.

MR. HACKBARTH: Anybody? Craig.

DR. SAMITT: I would be in favor of that, although I think one of the common sentiments around the table is really to underscore this notion of bundling as opposed -- bundling the -- or packaging all of the elements. I don't recall us stressing that to the same degree when we had this discussion last year. So the only enhancement would be the fact that it's sort of an all-or-nothing-type

recommendation.

MR. HACKBARTH: Yeah, so certainly that's something that we can highlight in the accompanying text.

Anybody else? Let me ask it this way: Anybody really uncomfortable with rerunning it without a separate vote?

[No response.]

MR. HACKBARTH: And, again, this isn't your final word on it. I'll talk to each of you about this within the next month.

MR. ARMSTRONG: Glenn, so while we won't necessarily take a vote on this, I assume we will have another chance to talk about this as a Commission before it is affirmed or --

MR. HACKBARTH: Yeah. Well, that too is a question in terms of how we run the January meeting. Certainly we can arrange to allot some time in January for another conversation.

MR. ARMSTRONG: Yeah. I just think, to Craig's point or to some of the other issues raised here, it might just be nice just to affirm this, we've reviewed this, we don't need to revote on this, and we want to emphasize a

handful of points that represent our view as this is reaffirmed.

MS. BUTO: Back to Jack's point, what's been going through my mind is this is being done without consideration as to the impact of the ACA, even though we are looking at Medicare margins. Disproportionate share in particular was a Medicare payment because there wasn't an ACA kind of coverage provision. So since this is a 2016 recommendation, we will have data in the next X months on the impact, at least in those states that have Medicaid expansion, of the ACA. And it just seems to me that that consideration should be in the back of our minds so that as we look at that 3.25 or whatever percent it is, we might decide that that's something we want to -- and I realize January is when the decision has to be made, but some mention of that factor going forward as Congress looks at this through the 2015 calendar year for 2016 update just seems to me something we ought to note, if nothing else.

MR. HACKBARTH: Certainly we can do that, you know, much as we note the trends in all-payer margins. You know, our approach in the past, which I strongly feel is the proper approach, is to base our recommendations on Medicare

payment rates and Medicare financial performance, Medicare access to care and so on through the payment adequacy framework as opposed to what's happening in ACA with Medicaid expansions, which aren't, as Herb points out, happening in all states at this point. There's uncertainty about the exchanges, lots of different dynamics in employer markets that vary across the country. Our focus is really Medicare policy and payment adequacy.

MS. BUTO: And my point was really about Jack's point, which was the disproportionate share payment, which was a Medicare payment, but it was a proxy for something that has now been taken up outside of Medicare, if you will.

MR. HACKBARTH: Yeah, yeah.

Okay. Any final word on that subject?

[No response.]

MR. HACKBARTH: We are right on time, so thank you all. Good work, Craig and Zach and Jeff.

We will now move on to physician payment adequacy -- and other health professionals as well, Mary.

[Laughter.]

MR. HACKBARTH: Okay, Kate.

MS. BLONIARZ: Kevin and I are going to discuss

three things: the assessment of payment adequacy for physicians and other health professionals, a review of the SGR, and the per beneficiary payment for primary care that you discussed in November.

For the payment adequacy assessment, we review measures of access, changes in volume growth, quality, and financial performance. Unlike other sectors, we don't have information on practice costs, so we don't report a margin.

Then we'll discuss the Commission's position in the past and the Chairman's proposed approach on the SGR, and we'll present a draft recommendation on a per beneficiary payment for primary care.

Medicare pays for the services of physicians and other health professionals using a fee schedule, with about 7000 individual codes. Total fee schedule spending was about $70 billion in 2013, basically unchanged from 2012, and it represents 16 percent of fee-for-service benefit spending.

There are 875,000 individuals billing Medicare: 575,000 physicians, 150,000 advanced practice nurses and physician assistants, and 150,000 other providers such as therapists. Nearly every beneficiary received at least one

fee schedule service in 2013.

We used a few data sources to assess access. The first is a yearly telephone survey of 4,000 Medicare beneficiaries and 4,000 privately insured individuals, asking them whether they can access the care that they need. The phone survey is very timely. It was fielded over the spring and summer of this year.

We also conduct focus groups of beneficiaries and providers every year, focusing in markets where beneficiaries have reported relatively more difficulty accessing the care they need. We also look at other surveys of beneficiaries and providers.

Generally, beneficiaries' access to ambulatory care services appears adequate. It is as good as or better than privately insured individuals, and this is consistent with last year.

Some groups experience more trouble with access. Specifically, minority beneficiaries report waiting a bit longer than they wanted to than white beneficiaries for an appointment. And beneficiaries entitled on the basis of disability also report more difficulty and dissatisfaction with the ease of access to their doctor.

From our telephone survey, Medicare beneficiaries report high levels of satisfaction with their overall care: 88 percent report that they are very or somewhat satisfied. This is higher than the 82 percent among the privately insured.

We also ask respondents to characterize their experience when they were looking for a new doctor. Most people aren't looking for a new doctor in any one year, as you can see in the first row. The second row shows the share who are: 8 percent are looking for a primary care doctor and 17 percent are looking for a specialist.

Within that group, most don't experience a problem: 1.2 percent of the overall population report that they experience a big problem among both groups. But among those looking for a new doctor, people looking for a primary care doctor face more trouble. In other words, beneficiaries looking for a primary care doctor are about twice as likely to report a big problem than are beneficiaries looking for a specialist.

We don't see much change over time in the share of providers who are participating in Medicare or who opt out of the program altogether. Last year I reported on some

data from CMS that the total number of physicians who had opted out were around 6,600, less than 1 percent of all providers.

With respect to quality, in prior years we've reported the results on clinical process measures using our own set of measures. But we've stopped reporting those this year because, as you've been discussing, there are concerns with Medicare's current quality measurement, which largely relies on clinical process measures. So as you continue your discussion of different approaches to quality measurement, in your briefing materials we've shown some illustrative examples of a population-based quality assessment approach using potentially avoidable hospitalizations.

Finally, with respect to financial performance, Medicare's payments relative to privately insured PPO payments averaged about 80 percent, similar to prior years.

DR. HAYES: For another indicator of payment adequacy, we use Medicare claims data to analyze changes in service use measured as the change in the volume of fee schedule services per beneficiary. Volume in this context is units of service multiplied by each service's fee

schedule relative value unit.

As a measure of service use, volume accounts for changes not only in the number of services but also changes in the intensity or complexity of services.

For example, growth in the volume of imaging would capture a change in intensity such as substitution of computed tomography for plain film X-rays.

Another advantage of analyzing volume growth is that volume growth, together with changes in fees, determines spending growth.

Across all services, the change in volume per beneficiary from 2012 to 2013 was a small increase of 0.5 percent. Looking more closely at the 2012 to 2013 increase, we see on this slide that it was composed of small increases in the fee schedule service categories shown by the bottom three lines: major procedures, evaluation and management, and other procedures. The other two service categories -- imaging and tests -- saw small decreases in volume. Let me make a few additional points about the decreases.

The decreases in imaging and tests do not raise concerns about payment adequacy. The volume of these services grew rapidly from 2000 to 2009. For imaging, the

increase totaled 85 percent. For tests, the total increase was 86 percent.

By comparison, the volume decreases since then have been small. Moreover, a decrease in use of cardiac imaging accounts for the imaging decrease, as we will see in a moment.

Note also that all of the growth that has occurred in imaging and tests has led to concerns about appropriate use of these services. These concerns have been expressed in the medical literature. In addition, specialty societies have drawn attention to appropriateness through, for example, the Choosing Wisely initiative.

There is one other point to make about the decreases in volume. As discussed during this meeting's session on hospital care, there has been a trend toward billing for some services in hospitals instead of professionals' offices. The shift in billing patterns explains at least some of the decreases in volume we see for imaging and tests. This trend increases program spending and beneficiary out-of-pocket costs.

Specific to our volume analysis, the shift in billing patterns should be considered when interpreting the

numbers on volume growth. Volume growth has its advantages as a measure of changes in service use, but it is sensitive to shifts in site of care.

Practice expense RVUs -- part of the volume growth calculation -- are often lower for services billed as if provided in a hospital or other facility setting.

To see how shifts in site of care can affect volume growth, let's look further at cardiac imaging. From 2012 to 2013, the number of echocardiograms per beneficiary furnished in hospital outpatient departments went up by 7.4 percent, but the number furnished in professional offices went down by 8.0 percent.

Over the same time frame, the number of cardiac nuclear medicine studies per beneficiary furnished in hospital outpatient departments went up by 0.4 percent, while the number furnished in professional offices went down by 12.1 percent.

If cardiac imaging is excluded from the calculations, the growth in the volume of imaging from 2012 to 2013 would be an increase of 0.8 percent instead of the decrease of 1.0 percent.

To summarize the points we would make about volume

growth as an indicator of payment adequacy, we can say that volume growth has contributed to an increase in spending, represented here as the red line, and, therefore, that volume growth has raised the revenues of those billing Medicare.

From 2000 to 2013, payment updates for these services increased by a cumulative total of 9 percent. That percent increase is less than the cumulative increase in the Medicare Economic Index of 28 percent. However, spending per beneficiary for the services went up by a cumulative rate of 67 percent.

It's true also that from 2012 to 2013 per beneficiary spending for the services of physicians and other health professionals declined by 1.6 percent. However, that decrease is small when compared to the increase in spending that occurred from 2000 to 2012. Over that time frame, spending increased every year at an average rate of 4.5 percent.

Payment adjustments outside of the update process can also have a significant effect on spending for fee schedule services. The adjustments are or three types:

One, adjustments applied to fee schedule payments,

such as the floor on the work GPCI.

Two, adjustments not applied to fee schedule payments but otherwise included in the Medicare spending totals. The standout here is the $2.6 billion electronic health record program.

And the third category of adjustments would be the other payments that go out via the various CMMI demos.

These adjustments have effectively increased payments for services by more than updates to the conversion factor. Note also that some of the adjustments, while positive so far, will soon become penalties.

The equity of payments under the fee schedule is another issue that the Commission has been concerned about. While some physicians assert that they lose money when furnishing services to Medicare patients, the Commission's concern has been that large disparities in physician compensation raise concerns about the accuracy of payments under the fee schedule.

Looking at physician compensation data for 2012, we see that actual annual compensation for primary care physicians averaged $222,000. By contrast, actual annual compensation for physicians in non-surgical, procedural

specialties averaged $475,000.

Simulating compensation as if all services were paid under Medicare's fee schedule, the disparity remains: $185,000 for primary care and $435,000 for the non-surgical, procedural specialties. Either way, the compensation of non-surgical proceduralists was more than double that of primary care physicians. Previous work for the Commission has shown that such disparities were observed when compensation was analyzed as compensation per hour worked.

At this point in the presentation, we can suggest that, in general, payment adequacy has not changed. Access indicators are stable. There was the small increase in the volume of services in 2013. And the disparities in physician compensation, if anything, raise concerns more about the distribution of payments within the fee schedule rather than the overall level of payment. These findings are consistent with our findings over the last few years.

In recent March reports, with our assessments of the adequacy of fee schedule payments, the Commission has also reaffirmed its principles on repeal of the SGR:

One, preserve beneficiary access to care.

Two, rebalance the fee schedule to make payments

more equitable.

Three, encourage movement toward reformed delivery systems.

Four, recognize the budget implications of repeal.

This year repeal of the SGR is still needed.

Here we see listed the specifics of the Commission's standing position on repeal of the SGR. Repeal is urgent. Temporary overrides of the SGR update formula have created uncertainty for beneficiaries and the practitioners who bill Medicare. The result is a continued threat of a disruptive reduction in payment rates, such as the 21 percent reduction in fees that would occur under current law on April 1st of next year. With such a reduction would come the threat of access problems for Medicare beneficiaries.

The SGR overrides have also been an administrative burden for CMS, and the focus on the overrides has been a barrier to broad-based reform. Meanwhile, the slowdown in spending has led to a decrease in the cost of repeal, a cost that could rise again.

Given no substantial change in the indicators of payment adequacy and given the continued need to repeal the

SGR, the Chairman's proposal is to maintain the Commission's SGR recommendations. They are:

Repeal the SGR and replace it with a 10-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.

Kate will now address the per beneficiary payment for primary care.

MS. BLONIARZ: So last month you discussed a policy option for per beneficiary payment for primary care. Your discussions on this topic started from the rationale that primary care is undervalued in Medicare's fee schedule. And the fee schedule contributes to disparities in physician compensation.

The current primary care bonus, which is 10 percent of fee schedule spending for eligible practitioners, expires in 2015. The per beneficiary payment for primary

care could replace this bonus.

Your discussions led to the following design decisions:

First, the payment amount for the per beneficiary payment will be set at the level of the current bonus.

Second, the payment will be set based on attributing beneficiaries to practitioners prospectively.

And, third, the payment will not be contingent on practice requirements.

The last issue is source of funding. The Commission appeared to favor the following approach: Payments would be reduced for all non-evaluation and management services provided by specialists other than primary care. That's the yellow box. It's a 1.4 percent reduction for 75 percent of the fee schedule.

For the services that could potentially be eligible for the bonus (such as office-based E&M services) that are provided by non-primary care specialties, they would not be subject to a reduction. That's the green box.

And the white box, which is eligible E&M services, delivered by eligible E&M practitioners, would be eligible for the bonus.

So the Chairman's draft recommendation reads: The Congress should establish a prospective per beneficiary payment to replace the Primary Care Incentive Payment program (PCIP) after it expires at the end of 2015. The per beneficiary payment should equal the average per beneficiary payment under the PCIP. Funding for the per beneficiary payment should come from reduced fees for all services in the fee schedule other than eligible primary care services.

The implications of the recommendations are as follows:

For spending, as a budget-neutral policy, the per beneficiary payment would not affect federal spending relative to current law.

For beneficiaries and providers, the payment would continue additional financial support for primary care practitioners by redistributing fee schedule payments from specialty care to primary care. Providers could use the payment to improve care delivery, care coordination, and access to primary care services.

This slide summarizes our payment adequacy findings, the Chairman's proposal to maintain the SGR recommendations, and the draft recommendation on the per

beneficiary payment for primary care.

We'll conclude and are happy to take questions.

MR. HACKBARTH: Thank you, Kate and Kevin.

A couple quick points before we begin the clarifying round. I want to emphasize that what I am proposing is that we rerun the SGR-related package without a separate vote, but there will be a separate vote on the per beneficiary per month payment issue. So that's my procedural plan.

The second thing I wanted to highlight, would you put up Slide 8, Kate? This is the summary of the data drawn from our annual survey of beneficiaries, and this is directed as much to the audience as to the Commissioners.

When we've testified, when I've testified in the past on the March report, one of the most common topics of discussion is what Members of Congress see as the discrepancy between our findings from our beneficiary survey and what they hear from their constituents, and often members will say, "Beneficiaries in my district tell me they cannot get access to a new primary care physician in particular." And so they're a little bit surprised, if not shocked, by our finding that on a nationwide basis access

for Medicare beneficiaries is pretty good -- indeed, as good or better than privately insured patients in the just under Medicare age group. How, they ask me, can they reconcile our findings with their experience? And here's how I answer that question, and you can judge whether it's sufficient or not.

First of all, our results are national results, and I believe -- in fact, my own experience in my home town is that there is variation locally from the national results. There are places in the country, in other words, where it is difficult for Medicare beneficiaries to find a new primary care physician in particular. Around the national average, there's going to be variation, and we know there are pockets of problems. So that's point number one.

But even if you take the small problem and big problem together -- so that's 2.5 percent of Medicare beneficiaries reporting a problem in finding a new primary care physician -- 2.5 percent of 50 million is a big number. You know, by my calculation we're talking about a million people nationwide, and that's about 2,500 on average per congressional district. Twenty-five hundred people having a big or a small problem in a congressional district can

generate a lot of mail, stories in the local newspaper, et cetera. So I don't think there's necessarily a conflict between our national finding of generally good access and what some individual Members of Congress or individual Medicare beneficiaries in towns like mine are experiencing. It's just a different measure.

I do think it is important to keep in mind two things. One is that, on a national basis, Medicare access is as good or better than privately insured access. That's point number one. And point number two is escaping me right now because I'm 63 years old.

[Laughter.]

MR. HACKBARTH: And wondering whether I will have access to a physician in my home town.

DR. MILLER: Well, was it your point that a small percentage can still be a lot of people?

MR. HACKBARTH: Well, I said that. I'll stop. I've gone on long enough. You got the basic point.

DR. CROSSON: What I thought you were going to say at the end was: And, therefore, it would not be good policy to increase payment.

MR. HACKBARTH: Oh, yeah. Thanks, Jay. Actually,

the second point I was going to make is where there are problems, like my home town, it's not necessarily because the Medicare payment rate is "too low." You know, we've got a significant imbalance between the number of physicians and a lot of retirees moving into our community, which is attractive for retirement. And it isn't a matter of, oh, Medicare rates are too low. It's just there's a fundamental imbalance between the supply of patients and supply of physicians that hopefully will remedy itself somewhat over time.

DR. CHRISTIANSON: You should move [off microphone].

MR. HACKBARTH: Or, yeah, I could move.

[Laughter.]

[Inaudible comments off microphone.]

MR. HACKBARTH: Okay. So --

DR. MILLER: Yeah, I mean, the other thing I would add to that is we've run the focus groups each year, and we try and go out to communities which the data would suggest would have this problem, and we often run into this particular story, that there has been a great influx in the area, and it's really -- it's hard to find an apartment,

it's hard to find a -- you know, it's also hard to find a physician or a nurse practitioner. And I'll just sort of add behind that, we do see a lot of the increase in nurse practitioners seeing patients. I think you went through some of that data.

MR. HACKBARTH: Let's turn to Round 1 clarifying questions, and this time we'll begin over here with Bill and come around this way.

DR. HALL: So in the arena of surveys of the ability of people to find a doctor, certainly among my colleagues this comes up a lot, that we have a population that's quite migratory in the winter. I can't imagine why they want to leave Rochester, New York, but --

[Laughter.]

DR. REDBERG: Going to Minnesota.

DR. HALL: -- if you're not living in Buffalo and buried. But the issue that comes up all the time is -- and it happens to be quite locale-specific. They go to Florida. And we have a large group of geriatric physicians. We are well connected. But I would say we have trouble almost all the time having people particularly if they have to find a new doctor in Florida. And one of the salvations of this is

that MA is an attractive plan, and mostly if they're in an MA program, they don't have much of a problem. But if they have sort of a North doctor and a South doctor, it really is a problem.

So I think the surveys miss the granularity that is out there, and I don't know how important it is, except that I think most physicians you talk to will find this, in fact, is happening a lot. And so maybe some focus groups in areas where this seems to be a more common problem would help us understand this phenomenon. Are the surveys giving Medicare a good rap or a bad rap in terms of accessibility?

At any given time, I'm not sure how many Medicare recipients out of the 40 or 50 million that are there are actually seeking a new doctor, but we do know there are 10,000 people a day turning 65, so that the anticipatory crisis might be out there. It would be nice if we had some localized data, I think.

MR. HACKBARTH: Okay. Round 1 clarifying questions.

MR. KUHN: I'd like to talk about some of the read-ahead material that you sent out and on page 35, Table 12. We're talking about quality of care and the movement

towards population health measures, and in this one you look at the variation of potentially preventable admissions as well as the variation of potentially preventable emergency department visits.

So what I was curious about the chart was the -- and correct me if I'm wrong, if I'm looking at this that way -- is that it's basically making the assumption that all these patients have access to appropriate ambulatory care, you know, access to community -- same level of community amenities out there. And I guess what I'm driving at is that I was wondering if we were to overlay an SES kind of variable here, would we see the variation that we have that's out there? Because as I look at this, if I look at that 90th percentile, I would think that those folks that live in that area live in a much more socioeconomically disadvantaged community than those in the first decile that's out there.

And so I'm just wondering, as we've talked about this issue in the past, if it would be appropriate to have some of that information just to see how that would look in terms of this stratification of this information out there.

DR. MILLER: I think you probably would see some

correlation. We can look at that. We'll be right back into the usual sets of questions of do you adjust or do you not adjust for the purposes of display of the data, but I wouldn't be surprised if there's some relationship there.

MR. KUHN: It would be helpful to look, because the gaps here are so big, I just would be interested to look at that.

And the second thing, I'm just curious. I went back and looked at the June chapter and just kind of -- maybe a refresh for me here. So as we move to these population health measures, I think the attribution issues are going to be monumental here. So what's the current thoughts on how we deal with the attribution issues as we continue to explore these population health measures?

DR. MILLER: Okay. Do you want me just drill this or do you want to take it?

Okay. So going from the Commission's June '14 report -- and I'll try and do this very concisely -- I think the thinking here is there was an interest in setting up population -- a small set of outcomes population-based measures for fee-for-service, ACOs, and MA, so at least for measurement purposes you could sort of see is MA, ACOs, how

do they perform relative to ambient fee-for-service, is kind of the words we were throwing around.

Next sentence. Next paragraph. There was discomfort in moving money around in the fee-for-service sector on the basis of a population base because of the lack of connection or system in a fee-for-service environment. And I think there were mixed views on that, but I think the thinking at that point in time when we wrote up the June '14 report was we weren't moving to using these kinds of measures for anything other than kind of measurement, not moving dollars around, at least at this point.

MR. KUHN: That's helpful. I appreciate that refresh, because I went back and looked at that --

DR. MILLER: Is that fair or--

MR. KUHN: -- I was thinking both ways, and I was just trying to recall. So that's helpful.

MR. HACKBARTH: I'll gently remind people that we are in Round 1 clarifying questions, and any question that requires a response from Mark is prima facie not a Round 1 question.

[Laughter.]

DR. MILLER: What the hell does that mean?

PARTICIPANT: It means he controls [off microphone].

MR. HACKBARTH: Okay. Round 1 clarifying questions.

DR. COOMBS: So this is for Kate. When you calculate the PPAs, are you including readmissions in the denominator? How does that work?

MS. BLONIARZ: I am not calculating them. They do not include readmissions.

DR. COOMBS: So they subtract them out.

MS. BLONIARZ: Yes. Yes, yes. Yes.

MR. HACKBARTH: I note increasing conviction with each yes.

DR. COOMBS: A Round 1 question.

DR. HOADLEY: On Slide 13, is the drop in spending per beneficiary at all related to sequester?

MS. BLONIARZ: Yeah.

DR. HOADLEY: Okay, so that is part of what's dropping that off.

Second question: What's the timing of getting a new CBO estimate on the SGR cost? Does that come out of this December-January baseline, or --

MS. BLONIARZ: They just released one in, I think, November.

DR. HOADLEY: Okay

MS. BLONIARZ: And it was around 119 --

DR. HAYES: For a ten-year freeze.

MS. BLONIARZ: For a ten-year freeze.

DR. HOADLEY: So it was a little bit lower than the previous -- or pretty -- a little higher, but close.

And, last, on the per beneficiary payment, there's no beneficiary cost sharing on that? That didn't actually get mentioned on the slide as you put it up.

MS. BLONIARZ: Right. That was in your discussions. It seemed like no cost sharing.

DR. HOADLEY: We should make sure that we make that point very clearly up front when we're talking about this.

DR. CHRISTIANSON: Yeah, actually three quick questions, I hope. One is that you've used different surveys to look at beneficiary access to care, which is good. And in the MCBS survey, you did a comparison between Medicare Advantage plans and fee-for-service. There isn't anything in the data in this report that compares

beneficiary access who are assigned to ACOs versus traditional Medicare. And so we know who those beneficiaries are, but obviously it's a big job to sort of cross-walk them to the people you surveyed in your survey, in the MedPAC survey. So I would just say something I think I said last year, too, which is try to encourage you to kind of think about in the future whether you want to oversample, whether you need to oversample beneficiaries in ACOs, whether that's an important enough question for you to want to make comparisons. For me it is, but if ACOs are at their zenith right now and they sort of decline over the next few years, it's probably not worth the effort. But if they become more significant in the future, having that subgroup comparison would be very nice. Hard to pull off, I understand that.

The second comment, on Slide 13, Kevin, you correctly, I think, wanted to refer to the whole trend in terms of per beneficiary spending, not just the last year. But I wonder if the aging of the baby-boom population into Medicare would mean that a chart or a slide that would do an age-adjusted comparison over time wouldn't become more and more important. I would like to sort of see for a common

composition of age in the Medicare beneficiary population what's happened to per beneficiary spending, sort of net out the sort of changing distribution of age within the Medicare population, just for comparison purposes, if you want to do these longitudinal comparisons, which I think you probably do.

And then the third thing is on Slide 22, so I think the language in the chapter was pretty nuanced, and I think in the chapter it's pretty clear that MedPAC isn't recommending that there are any particular conditions being placed on the use of the dollars that are going to go to physicians and/or physician organizations. And so you say "could," and I would like to underscore that. May. There's no requirement that this per beneficiary bonus, as I've said in the past, gets used for primary care, or any of these things that you have up here. If it's a small independent practice, maybe that's how it gets used. If it's a larger organization, it gets to be part of organizational revenue and will be distributed however the organization sees fit.

So I'm a little -- I think the chapter is a little clearer on that point. Here I think by even saying it, it could be used, just sort of implying this is what your

expectation -- I don't have that expectation. I think it's a good thing to do, but I don't think tying it to these things is necessarily a good way of portraying how it's going to be used.

DR. CROSSON: Yes, again, on Slide 13, as Jack and Jon focused on that flattening out, I think I heard -- Kevin, I think I heard you refer to this, but do we have any idea to what degree that flattening is a function of movement, again, of procedures from physician offices to hospitals?

DR. HAYES: We don't know that. I'm just trying to think out loud here whether it would be possible to do that or not. I mean, it's -- these numbers are from the trustees report that don't differentiate by setting, differentiate spending by setting. So with this data series, it would not be possible, but we just have to think some of whether there's another way to get at that point that you're making.

MS. BLONIARZ: The only other thing I was going to add is if you look at volume, if it's about 0.5 percent, and then the sequester was in effect for three-quarters of the calendar year, so that's a 1.75 percent reduction in

payment, so those things probably account for much -- most of this decline.

DR. CROSSON: Thanks.

DR. REDBERG: First, thanks, Kate and Kevin. It was a really informative chapter. I enjoyed it. My question is also on Slide 13.

You gave us some information on sort of the background on what's behind the spending per beneficiary. Clearly we have a lot more tests. We're doing a lot more tests and imaging and other things. But what we really care about, I think, is how are beneficiaries doing with all this increased spending. And do we have any data on outcomes? You know, are they feeling better? Are they living longer?

DR. HAYES: We don't know the answer to that question specifically. One way to get at that would be to think about what Kate described as our kind of evolving view toward how to assess quality in this sector. And so perhaps one goal, one guidepost for how that evolution should occur would be to address the kind of question that you're asking. But sitting here today, we can't answer that.

DR. REDBERG: That's sounds like a great guidepost.

MS. BUTO: Just a question on page 39 of the paper. There's a statement here that -- I'm sorry. I'm looking at the wrong page. Page 37, fee-for-service payment allows some specialties -- it's at the top of the page -- to more easily increase the volume of services they provide and, therefore, their revenue from Medicare, while other specialties, particularly those that spend most of their time providing E&M services, have limited ability to increase their volume.

The reason I ask, I wondered what you've got behind that, because at least in the early days of the fee schedule, E&M services were the ones that grew the most rapidly. They were services that could be billed by any specialty, virtually, consultations and other things. So we actually saw a lot of growth there with harder-to-document real services or the value-added from some of those E&M services. So I wondered why that's changed, if it has changed.

DR. HAYES: What I would draw your attention to is Slide 9 where we look at, you know, the most recent data, and we have seen pretty consistently, you know, in this time frame pretty modest growth in evaluation and management

services generally, and office visits, too. And that kind of underlies the point we make in the paper about how these are, you know, kind of -- delivery of these services is dependent on, you know, the physician or other health professional actually spending time with the patient. And, therefore, there is that kind of built-in limit on how rapidly they can grow. Whereas, with the other services that we see represented here by the top three lines over the time frame, we've seen very rapid growth. Oftentimes with those services we've got, you know, some equipment involved where there's been some technological advances that have maybe limited the amount of time that the practitioner needs to spend on the service. We've got other professionals, technicians and so forth, involved in the delivery so there's a potential there for some substitution of who does what during a participation, physician versus the technician.

So those are the kinds of dynamics that we had in mind when we made this statement.

DR. MILLER: I'm familiar with the trends you're referring to way back in the day, and there was a real sharp reversal and the testing and the imaging really took off,

and then the disparities in compensation across specialty that Kevin and Kate were referring to is some of the other evidence that underneath the SGR there was sort of volume growth that drove some of those compensation disparities.

MS. BUTO: Thanks.

DR. CHRISTIANSON: Kevin, I might actually look at those numbers and say, since they're on a per beneficiary basis, beneficiaries are getting 20 percent more E&M than they did ten years ago. So, you know, we talk a lot about problems with primary care and access to primary care and needing to promote primary care. They're getting 20 percent more primary care, in effect, if you use that term to cover E&M services.

MR. HACKBARTH: This is all E&M. This isn't just primary care.

DR. CHRISTIANSON: All E&M. I just said if you use that as sort of a proxy, you know, what's changed? Is the beneficiary population that much more in need of those services and so forth? It's not like things are going downhill for beneficiaries in this area.

MR. HACKBARTH: Okay. Let's move on to Round 2, for which we have 17 minutes. And we'll use the same

process as we used last time. We'll start with Alice. Let me see hands of people who want in on Round 2.

DR. COOMBS: Thank you very much.

I was interested in the survey and a couple of points. As Glenn described his personal experience with dealing with what's apparent and what the experiences are to the Congress versus local experiences, I am concerned that there is some data in our survey here, the survey that is used here regarding minorities and disabled and the duals, in terms of access.

I am concerned in the sense that if the access is impaired, we already have an uncoupling of access being okay and the quality being impaired, but when you have both access -- it implies that access and quality are dovetailed together because access is the lowest roost. If you can't get into the health care system, then there's some issues regarding whether or not you ever get good quality.

While we like to tie utilization into quality, I think that you might find that the beneficiary -- and I think there's some data on this, the spending per beneficiary for specifically duals that African Americans and minorities may not reflect utilization or access because

of the fact that to delay a diagnosis when patients present, they are much more advanced in terms of severity of disease.

So I think we cannot ignore the impact of workforce and the aging population, and we've talked about that in terms of maldistribution of workforce.

The one key thing I think we should focus on is the Medicare acceptance rate. What seems apparent in terms of acceptance rate may be very different from I have to give a percentage of my office slots to Medicare and a percentage of Medicaid on a daily basis, so that those slots are filled fairly quickly. It isn't that I don't accept Medicare or Medicaid. It is that I reserve a certain slot, and I think that may be a better barometer for what actually happens in the grassroots in terms of patient care.

To be honest with you, it may be one of the things that is perceived as, "Oh, it's okay. It's acceptable. First of all, that I have a doctor. I have acquired a doctor, but it's going to take me longer," and so whether or not you get in earlier to see a nurse practitioner, I think those things are really important, or you do the minute clinic.

I would also be interested in seeing how the

minute clinic can impact some of the surveys, the results that we see right here.

And then lastly, because I know we are on restricted time here, the calculation of the preventable admissions, when you take out the denominator of readmissions, which may be as high as 9 or 10 percent in certain areas, makes the readmissions and preventable admissions linked in the sense that it may be more likely that your denominator goes down significantly when you take those out, so it make it more likely that you're linking the inappropriate readmissions with preventable admissions. And so you're double-handicapping some of the institutions in some areas.

MR. HACKBARTH: Anybody want to pick up on something that Alice said?

Craig.

DR. SAMITT: I think mine is interrelated, and I think Alice leads to my views about the urgency of the SGR repeal, especially as it alludes to the impact on future accessibility.

My question is, to what degree do we think about payment policy today and how that affects adequacy and

accessibility in the future. Specifically, what I'm thinking about is we've got an aging primary care provider community at the same time we have significant agents of the Medicare beneficiary population, at the same time we have somewhat undesirable primary care reimbursement environment. So now is the time that future physicians are deciding between primary care and specialty.

So my concern is, having an inadequate payment policy today means that we have an irreversible problem five or six or seven years from now when physicians choose not -- or other practitioners choose not to go into primary care. So, for me, it underscores the urgency of repeal and a rebalancing between primary care and specialties today, because I think we are not dealing with accessibility issues today. I think we are dealing with accessibility issues in the more distant future, which we should be concerned about.

MR. HACKBARTH: I agree with that, Craig. I think that is well worth emphasizing in the text of the report.

In hearings, what I have tried to say to people is point one is currently based on our data. We don't see nationwide problems in access, but the balance between supply and demand in some individual markets and even on a

national basis, it's pretty tight. And with a big influx of beneficiaries, new patients coming in as a result of ACA and a big cohort of baby-boom clinicians retiring, that tenuous balance could be thrown out of whack, and it may not happen slowly over a long period. There could be some pretty abrupt changes, and we need to -- don't draw too much comfort, in other words, from our survey results. It is not a guarantee for the future by any stretch.

Any other? Bill. Yeah.

DR. HALL: Just responding to what Craig said, I think that this era of 2014, '15, '16 is kind of special in this regard. I suppose that we will get a temporary fix for SGR sometime before April 15th. Maybe not. But if the nuclear option drops and it stays, the end of the year, we're also getting for primary care physicians another 10 percent drop in payment, unless we come up with some -- what we are talking about here in terms of a different sort of form of compensation.

So, really, it's in the next two years at a time, as Craig mentions, the urgency starts to boil that we may be presenting the Medicare beneficiary population with the prospect of finding physicians who see themselves earning 33

percent less than they did the year before. I think that's a really wakeup call that we got to solve this problem, which I think our recommendations start to look at.

MR. HACKBARTH: This also, I think, links to the per-beneficiary, per-month payment method. I believe -- and there are others who are far more expert than I on this, but I believe that through practice redesign and changes in staffing mix, it is possible to take the current supply of clinicians and see more patients and provide as good or better quality of care. But a fee-for-service payment system does not lend itself to the sort of changes that we are talking about.

The motivation is still, "I got to bring them in," because that's the only way to get the revenue, when in fact some patients could be handled equally well through non-face-to-face encounters. And actually, they'd like it better because they don't have to take off from work to go in and see the doctor.

So there are productivity changes that could happen, but fee-for-service payment is not an environment that supports the sort of practice change that needs to happen.

Kathy.

MS. BUTO: I was building on that point, Glenn. I was wondering, as I was looking at the per-beneficiary payment -- and there is an attribution process that goes with that -- whether there is a way to build in more of a bundled payment, if you will, so some payment for office visits to those kinds of patients, some of the chronic care management fee -- and I realize that there is no total overlap between those two -- in a way that tries to bridge the gap a little bit for primary care physicians and make primary care practice more of a unique thing. And if there is any way we could think about -- and I realize this is not for January, but pulling primary care out of the SGR entirely and building a different model that's more prospectively based, maybe some attribution, maybe like an ACO, but I really think a bundled payment as opposed to fee-for-service payments for those services.

So I am just hoping that we can get beyond trying to backstop what we have now and look at something that will move us in the direction of better management and frankly more control on the part of the primary care physician.

MR. HACKBARTH: Okay. Any further Round 2?

Jack.

DR. HOADLEY: I wanted to go back and follow up on an earlier part of Alice's comment on some of the use of the minute clinics. I know we picked up a little bit of that in the focus groups this last time around, and I wonder if that is something -- I think we had a little bit of a conversation on this at an earlier meeting -- but something to continue to explore.

You can make a case that that's actually a creative or useful way to relieve some pressure, make sure that when somebody has that ear infection that they have got a quick way to get it checked or looked at or there's some concerns about their blood pressure, whatever it might be, and that takes some pressure off a primary care office that may be otherwise pressed to give same-day appointments.

On the other hand, it could be a sign of trouble if it just sort of tells us that, well, it's not as good a way to get continuity, and so maybe there's some way to think that through or explore some of that either in the focus groups or by some other means.

MR. HACKBARTH: Other Round 2?

[No response.]

MR. HACKBARTH: Seeing none, let's do our Round 3, which is very quick reactions to the recommendation. I will remind you here again that we are not talking about a new vote on, I'll call it, the SGR package, but we will have a separate vote on the per-beneficiary, per-month payment.

We will start with Bill.

DR. HALL: So I am fully supportive of the draft recommendations as they stand.

MR. KUHN: Yeah. I likewise support those, the replacement of the primary care incentive payment program.

DR. BAICKER: Likewise.

MR. THOMAS: I support the proposal.

I think the question I have is, given the discussion, are we doing enough in primary care? Should we be doing something more there?

And the comments around virtual or telemedicine, maybe it doesn't kind of fit into this discussion, but I think that needs to be a bigger component of our discussion going forward.

DR. COOMBS: I agree with Craig and the others regarding primary care, and I support the recommendations.

DR. HOADLEY: I also support the recommendations.

I like Warner's comment about thinking at some point more about other kinds of non-face-to-face and how that might fit in because, in a way, that could be part of what this could reflect.

And my only other comment goes to my earlier question to make sure that we have prominently in here that there not be a beneficiary cost sharing as part of this. Maybe that belongs in the recommendation language or at least right below it.

DR. CHRISTIANSON: No, I support the recommendation, but I also want to encourage the writing of the chapter that we be clear about what problem we are trying to solve here. If the problem is that patients aren't getting enough evaluation and management kind of care -- there's been a 20 percent increase in that, according to the data over the last decade. If you measure that by visits, so then you could say maybe the visit time is shortened up and that's a problem. Other surveys we've seen suggest that that isn't the case, that the time for a visit has not declined. So I think in terms of looking at that data, we need to be clear what we hope to accomplish that isn't already happening.

MR. ARMSTRONG: Same. I support the recommendations as it's getting packaged.

DR. NAYLOR: I support the recommendations, with Jack's comment that this does not include beneficiary cost sharing. Also support the motion of looking at primary care very differently than we have, with all the models that have evolved.

DR. CROSSON: I support the recommendations as well.

I would make one comment with respect to SGR repeal. I think there may come a time -- not now, but there may come a time, if it becomes clear that SGR repeal is not going to happen for one reason or the other, that we might explore within the context of SGR, alterations to SGR to support and promote some of the other goals we have here, including primary care as well as the advancement of appropriate kinds of accountable care organizations. The time is not now.

I also support the recommendation for improving primary care payment as a per-beneficiary increase in payment for exactly the reasons that Craig and Glenn said. I think while we may look at the adequacy of access to

primary care right now and feel comfortable about it, if you look not too far ahead at the number of physicians coming out of medical school who are choosing adult care primary care as a career, it does suggest that there is a cliff coming. And as has been mentioned, the sooner that can be addressed and the more aggressively it can be addressed, the better off I think we are going to be.

DR. REDBERG: I support all of the draft recommendations.

MR. GRADISON: As I do.

MS. BUTO: I support the draft recommendations, but I would hope that a year from now when we are looking at the same recommendations that we actually have made it clear, this is a building block to look at something potentially more ambitious, if you will, with respect to primary care.

DR. SAMITT: I can support the recommendations as well. I do not believe we are moving fast enough and substantively enough to preserve and nurture primary care. So if there is anything we can do to accelerate that, that would make the recommendations even stronger.

MR. HACKBARTH: Okay. Thank you very much, Kate

and Kevin.

[Pause.]

MR. HACKBARTH: Okay. So, we have gone from being 15 minutes behind to being 15 minutes ahead.

MR. KUHN: Good leadership.

MR. HACKBARTH: So -- all of the Commissioners who used this as their rest room opportunity are with you in spirit.

[Laughter.]

MR. HACKBARTH: Let's go ahead. Ariel, are you -- Dan.

DR. ZABINSKI: Okay. Ambulatory surgical centers. Important facts about ASCs in 2013 include that Medicare payments to ASCs were $3.7 billion. The number of fee-for-service beneficiaries served in ASCs was 3.4 million. And the number of Medicare-certified ASCs was 5,364. Also, the ASC payment system, or payment rates, will receive an update of 1.4 percent in 2015. And, finally, most ASCs have some degree of physician ownership.

It's important to compare ASCs to hospital outpatient departments because OPDs are the setting that's most similar to ASCs and the ASC payment system is based on

the outpatient payment system. A benefit of ASCs is that they offer efficiencies over OPDs, such as shorter waiting times for patients and greater control over work environment for physicians. Also, ASCs have lower Medicare payment rates than OPDs, which can result in lower aggregate payments for Medicare and lower aggregate cost sharing for patients.

A concern is that most ASCs have some degree of physician ownership and this ownership status may give owners an incentive to furnish more surgical services. Evidence from recent studies indicates that physicians who own ASCs perform more procedures. Other studies indicate that markets that had ASC entry had higher growth in ambulatory surgeries than did markets that did not have any ASC entry.

A final issue is that relative to OPD patients, ASC patients are less likely to be dual-eligible, minority, under age 65, or age 85 or older. Factors that may contribute to this difference include that ASC patients had better average health than OPD patients, minorities are more likely to be dual-eligible, who are less likely to be treated in ASCs, and ASCs may tend to be in less convenient

locations.

MR. HACKBARTH: And George Miller thanks you for that last bullet.

[Laughter.]

DR. ZABINSKI: In our assessment of payment adequacy, we used the following measures: Beneficiaries' access to ASCs and overall supply, access to capital, and aggregate Medicare payments. We can't assess quality of care because there is not yet sufficient information to assess ASC quality. In addition, we're not able to use margins or other cost-dependent measures because ASCs do not submit cost data.

We found that the measures of payment adequacy were all positive in 2013, 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. Note that 91 percent of the new ASCs were for-profit. Also, the change in Medicare payments for 2013 includes a 1.2 percentage point reduction due to the sequester.

And, even though the growth in the volume per fee-

for-service beneficiary and the number of ASCs increased in 2013, their growth was lower than in previous years. Factors that may have contributed to this slowdown include increasingly higher Medicare payments when a service is provided in an OPD than in an ASC. This may be why we are seeing hospitals increase their capacity of outpatient surgery while there is a slowdown in ASC creation. Also, more physicians are becoming hospital employees, so they would be more inclined to provide surgical services in hospitals instead of ASCs.

But, despite the slowdown in some measures, all the measures in the table are positive, as the number of beneficiaries served, the volume and number of ASCs all increased. And, also, remember that most ASCs are physician-owned.

Now, a final point is that through 2011 or perhaps 2012, it appeared that surgical services were shifting from OPDs to ASCs. But, now, surgical volume is actually growing more slowly in ASCs than in OPDs, and some of this may be because more physicians are being employed by hospitals and fewer are becoming ASC owners. Also, we know that ASC payment rates are increasingly higher than -- oh, sorry --

OPD payment rates are increasingly higher than ASC rates. And, the Commission has recognized this difference between ASC and OPD rates and has discussed equal payment rates in ASCs and OPDs for 12 procedure groups.

The higher rate of growth in OPDs raises a question of whether surgical services are now shifting from ASCs to OPDs. However, analysis of surgical volumes in ASCs and OPDs does not indicate a shift from ASCs to OPDs. For example, about 75 percent of ASC volume occurs in 31 services, and there has not been an appreciable decline of these services in ASCs, nor has there been an appreciable increase in OPDs. Instead, it appears that the increased volume in OPDs is due to a shift from physicians' offices to OPDs for minor surgical procedures, especially wound debridement.

What appears to be happening is that the growth in ASC volume has slowed because services are no longer moving from OPDs to ASCs. At the same time, as the physicians become employed at hospitals, they may be taking services that were done in offices to the OPD setting.

Now, Ariel will discuss quality, access to capital, and a draft recommendation.

MR. WINTER: Owners of ASCs require capital to establish new facilities and upgrade existing ones. The change in the number of ASCs is our best available indicator of their access to capital. And, as Dan said, there has been positive growth in the number of ASCs. But, it's important to remember that Medicare accounts for a relatively small share of total ASC revenue, so factors other than Medicare payments probably influence their access to capital.

We do not have sufficient data to examine the current level of ASC quality or changes in quality over time. Under the ASC Quality Reporting Program, ASCs began reporting data on five claims-based measures in October 2012. CMS's contractor has released preliminary national results for these measures for 2013, but CMS does not plan to release final data until 2015.

The preliminary data include four patient safety indicators that measure preventable events, such as patient fall in an ASC or patient burn in an ASC. These events occur very rarely, less than once per 1,000 ASC visits. There is also one process measure, timely administration of IV antibiotics before surgery. Ninety-six percent of ASC

visits met this standard in 2013, according to the preliminary data.

The Commission has recommended that CMS implement a value-based purchasing program for ASCs that would reward high-performing facilities and penalize low-performing ones, but CMS does not have the statutory authority to implement such a program.

In summary, we find that access to ASC services is adequate, as shown by growth in the number of beneficiaries served, volume per beneficiary, and the number of ASCs. Also, access to capital is adequate. However, our analysis is limited because we have insufficient data to examine quality and we lack ASC cost data.

On this point, the Commission has previously recommended that ASCs be required to submit cost information. Cost data are needed to identify an appropriate input price index for ASCs. CMS currently uses the Consumer Price Index to update ASC payments, and the Commission has expressed concern that the CPI may not be a good proxy of ASCs' input costs. Cost data would also help us assess payment adequacy by allowing us to determine the relationship between Medicare payments and the costs of

efficient providers.

CMS and ASCs have raised concerns about the burden of requiring ASCs to provide cost data. However, we believe it's feasible for ASCs to submit a limited amount of cost information, either through a survey of a random sample of facilities or through streamlined cost reports.

So, here, we have the Chairman's draft recommendation. The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2016. The Congress should also require ambulatory surgical centers to submit cost data.

And, here are the implications. In terms of spending, under current law, ASCs are projected to receive an update in 2016 of 0.9 percent. Therefore, relative to the statutory update, this draft recommendation would produce small savings. Further, 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 ASC services or providers' willingness or ability to furnish care. ASCs would incur some administrative costs to submit cost data, but we think that a streamlined process would limit this burden.

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

MR. HACKBARTH: Could you put up Slide 3, please. So, Dan, in your presentation, you noted that OPD rates are substantially higher than ASC rates, 82 percent. In passing, you mentioned some work looking at potentially doing site-neutral payments for certain procedures. Could you just elaborate a little bit on that.

DR. ZABINSKI: Yeah. In their, I believe it was a June 2013 -- is that right -- yeah, June 2013, we looked at site-neutral for hospital OPDs and physician office, but we also looked at hospital outpatient departments and ASCs. We arrived at 12 APCs where we thought it would be reasonable to have equal payment rates between those two settings. As usual in the ASC world, the big player of those 12 was cataract with IOL insert and some pain management services. We estimate that -- I think we came in somewhere around $600 million in combined program spending and beneficiary cost sharing that could be saved in that situation.

MR. HACKBARTH: And, the criteria for the 12 were similar to what we've used for other settings --

DR. ZABINSKI: Right.

MR. HACKBARTH: -- so, in this case, they would be services now predominately provided in ASCs, et cetera?

DR. ZABINSKI: Yes.

DR. MILLER: The same risk profile.

MR. HACKBARTH: Same risk profile. Okay.

Clarifying questions. Let's mix it up. Scott, we'll start with you. Clarifying questions? Jon, Jack --

DR. HOADLEY: When you say on the last slide that the spending would decrease relative to the statutory update, this is without taking into account the sequester?

MR. WINTER: Correct.

DR. HOADLEY: So, it would actually be -- it would end up at a higher rate than what would happen if the sequester were allowed to go forward?

MR. WINTER: Correct.

DR. HOADLEY: Okay.

DR. COOMBS: There's a slide in the handout material that does a breakdown in for-profits and not-for-profit. Do you have a breakdown of the for-profits in terms of surgical-based ASCs versus non-surgical, comparing the two groups?

MR. WINTER: By non-surgical, do you mean focusing

on endoscopy, or --

DR. COOMBS: Focusing now on actual day surgeries.

MR. WINTER: These are all day surgery facilities.

DR. COOMBS: So --

MR. WINTER: None of them -- I mean, none of them -- to be Medicare certified. They're not providing procedures that require an overnight stay --

DR. COOMBS: Right.

MR. WINTER: -- unless they do so on the commercial side.

DR. COOMBS: Right. So, if you were to look at DRGs, DRGs that focus on hand surgery, plastics, and that kind of venue, versus endoscopies and non-operative-type interventions --

MR. WINTER: Right. So, we don't have that breakdown. We could try to look at that, probably -- it would have to be for the next update cycle, because it would require looking at claims to see what kinds of procedures they actually do and then linking it back to the provider services file. In the past, three have been difficulties linking the provider services file, where we get the nonprofit/for-profit information to actual claims, but we

can look again and see if there's a better way to do that now. But, I don't think we could do it in time for the March report.

DR. MILLER: I'm not sure -- so, let's say we could do it. Where would you be going?

DR. COOMBS: So, it's a round two question and I don't want to violate things.

DR. MILLER: [Off microphone.]

MR. HACKBARTH: We'll come back to Alice. I appreciate Alice's discipline.

Round one clarifying questions, going down. Over here, Bill.

MR. GRADISON: On page 21 of the paper, it indicates that CMS should also publicly report quality measurement results to help researchers and consumers compare quality among facilities. My understanding is that they should be able to do this sometime in the next calendar year, is that correct?

MR. WINTER: They said that's their intention. They want to give ASCs a chance to review their own quality measures first before they release them publicly, but they said in the final rule for 2015 that they plan to do this in

2015, but there's not a specific time frame for when that would occur.

MS. BUTO: Clarifying question. Are the ASC payment rates based on a combination of the outpatient PPS and Physician Fee Schedule? How is -- since they don't have cost data, how do they actually set those rates?

DR. ZABINSKI: Yeah. Well, in general, for most of the services, it's directly based on the OPPS. For some services, particularly ones that have been introduced in recent years and are predominately provided in physician offices -- they're called office-based services -- they take the greater of what you would get if you based it on the OPPS or the, what is it, the non -- or is it facility -- is it -- no, non-facility PE, the lesser of those two.

MS. BUTO: Okay. So, I was just trying to understand how you would even apply a kind of site-neutral policy in a system which is already kind of based on the OPP. I mean, in other words, applying the ASC rate to the outpatient hospital department when the ASC rate is, in part, derived from the hospital outpatient.

DR. ZABINSKI: Oh, it's just a matter of just taking the --

MS. BUTO: Flattening --

DR. ZABINSKI: Yeah, just taking the OPD rate and dropping it to the ASC rate.

MS. BUTO: Which isn't as high because it doesn't take into account some of the overhead and that kind of thing?

DR. ZABINSKI: Yeah, it -- well, you know, in general, the relative weights -- what's really used from the outpatient system is the relative weights --

MS. BUTO: Okay, but not the conversion factor.

DR. ZABINSKI: Not the -- the conversion factor is a lot lower in the ASC system than the --

MS. BUTO: Okay.

DR. ZABINSKI: -- the outpatient payment system.

MS. BUTO: Okay. And, the last question is that we're talking mainly cataract surgeries, GI procedures, and, I guess, some orthopedic types of ASC --

DR. ZABINSKI: Yeah, some orthopedic, a lot of pain management.

MS. BUTO: Thanks.

MR. HACKBARTH: I may be confused and just asking Kathy's question in a different way. So, the ASC system has

same or very similar relative weights as the OPD system. It's got a lower conversion factor, a substantially lower conversion factor. How was the conversion factor for ASCs calculated when they went to a parallel but not identical system?

MR. WINTER: What they did is they set a conversion factor in 2008 under the revised payment system so that total payments under the new system --

MR. HACKBARTH: Budget neutral --

MR. WINTER: -- would be budget neutral to total payments under the prior system.

MR. HACKBARTH: Yeah.

MR. WINTER: And, then, over time, the updates have been generally -- have been lower for the ASCs and for OPDs, in part because from 2003 through 2010, there was no update at all for ASCs, and then since then, it's been based on the CPIU --

MR. HACKBARTH: Yeah.

MR. WINTER: -- which is generally lower than the hospital market basket.

MR. HACKBARTH: Yeah. So, that was my recollection. So, the conversion factor for ASCs was based

on historical ASC aggregate level of payment without any cost information, and then if you were to move OPD rates towards ASC rates for, say, the 12 procedures that we're talking about, basically, it would be not a cost-based calculation, it would be sort of a market test. Are people willing to provide these services at the ASC rates, and the answer would, in fact, by definition, be yes, because the 12 are chosen because they're predominately provided in ASCs.

Rita.

DR. REDBERG: On Table 5, page 16 in the mailing materials, you have the list of most frequently provided ASC services, and revision of upper eyelid is in there, which usually, I think, most of them are cosmetic procedures and maybe a very small percentage are medically necessary. So, I just wanted to confirm, Medicare would only cover medically necessary as opposed to cosmetic --

MR. WINTER: Correct.

DR. REDBERG: -- so, these would all be medically necessary revisions of the upper eyelid --

MR. WINTER: Correct.

DR. REDBERG: -- is that correct? And, I'll just comment that I know a lot of the -- well, the spinal

injections are, again, procedures that I don't know of any data showing improved outcomes. They seem to be prevalent in this list.

MR. HACKBARTH: Round one clarifying questions?

Round two. Alice.

DR. COOMBS: Yes. So, the reason I asked the question is there are ASCs that are under the, what they call the quote-unquote "company model," and as you review the literature, you'll see that it's a very profitable arrangement, whereby everyone under the umbrella of the ASC is actually employed and there are incentives for anesthesiologists who work within that system to be in line with the visionaries of the ownership of that entity.

And, as a result, decisions are made to, basically, select the patients that are going to result in the quickest discharges, and I think I mentioned this before, is that if a patient is actually transferred to a hospital, that breaks your budget, one round, $500, easily, to be transferred, and that cost is paid by some person, the patient usually, for being transferred. So, the decisions for some patients to be done at the ASCs may be very broad and it may be also related to the compliance of the patients

who are done there, as well, not just their comorbid conditions, but it may be their, whatever, socio-economic status and other ideas, as well.

But, if I were going to design a system that was going to be profitable, one of the things is to look at the actual DRGs, and you would select certain patients based on their demographics, as well. So, I think that this new company model is something to look at, particularly it's not just endoscopies. It's actual surgery. And, those surgeries are the most profitable, whether they be paired on the private side or the Medicare side, because they're interventions that would result in the greatest margins for the ASCs.

I don't know whether or not we can look at the percentage of actual invasive surgeries, whether they're levatorplasties [?] or face lifts or things of that nature versus some of the other things. I think we picked the top ones, but the top ones are not the revenue generating ones. So, that's why I asked the question in terms of the distribution of the DRGs in the ASCs.

MR. WINTER: In terms of -- I think you're getting at profitability of different procedures, and unfortunately,

we have no way to get at that because we don't have cost data, so we can infer, just based on what are the ones they focus on, which ones are growing faster --

DR. COOMBS: Right.

MR. WINTER: We can make maybe inferences about that, but in terms of actually directly assessing profitability, we don't have the data to do that.

DR. COOMBS: So you may not know cost, but do an ICU billing at my hospital, I kind of know what generates the best kind of end result. So you can actually look at the DRGs and go backwards is what I'm saying.

DR. MILLER: I keep getting -- all right. So one thing that exchange clarified for me was that it was the profitability of different services that you were going after, and this is where we are just completely dead in the water here and have been for years. We don't have the cost data.

Then you keep saying look at the DRG, and I don't follow.

DR. COOMBS: I'm sorry. So you can look at DRGs to see what kind of patients there are. You can also look at the CPTs, but what I was looking at is the strategy of

the ownership of the ASC and how they direct what the ASC does, so just the overall strategy.

If you looked at the breakdown in the procedures based on a number of demographics and who winds up going there and what procedures are done, then that combination might lend itself to --

DR. MILLER: Now, that I do understand, and I do think we have done some of that in the past of looking at which procedures are going on there. We may be able to bring something to this question.

We have looked at things like where they are located, what kinds of areas, that type of thing, and we have -- and this is where I am struggling -- we have looked at some of the demographics.

MR. WINTER: Yeah. And that's the bullet on the slide here. There is a table in the paper. I think it's Table 1. I don't know the page number, but Dan does it every year. That compares the demographic characteristics of ASC patients and OPD patients.

We also look at patient severity using HTC risk scores that is included in this year's paper based on data from 2010. So we looked at that sort of across all

procedures.

DR. MILLER: And that's why I bring it up because I do think some of this is year, and we do think that there is patient selection occurring here. Frankly, if you talk to physicians -- we haven't done it lately, but back in the day when we talked to them, they were very clear they selected which patients came to these facilities.

MR. HACKBARTH: And often for very legitimate clinical reasons that patients who are higher risk need to have hospital backup close by, whereas other patients don't present the same potential for complications.

DR. COOMBS: My point is that to the degree that we -- that makes the argument strong in terms of the comparison between the hospital versus the ASC.

DR. MILLER: I think we can bring that out a little bit more. You and I will talk. All right.

MR. HACKBARTH: Round 2. Building on Alice or something else.

Bill.

MR. GRADISON: I guess building on Alice.

Do we know that we're only -- we're missing about 30 percent of the volume in Table 5 in the stuff we were

reading. That's a big gap in our information. Do we know what that 30 percent is comprised of?

DR. ZABINSKI: Not offhand, but it's easy to find out.

MR. GRADISON: Well, it might help. It could clarify things a bit more. It's actually more than 30 percent in the most recent data in 2013.

Maybe those are procedures that are much more intense. I just don't know what they are. I mean, clearly, you have listed the very common things that are there, but one out of every three is missing in the data.

MR. WINTER: So CMS in the final rule, I think they list -- they break down either spending or volume by category of body type, like nervous system, digestive, eye.

MR. GRADISON: I understand.

MR. WINTER: Would that be helpful to see, sort of looking across the whole range of procedures, how it is broken down by --

MR. GRADISON: Well, I am just wondering what these other procedures are. I mean, for example, it could be a lot of -- it could be a lot of biopsies. It could be a whole number of different things. So if it's not too much

work, I think that would be worth doing.

DR. ZABINSKI: What I am thinking of, when you look at the remaining 30 percent and sort of get an idea of what general categories are represented, that's what I'm thinking of.

MR. HACKBARTH: Round 2.

[No response.]

MR. HACKBARTH: Okay. Round 3.

Scott.

MR. ARMSTRONG: Yes, I support the direction the recommendations are going in.

DR. CHRISTIANSON: I support the recommendations.

DR. HOADLEY: I agree. I support them.

DR. COOMBS: I support the recommendations, and I'd like to go on record saying that these presentations have been awesome.

MR. THOMAS: I support the recommendation.

DR. BAICKER: As do I.

MR. KUHN: I support the recommendation.

MR. GRADISON: I support the recommendation.

DR. SAMITT: I support them as well.

MS. BUTO: Same.

DR. REDBERG: I support the recommendations.

DR. CROSSON: I support the recommendations.

I just want to clarify, based on the table, are we voting on this recommendation in January, or are we not? Because it is the same as last year.

MR. HACKBARTH: We will vote on this, but we may do so with a very streamlined process.

DR. CROSSON: Thank you.

MR. HACKBARTH: And the reason for the difference between this and physician is this really isn't a complex, multiyear package.

DR. CROSSON: Got it.

MR. HACKBARTH: So rules the Chair.

Mary.

DR. NAYLOR: I support.

MR. HACKBARTH: Okay. Thank you.

So we are ready to go to lunch after we do our public comment period, and could I ask people who wish to make a public comment to line up at the microphone, so I have an idea how many are in the queue?

Okay. It looks like we've just got two.

Before you begin, let me just briefly state the

ground rules. Begin by introducing yourself and your organization. I will remind people that this isn't your best opportunity to provide input on our work. It certainly isn't the only one. The best opportunities are to talk to our staff, send letters to Commissioners, which we read, or file comments on our website.

When the red light comes back on, that will signify the end of your two minutes.

MR. AMERY: My name is Mike Amery. I am representing the Academy of Neurology and the Cognitive Specialty Coalition, which includes groups like allergy, rheumatology, infectious disease, endocrinology, representing more than 115,000 physicians.

We strongly urge the Commission to reconsider whether to include our specialists that routinely exceed the 60 percent E&M threshold in the eligibility for the per beneficiary payment.

First, there is no such thing as primary care services in the fee schedule. Our specialties bill the exact same codes as primary care providers. These evaluation and management codes are for new and return office visits, not for primary care services.

Second, data that I previously provided to all Commissioners shows that not only do our specialists bill the same codes, but we also have similar incomes and recruiting challenges as primary care providers. These policies simply pick winners and losers based on specialty designation, not on care being provided to patients.

The Commission's data shows that millions of beneficiaries are not relying on primary care providers for their coordination of care. Who are these patients? They have conditions like Alzheimer's, Parkinson's, MS, HIV, RA, diabetes, yet care coordination payments for some of Medicare's highest-cost, highest-need beneficiaries will not be available.

There is an unintended consequence here. Ultimately it will be clear that specialties like neurology, rheumatology, endocrinology, infectious diseases are specialties to be avoided. Why put in the extra time to be paid less for taking more specialized training and then more difficult patients?

We ask you to listen to the comments of Commissioner Coombs, who at the last meeting said she knows many of her rheumatology colleagues who are the primary

providers for their patients. This is true across all of our specialties. This shouldn't be about primary care versus everybody else. It should be about patients who need the time to talk with their appropriate physicians, discuss medications, manage symptoms, regardless of whether that physician is in family medicine or neurology, a general internist, or an endocrinologist.

Your own decision last meeting agreed that it's unfair to take E&M resources from our physicians to pay for the per beneficiary payment. We urge you to take the next step on this program and any program where you're discussing primary care to ensure fairness and include physicians above the 60 percent threshold who coordinate care, regardless of specialty designation.

MS. LANSEY: Debra Lansey, staffer for the American Psychological Association. The American Psychological Association is pleased that MedPAC is reviewing payment adequacy for non-physician Medicare providers such as psychologists. This topic is very important to us because the structure of Medicare's physician payment system has resulted in several years of declining reimbursement rates for psychologists' services.

Psychologist reimbursement rates are now more than 33 percent below where they were just seven years ago, even accounting for inflation, and are now 17 percent below private indemnity market rates for psychologist services.

Psychologists are the predominant provider of behavioral mental health services to Medicare beneficiaries, and the steady decline in reimbursement rates has led to many psychologists leaving the program or limiting their participation at a time when the program is suffering from a dire shortage of mental health providers.

Addressing biases embedded in the Medicare physician payment formula, which uniquely disadvantages many of these services, is paramount to safeguarding beneficiary access to psychologist services.

MR. VYVERCHEK: Hi, my name is James Vyverchek [phonetic]. I'm on staff of the American College of Cardiology. I wouldn't normally get between the Commissioners and their lunch, but I know that our members would be desirous of commenting on given that echocardiography was discussed so much this morning.

I just wanted to share some history about there was a question regarding the adequacy of the payment and the

physician site, and I thought some additional history might be helpful for this group of Commissioners and wanted to take advantage of you all being here to sort of address that because you might not all be familiar with the history.

There were significant cuts to echocardiography and some cardiovascular nuclear services starting in 2010 as a result of the AMA PPIS. Some of those services went down 40 percent in their practice expense payments. Up to that time, payment in hospital outpatient versus physician office was roughly equal, so there wasn't a lot of this migration back and forth based off those sort of incentives.

So, you know, one thing our members I think would want to reiterate to you is it's not necessarily correct to assume that the fact that the service is still provided in the office means that it's adequately paid. I think many of them would say there's a lot of them that are not -- that still want to take care of their patients, and they're willing to take that loss to facilitate that.

And so we're not entirely opposed to some sort of site-neutral policy, but that assumes that the underlying payments are accurate. And right now we don't think that they are for some of these services, and so we'd urge the

Commission to maybe think of some additional criteria when they're grouping these 66 services together. For instance, utilization came up in the physician payment adequacy section, and there was that chart about, again, echocardiography down in the office, up in the hospital. But overall utilization -- and this is based off our calculations that are probably simpler, but overall utilization of those services is declining both in their entirety and as some of per beneficiary payment.

So I just thought I'd finish with a pitch. I look forward to seeing 62 services -- 62 APCs in the report.

MS. BATHIJA: Hi. My name is Priya Bathija. I'm with the American Hospital Association. We are pleased that the Commission has recognized the substantial challenges facing hospitals in the coming years. Hospitals are committed to improving quality and providing the best possible care for their communities. In fact, they actively partner with their patients and their communities to promote and achieve health and wellness. They are not just a means to an end.

Hospitals have embraced implementation of the ACA's pay for performance programs, and as noted, they have

had a positive effect on quality of care. However, these programs are not without their problems, namely, the readmissions and HAC programs, which have had negative unintended consequences on hospitals. We've spoken with MedPAC about our concerns with the structure of these programs and urge you to continue evaluating them.

In addition, while hospitals are committed and will remain committed to serving all of their patients, the reality is that a negative 9 percent margin does have consequences. While the consequences may not be so draconian as to no longer serving Medicare patients, it could lead to hospitals' discontinuing certain service lines. We've seen this especially with the shutting down of hospital psych units. So while hospitals will continue to care for Medicare beneficiaries, they may not be able to serve them in all the ways that they would be able to if Medicare actually paid its costs.

Finally, I'd like to comment on the 66 APCs for which MedPAC is making its site-neutral recommendation. The identification of those 66 APCs was based on an analysis of 2010 data. Much has changed since 2010, including that in calendar years 2014 and 2015, CMS enacted sweeping changes

to the outpatient PPS that significantly increased packaging and changed the structure of many APCs. This could greatly affect which and how many APCs qualify under MedPAC's criteria as well as the amount of money associated with the recommendation. We believe this warrants a fresh look at the analysis and recommendations.

Thank you.

MR. HACKBARTH: Okay. We will adjourn for lunch and reconvene at 1:30.

DR. MATHEWS: If I could have the Commissioners' attention, because we're ahead of schedule, the Reagan Building needs about ten more minutes to set up for lunch. So if you could make your way over there more slowly than usual.

[Whereupon, at 12:08 p.m., the meeting was recessed, to reconvene at 1:30 p.m. this same day.]

AFTERNOON SESSION [1:30 p.m.]

MR. HACKBARTH: Okay. It is time to begin. We start this afternoon with outpatient dialysis. Nancy.

MS. RAY: Good afternoon.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2013, there were about 376,000 fee-for-service dialysis beneficiaries treated at about 6,000 dialysis facilities. 2013 Medicare spending for dialysis services was $11 billion.

My presentation this afternoon is composed of two 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 to help support your assessment of the adequacy of Medicare's payments for dialysis services and the Chairman's draft recommendation for the 2016 payment rate.

MIPPA mandated that CMS modernize the outpatient dialysis payment method. The statute implemented a MedPAC recommendation to broaden the dialysis payment bundle. Under the new PPS, the broader payment bundle includes dialysis drugs that facilities were paid separately in prior years. The new PPS adjusts for patient-level factors that

are listed on the slide. There was a four-year phase-in of the new PPS, but nearly all facilities bypassed the phase-in and elected to be paid 100 percent under the new PPS in the first year. That was 2011.

So now I'd like to shift gears and move to our payment adequacy analysis. We will look at the factors listed on this slide.

We look at beneficiaries' access to care by examining industry's capacity to furnish care as measured by the growth in dialysis treatment stations and facilities. Between 2012 and 2013, the growth in dialysis treatment stations and facilities each grew at 3 percent, kept up with beneficiary growth, which grew at 2 percent. In 2013, the latest year we have closure information, the roughly 40 facilities that closed were smaller, more likely to be hospital-based, and nonprofit. In 2013, there was a net increase of about 190 facilities.

Few patients -- less than 1 percent -- were affected by the closures. There is no indication that affected patients were unable to obtain care elsewhere. There are a 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. Between 2012 and 2013, the total number of fee-for-service beneficiaries and total treatments each grew by 2 percent. Treatments per beneficiary remained steady in each year at about 117 treatments per beneficiary.

The second way we look at volume changes is by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of care. Now that dialysis drugs are in the payment bundle, providers' incentive to furnish them -- in particular, erythropoietin stimulating agents (ESAs) -- has changed. ESAs are the leading dialysis drug class in terms of use.

Before implementation of the new PPS, there were both clinical reasons and financial reasons for their overuse. As anticipated, after the PPS, ESA use went down significantly. Between 2010, the year prior to the new PPS, and 2013, use of ESAs declined by 45 percent per treatment. And between 2012 and 2013, use declined by about 7 percent

per treatment.

Next, we look at quality by examining changes between 2010, the year prior to the new PPS, and 2013. CMS compiled these data. Mortality and admissions are trending down while ED use has remained steady.

The percent of dialysis beneficiaries using home dialysis has modestly increased from a monthly average of about 8 percent per month in 2010 to 10 percent in 2013. Home dialysis is associated with improved quality of life and patient satisfaction.

As we just discussed, under the new PPS, per treatment use of ESAs, which are used to manage anemia, has declined. As expected, hemoglobin levels declined between 2010 and 2012 and then leveled off in 2013. The percent of dialysis beneficiaries receiving a blood transfusion increased from a monthly average of 2.7 percent in 2010 to 3.4 percent in 2012 and then declined slightly to 3.2 percent in 2013.

Regarding access to capital, indicators suggest it is adequate. An increasing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized chains.

In addition to acquiring more than 500 existing dialysis facilities between 2011 and 2013, the two large dialysis organizations also acquired during this time period physician medical groups as well as urgent care centers.

Moving to our analysis of payments and costs, in 2013 the Medicare margin is 4.3 percent. This reflects the sequester in 2013. The biggest difference across freestanding providers is the difference between rural and urban facilities.

The Medicare margin for rural facilities is 0.6 percent. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban facilities. And as you can see on the slide, the Medicare margin is closely associated with treatment volume.

The 2015 projected Medicare margin is 2.4 percent. This margin reflects the statutory updates listed on the slide for 2014 and 2015; policy changes implemented by CMS that result in increasing total payments in 2014 and 2015. It includes the small estimated reduction in total payments due to the ESRD Quality Incentive Program. Finally, it includes the 3.3 percent rebase of the base payment rate in

2014.

It also includes the effect of the sequester. If the sequester was not in effect, the margin would be nearly 4 percent -- would be projected at nearly 4 percent.

Other policy changes to occur in 2016 include the statutory update of the base payment rate reduced by the productivity adjustment and reduced by 1.25 percentage points. There is also the small reduction in total payments due to the ESRD QIP that I've also listed on the slide.

So here is a quick summary of the payment adequacy findings. Access to care indicators are favorable. Quality is improving for some measures. The 2015 Medicare margin is projected at 2.4 percent.

The Chairman's draft recommendation then is as follows: The Congress should eliminate the update to the payment rate for calendar year 2016. This would lower spending relative to current law. 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. We do not anticipate this recommendation impacting beneficiaries.

That concludes my presentation, and I look forward

to your discussion.

MR. HACKBARTH: Thank you, Nancy.

So I have a clarifying question. Congress mandated a rebasing of sorts to reflect the decreased use of ESAs, and that was envisioned to happen over a several-year period, as I recall.

MS. RAY: That's how CMS intended to implement it, over a three- to four-year period.

MR. HACKBARTH: Right, and so they did one reduction of $8, or something like that.

MS. RAY: Right.

MR. HACKBARTH: And more are to come.

MS. RAY: Well, then Congress intervened again, and in PAMA they said no more rebasing, we are going to instead reduce the statutory updates in 2015, '16, '17, and '18.

MR. HACKBARTH: I remember now, yeah.

MS. RAY: So in 2015 it's zero; in 2016 and '17 it's reduced by 1.25 percentage points; and then in 2018 it's by 1 percentage points.

MR. HACKBARTH: I remember now. Thank you.

Okay. Other clarifying questions?

DR. CROSSON: So, Nancy, in relationship to the decreased use of erythropoietic drugs and the frequency of transfusions, the frequency of -- these two things are not necessarily causally related. They may well be, but they happen simultaneously. The frequency of transfusions is still above the baseline that you described, and I wonder, if you look at the mean hemogloblins, to me the difference doesn't look clinically significant. I forget, it was less than one point. But I just wonder whether or not we have comparable ranges and, in fact, whether there could be a subset of dialysis patients, beneficiaries, who are more affected by lower use of erythropoietin than others who represent a higher-risk group.

MS. RAY: Okay. So a couple of points. Yes, I can bring you back ranges in terms of hemoglobin levels, and you can see -- and that will show you the changes before and after the implementation of the new PPS.

Last year the Commission recommended that CMS adopt a measure of anemia management, reflecting the low use of ESAs. And since then the Quality Incentive Program will, beginning in I think it's 2017 -- it's either 2017 or 2018; I think it's 2017 -- implement a standardized transfusion

ratio that will be a part of the ESRD Quality Incentive Program.

MS. BUTO: A quick question about home dialysis. Can you give us just a sense of how the reimbursement rate is set for home dialysis versus facility? Are they related in any way? And are they comparable or not comparable?

MS. RAY: Right, they're -- right. So Medicare pays up to three dialysis sessions per week. If you're undergoing peritoneal dialysis, most frequently at home, it will be pro-rated at the three-times-a-week level, even though PD patients do perform more I guess I'll use the word "sessions." Providers, nephrologists, can prescribe an additional session, and typically they have to put down a medical necessity reason for the MAC to reimburse for more than three sessions per week.

MS. BUTO: More than three sessions of peritoneal -- hemodialysis.

MS. RAY: Hemodialysis per week.

MS. BUTO: I was just trying to figure out --

MS. RAY: I'm sorry.

MS. BUTO: -- the relationship with home dialysis payment to --

MS. RAY: Right.

MS. BUTO: And you're saying it's basically a pro-rated version of --

MS. RAY: Yes, for peritoneal. If you undergo home hemodialysis, again, you would be -- the payment is based on the three sessions per week. If you are prescribed the more frequent home hemo, either the short daily or the long nocturnal, again, it's three per week. Typically the MACs require a reason of medical necessity to be paid more than three sessions per week.

DR. MILLER: Just to make sure I followed all of that, what we're saying is the facility gets a payment. The payment is comparable to what it would have done if the patient had been in the facility, but they're just managing the patient at home, either through PD or through, you know, a home dialysis machine. I think that's what --

MS. BUTO: Okay. The facility gets the home dialysis payment.

DR. MILLER: Yeah, in case that wasn't --

MS. BUTO: Okay. That's the part I wasn't -- that's helpful.

DR. MILLER: I saw Rita move, and I figured that's

where she was going.

MS. BUTO: Good.

[Laughter.]

DR. MILLER: I like to get in front of her when she starts moving.

MR. HACKBARTH: Rita, something beyond that?

DR. REDBERG: Even though Mark did head me off, I'll leave that one alone. So now it's just a clarifying comment, or do you want me to -- it's not really -- no, it's not a question. I'll wait.

MR. HACKBARTH: That's Round 2.

Clarifying questions?

DR. HOADLEY: I want to just follow on your dialogue with Glenn on Slide 14. So the update that's -- the market basket forecast is 2.9. The 1.25 in the second bullet is what you were talking about the Congress put in instead of rebasing?

MS. RAY: Yes.

DR. HOADLEY: And so from what it says elsewhere here, the net projected update is, I think, 1.15 when you do all this math here?

MS. RAY: Yes.

DR. HOADLEY: And so our proposal of zero update, that's the basis on the savings comparing the zero to the 1.15. Okay. And the sequester is not figured into those -- either of those numbers. Okay.

MR. HACKBARTH: [off microphone] current law under Medicare.

DR. HOADLEY: Right.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: Let me see hands of people with Round 2 comments they'd like to make, and we'll start with Rita, but let me just -- so we've got Rita, Jay, Alice. Anybody else? Okay. Rita.

DR. REDBERG: Thank you. So thanks for this very informative chapter, and I just appreciate you putting the outcomes data in, and my comment is really just to point out two things.

One, it appears that outcomes improved as our use of erythropoietin decreased, which is certainly suggested by the data, but I hope is a lesson, because Medicare did spend billions on ESA for many, many years, and really the data was always very weak. We were treating a lab value -- I

mean, patients didn't -- weren't saying they were feeling better, and then, you know, as ESA use expanded, in some patients it was clear it was making them worse and increased mortality. And certainly the fact that mortality has declined as ESA use declined suggests there's a relationship. And, you know, certainly this is not the only drug, I would suggest, that we're paying for that not only has been associated with a lack of outcomes benefit but has been associated with harms.

So it's kind of a win-win that beneficiaries are doing better and the program is spending less money, but I think we could expand this and think about it and a lot of other things that we're currently covering that are in the same category.

The other comment was just about the hemoglobin and transfusions, because there has been a trend in the last few years away from lowering hemoglobin levels, basically the belief that we're transfusing too much in general and that it's very hard to -- because some people get transfused not because they're feeling poorly, but they hit a certain hematocrit or hemoglobin level and they get a transfusion. And we're now understanding that that is also not good for

patients, and so there could be a drop in transfusions because of difference in data, and it's very hard to correlate because it's a very subjective -- you know, different institutions, different providers have different levels. But I think nationwide we are seeing some slow trends towards just less transfusion as we realize that we don't need to transfuse so much just for lab values and that it should be more symptom based.

MR. HACKBARTH: Transfusions are inside the bundle, correct?

MS. RAY: No, they are not.

MR. HACKBARTH: They are not.

DR. CROSSON: So this is just a little comment, I think for background, potentially for the text of this chapter. One of the things that struck me demonstrably -- and I probably knew this at some point, but I didn't realize it until I saw it again -- was that 36 percent of patients with end-stage renal disease are African American compared with 10 percent of Medicare beneficiaries. A lot of that --

DR. REDBERG: Hypertension [off microphone].

DR. CROSSON: Thank you. My consultant helped me there. A lot of this is due to hypertension, not just the

frequency of hypertension but the unique susceptibility of 60 or 70 percent of African Americans to renal damage from hypertension.

We learned in the last couple of weeks from an article by a prior MedPAC Commissioner, Joe Newhouse, for the first time that, at least in the West, it is possible, it has been demonstrated in the West of the United States through the appropriate provision of aggressive primary care services to get to the same at least intermediate outcomes for African Americans as for Caucasian populations and Asian populations.

So the point here is that there's a connection, I think, sometimes between the silo recommendations that we make, and I would just like to see us underscore somewhere, irrespective of the update recommendation itself, that in other areas, for example, our attempts to improve the funding of primary care, which is where most treatment and management of hypertension takes place, that if we succeed in that arena, we may succeed in one of the fundamental reasons that we exist as a commission, which is to try to in this case prevent through the payment policy, the broader-based payment policy, people from getting hypertension-

induced nephropathy and need for end-stage renal disease and dialysis in the first place.

MR. KUHN: I would just ask on that one, you know, in the materials that you sent ahead for reading, it talked about a couple of demonstrations through CMI, one dealing with kidney disease education, and the other, I think you called it this seamless care organizations. Are they pretty much after the onset of a disease or would they help with some of the things that Jay was talking about, about earlier interventions?

MS. RAY: That's a good question. The education that you refer to, that is a Medicare benefit implemented by Congress, I forget when, and that began in 2010, and that's aimed for individuals with Stage IV chronic kidney disease. That's the phase before end stage renal disease. And, so, that educational benefit, which is a beneficiary can gain up to six education sessions, is designed to partly help delay chronic kidney disease as well as to inform beneficiaries about their potential treatment options if they do become end stage.

The other effort that you referred to, that's the ESRD ESCO. That's like the ESRD ACO, and that is under

CMMI, and that is directed specifically for dialysis -- fee-for-service dialysis beneficiaries.

MR. KUHN: Then, on that, in terms of the interventions that Jay was talking about, so to even front-load that further, are there any specific CPT codes with the code descriptors for this kind of intervention or any kind of work that CMS might or CMI might be looking at to test this concept a little bit further that you're aware of?

The earlier intervention opportunities.

MS. RAY: The chronic kidney disease. So, there are CPT codes for that, and when I have tracked that, there is relatively little use of that benefit to date, between 2010 and 2013. I put the numbers in the text. There has not been a huge take-up of beneficiaries and provider -- beneficiaries using the service, being referred to the service, as well as providers furnishing the service. And, to be clear about that, dialysis facilities under the statute are not permitted to furnish the chronic kidney disease education --

MR. HACKBARTH: Although, if I understand, Jay correctly -- you're talking about an intervention even before that, when patients simply have hypertension and it

hasn't advanced to where there's kidney damage and --

DR. CROSSON: Right, and my concern is that we're looking at these statistics and at the same time from this morning's discussion the potential in a few years to lose primary care practitioners, and that that is the level, particularly early on, before people become more acutely ill, that's the level at which you can prevent hypertension, and particularly in African Americans, treat aggressively and forestall the development of end stage renal disease, which then brings about all these added Medicare costs.

MR. HACKBARTH: [Off microphone.] Is there anybody else who wants to pick up on -- Alice.

DR. COOMBS: As I looked at the appendix and the description of ESCO and I thought about this whole notion of seamless care, in light of what Jay has said, the key ingredient to the treatment in terms of being able to aggressively control blood pressure happens before that. What's the relationship between Accountable Care Organizations that would control blood pressure and this ESCO, because it seems to me that it's not seamless care if this is just one entity that's separate. I don't see that the LDOs are going to -- I mean, it's kind of a twisted

arrangement where the LDOs may not want to actually invest in that pre-renal failure stage.

And, just one point is that it's not just hypertension, it's the quadruple effect of having diabetes with hypertension, and there's something called health care disparities which might talk about the lack of intervention and aggressive blood pressure, but there's also something, just health disparities which result from most blacks having an increased incidence of essential hypertension, which you combine the two things in terms of the management before you hit your CKD Stage I, II, III, IV, a lot of patients are actually in Stage II and III and don't even realize it because of the creatine being a very gross measure versus the creatine clearance. So, I think that the ACOs, if they were aggressively treating these early stages, it would prevent some of the ESCO kind of escalation.

I'm happy to see this, which is really good, but the next phase would be that there would be some intermediary phase where there would be an assessment, a risk stratification or some kind of prognostication of this person going on to this stage kidney disease and some really aggressive intervention in that term.

I've heard of one case where a dialysis doctor said a patient came to them with a blood pressure of 200 over 100 diastolic, and when asked about that particular blood pressure, the black patient said, "My doctor says I run high." And, so, there's this bar of acceptance for people who are chronically hypertension not to be aggressively treated for various reasons. But, I think you have to really understand the process of health disparities and health care disparities, and I'm glad to see this, but there seems to be a need for an intermediary step in that to deal with -- to better address this progression.

DR. CROSSON: I would -- I've said this once, and again here, I'm just emphasizing the context for writing this up, that sometimes we have, you know, silos as how we write them up and there are, in fact, cross connections. So, that's one thing.

The second thing is I really would recommend to everyone to read the article that I'm discussing in the New England Journal, because to me, it's a seminal article. It shows for the first time, I think, that, in fact, with proper and early management, you can get the same results in terms of the management of hypertension in African Americans

that you can get in other populations.

DR. MILLER: Can I just say a couple things about all of that. One thing is, is John, is that the same article that we were talking about, the within and between hospital --

MR. RICHARDSON: [Off microphone.] No.

DR. MILLER: Okay. So, there may be another article to bring to bear to this. That's all I'm going to say. I don't need to -- I was just making some connections in my mind. The other thing -- and, so, we'll get that into the discussion, and there may be actually another one, because there was another article about --

MR. HACKBARTH: Disparities.

DR. MILLER: -- closing the disparities, as well, and so I'll put those in kind of the same thing and we'll get that in there.

The other take-away I take from this is -- and I think there was agreement in this, but just to put a pin in it, I think Nancy and all of us understand that the ESRD ACO concept is really -- if there are opportunities there, it's not the ones that you guys have in your current conversation. It's really about avoiding hospitalizations,

that type of thing that we have a lot of fallout from, from the people who are currently on ESRD.

I think these conversations probably run in some other directions, and I'm going to get myself into trouble, but I'll get it all straightened out in the chapter. There are some other codes, complex condition management codes, that are more broad than just for kidney service, or kidney care, that have been introduced into the fee schedule that may have something to do with it, because you were asking, are there codes that deal with.

Then there's Kathy's concept earlier today of, like, well, shouldn't we be thinking of primary care as a bundle with the notion of sort of approaching the payment system differently and how practitioners go at those patients.

And then, finally, there is the ACO concept, which is not ESRD ACO, but, again, they should have the incentive to manage along the lines that you're talking about. And, of course, we've said as part of that, maybe there should be some forgiveness for primary care visits precisely to get the beneficiary to have their first connection with their primary care provider and establish that relationship, which

are not answers, but those are all the oars in the water I see around this issue.

And, to your narrow point, we'll try and get some of this into the text in the right places, in the physician chapter and in this ESRD chapter.

MR. HACKBARTH: Since we're reviewing connections, remind me where we stand on ESRD patients choosing to enroll in Medicare Advantage plans. There was a point in time, as I recall, where if you had ESRD before enrollment, you couldn't subsequently enroll in MA, although if you came down with ESRD, having already been enrolled, you were allowed to stay. Is that still the law?

MR. ZARABOZO: [Off microphone.] It's still the case.

MR. HACKBARTH: Okay.

MR. ZARABOZO: [Off microphone.]

MR. HACKBARTH: Yeah, with the exception of special needs, yeah.

MS. RAY: Right. CMS does -- it's my understanding, fee-for-dialysis beneficiaries cannot enroll in the MA plan, but transplant patients can, for the purposes of Medicare Advantage.

DR. MILLER: I also didn't anticipate where you were going to go, which is we have a recommendation --

MS. RAY: And, we do have a recommendation, yes. Yes.

MR. HACKBARTH: Okay. We are still on round two. Anybody else want to jump in and go in a different direction?

[No response.]

MR. HACKBARTH: Seeing nobody, we will then move to round three, and, let's see, we'll start with Jack this time.

DR. HOADLEY: [Off microphone.] And, so, are -- this is the recommendation?

MR. HACKBARTH: Yeah.

DR. HOADLEY: So, yeah, I think the recommendation here makes a lot of sense. Yeah. I'm for it.

DR. COOMBS: I support the recommendations.

MR. THOMAS: I support the recommendations.

DR. BAICKER: I support them.

MR. KUHN: I support the recommendation.

DR. HALL: Support.

DR. SAMITT: Support the recommendation.

MS. BUTO: I support it, also.

MR. GRADISON: I support the recommendation.

DR. REDBERG: I support the recommendations.

DR. CROSSON: I support the recommendation.

DR. NAYLOR: As do I.

MR. ARMSTRONG: Me, too.

DR. CHRISTIANSON: [Off microphone.] I, too, support the recommendation.

MR. HACKBARTH: Thank you, Nancy.

Next, we are discussing hospice services.

MS. NEUMAN: In 2013, more than 1.3 million Medicare beneficiaries used hospice, including more than 47 percent of beneficiaries decedents. Over 3,900 hospice providers furnished care to Medicare beneficiaries, and Medicare paid those providers about $15 billion.

Before we go through our indicators of hospice payment adequacy, I have a couple slides with background on hospice and the Commission's prior recommendations.

The hospice benefit provides palliative and supportive services for beneficiaries who choose to enroll. To be eligible, a beneficiary must have a life expectancy of six months or less if the disease runs its normal course.

At the start of each hospice benefit period, a physician must certify that the beneficiary's life expectancy meets this criteria. There is no limit on how long a beneficiary can be in hospice as long as he or she continues to be meet this life expectancy criteria.

A second requirement of the hospice benefit is that the beneficiary agrees to forgo conventional care for the terminal condition and related conditions.

While the hospice benefit does not permit concurrent hospice and conventional care, it is important to note that CMS is launching a demonstration to test a new model of concurrent palliative care and conventional care, and I can discuss that on question.

This next slide reviews the Commission's work that led to recommendations in March 2009. We plan to reprint some of those recommendations in this year's March report, so I will review this briefly.

In 2009, Commission's analyses uncovered several 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 non-profit hospices across

all diagnoses. And this pattern of events suggested that there were new actors entering the hospice field with revenue generation strategies.

So that led us to look at the payment system, and we found that it doesn't align well with hospice's provision of care. Medicare generally makes a flat payment per day for hospice, while hospices typically provide more services at the beginning of an episode and at the end of the episode near the time of the patient's death and fewer visits in the middle. 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 that suggested the hospice benefit needed stronger oversight. We had information from a panel of hospice physicians and administrators who gave reports of lax admission practices and recertification practices at some hospices, and the panelists expressed concern about questionable financial arrangements between some hospices and some nursing homes as well as aggressive marketing of hospice toward nursing home patients by some hospice providers.

To address these issues, the Commission

recommended in March 2009 to reform the hospice payment system, improve accountability of the hospice benefit, and increase data reporting. I will highlight two of these recommendations where action has yet to be taken. We plan reprint the two recommendations in the March report.

First is payment reform. The Commission recommended the payment system be changed to a U-shaped payment model with the payment rate higher at the beginning of the episode and higher at the end of the episode near the time of death and lower in the middle. Subsequent to this recommendation, Congress gave CMS the authority to revise the hospice payment system in 2014 or later in a budget-neutral manner, as the Secretary determines appropriate. CMS has been conducting research on payment reform but to date has not made changes to the payment system.

The other recommendation relates to accountability. The Commission made several recommendations to increase accountability, and most have been implemented. But one has not, and that's the recommendation for medical review focused of hospice providers with an unusually high share of long-stay patients.

PPACA included a provision for hospice-focused

medical review, but there were some technical issues with the statutory language. Those technical issues were resolved in the recently enacted IMPACT Act of 2014. So we plan to reprint the recommendation that focused medical review be implemented.

So this brings us to our payment adequacy analysis. Like the other sectors, we use the standard framework to assess payment adequacy.

First, we have a chart showing growth in the number of hospice 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 2013, the number of hospice providers grew more than 5 percent. Looking at the other lines in the chart, which show the number of providers by type of ownership, we see that growth in provider supply is being driven almost entirely by growth in for-profits. The number of non-profits and government providers have been on a slight downward trend.

The next chart shows the growth in hospice use among Medicare decedents. Between 2012 and 2013, the share of Medicare decedents who used hospice increased from 46.7

percent to 47.3 percent. The hospice use rate among decedents in 2013 was more than double the rate in 2000.

Hospice use has grown most rapidly for beneficiaries age 85 and older. As of 2013, 55 percent of these beneficiaries used hospice at the end of life. Minorities and beneficiaries in rural areas continue to have lower hospice use than other beneficiaries, although hospice use has been increasing for these groups as well.

The next chart gives us a further picture of utilization. The number of hospice users grew to more than 1.3 million beneficiaries in 2013, about a 3 percent increase from the prior year.

Length of stay changed little in 2013. Average length of stay among decedents held steady at about 88 days in 2013, following a period of substantial growth between 2000 and 2012. Median length of stay was 17 days in 2013 and has been stable at 17 or 18 days since 2000.

Underlying these data is a very wide distribution in length of stay. About one-quarter of hospice decedents have stays of 5 days or less, and about 10 percent of decedents have hospice stays that exceed 246 days.

As we've talked about before, both very short

stays and very long stays are a concern. With very short stays, there's concern that the patient doesn't get the full benefit that hospice has to offer. And with very long stays, particularly when they make up an unusually large share of a particular provider's caseload, there is concern that providers may be seeking patients with long stays who may not meet the eligibility criteria.

So, 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 non-profits in 2013, 105 days versus 68 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. U-shaped payment reform, like the Commission has recommended, would lessen the variation in financial performance across

providers.

Next, we have quality. We currently lack publicly reported data on hospice quality.

Per PPACA, hospices began reporting quality measures in 2013 and face a 2-percentage-point reduction in their update for the subsequent fiscal year if they do not report data.

Initially, two quality measures were adopted. Those measures have been discontinued, and in their place, as of July 2014, hospices are required to submit quality data for seven process measures through a standardized instrument. For example, process measures include things like screening and assessment for pain, and assessment and treatment of shortness of breath.

In 2015, hospices will also be required to participate in a hospice CAHPS Experience of Care survey. The survey will be sent to the family members of deceased hospice patients. Public reporting of data from these initiatives is not expected before 2017.

Also, as discussed in your mailing materials, there may also be opportunities to develop quality measures with claims data, and I can discuss that more on question.

So 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 increased over 9 percent in 2013, suggesting that capital is readily accessible to these providers. We also see for-profit chains and private equality firms engaged in acquisition of hospice providers.

We have less information on access to capital for non-profit freestanding providers whose access may be more limited.

Provider-based hospices have access to capital through their parent providers, and as we will discuss in the other sessions today, home health agencies and hospitals appear to have adequate access to capital.

So this brings us to Medicare margins. Different from other sectors, our margin data goes through 2012 because 2013 margin data are incomplete. Because the sequester was not implemented until 2013, it's not reflected in the margin figures on this chart.

So, for 2012, we estimate the aggregate Medicare margin for hospice providers was 10.1 percent, up from 8.8

percent in 2011.

A note about how we calculate margins. Like previous years, our margin estimates exclude non-reimbursable costs, so they exclude non-reimbursable bereavement and volunteer costs.

Next, we have margins by category of hospice provider.

As we've seen in prior years, freestanding hospices have strong margins, about 13 percent in 2012. Home health-based and hospital-based hospices have lower margins, and this is partly because these types of hospices report higher indirect costs; that is, overhead costs associated with things like management and administration, capital, billing, and accounting.

Due to the structure of the cost report, there is likely some over-allocation of overhead from the hospital or home health agency to the hospice provider. If hospital-based and home health-based hospices had the same level of overhead as freestanding hospices, their margins would be substantially higher.

The chart also shows margins by type of ownership. For-profit hospices have margins of about 15 percent. The

overall margin for non-profits is lower, 3.7 percent, but when we look just at freestanding providers, the non-profit margin is 7.7 percent.

Also, note that urban hospitals do have higher margins than rural hospices, but the difference is not that large.

These next two charts show a phenomenon we have seen before. On the left, we see that hospice margins increase as average length of stay increases. For example, if we break hospices into quintiles by the average length of stay of their patients, the hospices in the quintile with the shortest stays had a margin of negative 6.56 percent, and the hospices in the second highest length-of-stay quintile had a margin of roughly 18 percent.

In the right chart, we look at how margins vary by the percentage of a hospice patients in nursing facilities. The margin ranges from 3 percent for the 25 percent of hospices with the smallest share of nursing facility patients to margins of about 17 percent for the 25 percent of hospices with the most nursing facility patients.

And the reasons we are looking at the nursing facility patients is, as mentioned earlier, the nursing

facility is a setting where there have been anecdotal reports of aggressive marketing practices, and hospices may find there to be advantages to the nursing home setting, including access to patients that have conditions associated with longer stays, potential economies of scale from treating patients in a centralized location, and overlap in services provided by the hospice and the nursing home. So, to summarize, longer stays, higher margins; more patients in nursing facilities, higher margin.

So next, we have our 2015 margin projection. To make this projection, we start with the 2012 margin, and we take into account the market basket updates, including productivity adjustments and additional legislated adjustments that occur between 2013 and 2015. In addition, we taken into account the effect of the sequester starting in April 2013. We also take into account the phase-out of the wage index budget neutrality adjustment and other wage index changes. In addition, we make assumptions about cost growth. We assume a higher than historical rate of cost growth in 2014 and 2015 because we anticipate that hospices may face additional administrative costs related to new claims data reporting, new quality initiatives, and revised

cost reports.

Putting that all together, we project a margin of 6.6 percent in 2015. This includes the effect of the sequester. If the sequester was not in effect, the margin would be about 2 percentage points higher.

Finally, one policy of note for 2016 is that the phase-out of the wage index budget neutrality adjustment will reduce payments by an additional 0.6 percentage points in 2015.

To summarize, indicators of access to care are favorable. The supply of providers continues to grow, due to entry of for-profits. The number of hospice users increased, and average length of stay was stable. Quality data are unavailable. Access to capital appears adequate. The 2012 margin is 10.1 percent, and the projected 2015 margin is 6.6 percent.

So that brings us to the Chairman's draft recommendation. It reads: The Congress should eliminate the update to the hospice payment rates for fiscal year 2016. This would decrease spending relative to current law. Given the margin in the industry and our other payment adequacy indicators, we anticipate that providers could

cover cost increases in 2016 without an update to their payments. Therefore, the draft recommendation is not expected to have an adverse impact on beneficiaries' access to care nor providers' willingness or ability to care for Medicare beneficiaries.

So that concludes the presentation.

MR. HACKBARTH: Thank you, Kim.

Round 1 clarifying questions. I have Kate and then Herb. We'll go around this way. Kate?

DR. BAICKER: Thanks. There was a lot of interesting information. One of the charts suggested that longer length of stay equals higher margins, as you highlighted, and one suggested that certain illnesses have longer lengths of stay, and there was the implication, which you sort of mentioned indirectly that, therefore, certain disease categories have higher margins, operating through this U-shaped cost over length of stay.

But what I wasn't sure about is whether that third step is a logical conclusion or if the correlations among these three mean that in fact some diseases are very expensive, so even if they have longer lengths of stay, they have lower margins. Does it necessarily follow that we

think that with the current shape of payment versus shape of cost, selecting on diseases lets you get higher margins, or is that not a logical conclusion?

I didn't say that very clearly. If you can answer, more power to you.

[Laughter.]

MS. NEUMAN: So I think that the length-of-stay distribution by disease shows that some diseases have a higher preponderance of very long stays, and very long stays tend to be quite profitable. So I think that there is opportunity to focus on a particular type of patient, to develop a particular line of service, cater to a kind of disease that could lead you to a more profitable business model.

That said, there may be certain diseases where you could have a long stay, but you need really expensive drugs, you know, that kind of thing. That's not probably the norm, but there are probably cases like that.

DR. MILLER: Just a couple of other things. Also, the length of stay by disease -- and we have shown this in other settings. You've probably got this, but just in case anybody else didn't, those lengths of stay even by disease

vary differentially between for-profit and not-for-profit, suggesting that even for a given disease, the length of stay --

DR. BAICKER: Right. So it's the multivariate progression. It's more telling than the multiple bivariate regressions. That's what you meant.

DR. MILLER: Didn't I just say that?

[Laughter.]

DR. MILLER: I thought those very words --

MR. KUHN: So, Kim, in previous years, you had shared with us a growth we were seeing in terms of live discharges from hospice. I didn't see that information in this, the material we received in advance. Is that number stable, or what's going on in that area right now?

MS. NEUMAN: So what we have seen in the past is that about in the neighborhood of 17 or 18 percent of discharges tend to be live discharges, and we have seen a big rate for above-cap hospices and around that rate for below cap. And that rate has been, in the last few years, relatively stable, and we can put some information on that into the next round of materials.

MR. KUHN: Yeah. And it's also helpful to know

what kind of facilities were seeing those, so those above the cap is there that is. And also, if we could see where they might be geographically located as well, that they're concentrated in certain parts of the country.

MR. HACKBARTH: Okay. Other clarifying questions? Craig, and then it looks like Bill and Rita.

DR. SAMITT: Very similar to the questions about extended length of stay. Have we looked at the very short lengths of stay to see if there is anything in common in those cases? Are these diagnoses with a rapid decline, or is this just insufficient and too late of a referral process to hospice?

MS. NEUMAN: So there's a chart in your materials that has, by disease, the distribution of length of stay, and you can see within every disease category that we have that the 10th percentile and 25th percentile of length of stay is about the same, you know, two days, five days, in that range. And so it seems like across diseases, we have a pretty similar chunk of the population that continues to be referred very close the end, and it's hard for me to say which factor is leading to that. It is clearly a combination of the things that you have said, and it's hard

to say beyond that.

MR. GRADISON: I'm confused or maybe have just simply forgotten. If an MA plan is permitted to offer hospice services, how does the reimbursement work out?

DR. MILLER: Well, you know this too. So, right now, hospice is not part of the MA benefits. So when a beneficiary --

MR. GRADISON: Exactly.

DR. MILLER: -- opts for hospice, that there is a reduction in the payment rate for the MA plan, and the beneficiary essentially rolls over into the fee-for-service environment.

We made a recommendation last year to reverse that -- I mean to let hospice offer this as a continuous benefit and adjust the payment rate for -- sorry -- managed care plans offer hospice as part of their continuous benefit and to adjust the payment accordingly.

MR. GRADISON: Okay. What do you mean accordingly? It goes up?

DR. MILLER: Yeah, because --

MR. GRADISON: And how much? What's it based on? What's the principle?

DR. MILLER: It would be based on like current rates for managed care plans. You would look at the fee-for-service environment. You would build that into the base rate and then adjust on the basis of risk, what that individual payment is to a plan, based on the beneficiary's risk profile, which would also take into account --

MR. GRADISON: The hospice benefit.

DR. MILLER: -- services in calculating it.

MR. GRADISON: And if an MA plan does that, can they, if they wish, continue to provide therapeutic benefits as well as the regular hospital benefits at their discretion?

DR. MILLER: Just to be clear, we are still talking to each other. That's not what goes on now under our --

MR. GRADISON: I understand that. Under our proposal. That's what I'm trying to understand, our proposal.

DR. MILLER: I think our proposal would allow them the flexibility.

MR. GRADISON: Okay. Thank you.

DR. MILLER: Unless I'm missing something. I need

a nod from -- I got it.

DR. REDBERG: Thanks, Kim.

Bill, did you want to comment?

DR. HALL: No, go ahead.

DR. REDBERG: Okay. I think you referred early on that there was a new model and we could ask you about it, and that's what I would like to do.

MS. NEUMAN: Okay. So the CMMI is launching a demonstration called the Medicare Care Choice Model, and it is for hospice-eligible patients who have not enrolled in hospice, and the idea is that the hospice would provide some support of palliative care services, not the full hospice benefit, but they would provide some support of palliative care services, share decision-making care coordination, and home visits and some of the same things they provide in hospice.

But the point would be their community physician who is in charge of their conventional care would be leading the care, and the hospice would be doing this in a supportive manner. CMS is trying to enroll at least 30 providers and 30,000 beneficiaries over a three-year period, and it has yet to sort of identify those providers or

launch, but it's in the works.

MR. HACKBARTH: Okay. I have got Mary, Scott, Bill Hall, Jack, and John.

DR. NAYLOR: So I am wondering if you might just give us some highlights of how the recommendations around hospice from MedPAC align with the new IOM findings around directions for end-of-life care. Can you --

MS. NEUMAN: Well, I think that the idea that we're trying to get the payment system to be neutral and sort of let care be directed based on the patient's need and not sort of influenced by financial incentives and so forth is consistent with the spirit of trying to meet patients' needs.

I think that some of the things that we have in our report, looking at potential hospice quality measures from the claims data and so forth and trying to get at better information for beneficiaries about what kinds of care, what kinds of option they have, and that transparency and so forth, that also sort of is in that spirit.

A lot of what we have in our report today has been about getting the payment system right and making the benefit more accountable, and so it is kind of a little bit

of a different lens from the IOM.

DR. HOADLEY: This is a Round 1 question. On Slide 14, you pointed out the margin difference between the for-profit and the not-for-profit, and then you had earlier talked about the length-of-stay relationships. The recommendations we made back in '09, do you have a sense of how much that would narrow, if it would narrow the gap in margins between for-profit and not-for-profit?

MS. NEUMAN: So in our June 2013 report, we did a hypothetical payment system, and we tried to show what the revenue impacts would be, and it did show that money would move from for-profits to non-profits.

I can't tell you offhand the specific amount that the gap would close, but the message was that it would close some, but by no means all, and that it was sort of a moderate -- modest to moderate effect, I would say.

DR. HOADLEY: Okay. That's helpful.

And then in the recommendation, you didn't actually lay out what the statutory update is projected to be. So where do we stand on that?

MS. NEUMAN: So the statutory update is that there's a little funny piece to it. There is the market

basket minus productivity and then this additional potential .3 percent, and that's been effective for the last few years. So assuming that occurs again, it will be 2.1 percent.

DR. HOADLEY: Okay. So, in this case, a zero update, even if the sequester were filled in, we're actually a little bit lower or very close to where it is with the sequester, just to sort of calibrate that.

MR. HACKBARTH: I just want to pick up on Jack's question about the difference between for-profit and not-for-profit margins. There are different potential reasons why you might see a difference. One might be if they're systematically treating different types of patients under different levels of profitability in those patient categories, but even if all of the patients are the same, it seems to me -- and I'll call my economist friends here to help me. You might see the difference in for-profit and not-for-profit margins because the difference in the nature of the institutions.

For-profit institutions fundamentally exist to make profits for their shareholders, and so if they can hold their cost below a Medicare payment rate or a private

payment rate, they are motivated to try to take that money and distribute it out the health care system to their shareholders.

Not-for-profit organizations exist to provide health care, so to the extent that they have a positive margin, they may well be motivated to plow it back into the business and enhance their services in ways that tend to increase their costs. So they're motivated by fundamentally different forces, and, therefore, you might expect different bottom lines in the two categories, even if they have exactly the same types of patients and are not, you know, skimming or trying to do anything like that. They're just different.

DR. HOADLEY: And presumably part of this question about we think there's something wrong with the payment system is that it's not all of that. It's some of it. It is some mix.

MR. HACKBARTH: That's right.

DR. HOADLEY: And sort of trying to think about quantifying what mix, and then we can then make a judgment on how does that play into --

MR. HACKBARTH: Right. And I think, you know,

across all the different payment categories, there are differences between for-profits and not-for-profits, and, you know, from time to time I've said I think of for-profits sometimes like the die that is used in imaging studies, because for-profits often respond very aggressively to incentives. They can often help you identify where there are flaws in the payment system. They're, you know, playing by the rules of the game, but their behavior signals profit opportunities. And so it's useful to track where they tend to go.

DR. MILLER: And I'm going to say this: I wouldn't have brought it up, but since you came back to it -- and I hate to ask questions when I'm not sure I have some sense of the answer. But I recall the distribution of payment impacts could be fairly substantial. They just didn't necessarily close the margin significantly.

MS. NEUMAN: Right. I have a number in my head, but I don't want to say it. It could be wrong.

DR. MILLER: And I don't like saying stuff out loud when I'm not sure either. You and I should talk and come back to this, because my sense, which won't go on the record because she's not going to write it down, is the

payment adjustments are kind of -- they're big. I mean, you can see them. The people who would receive the dollars would not go, "Oh, this is nominal." It just doesn't close the seven-point gap. That's more, I think, what we're saying. Okay, but we'll come back.

DR. CHRISTIANSON: It's a nice chapter, Kim. A lot of good information. I want to go back to Jack's comment about the sequester and maybe Slide 16, if you could. I'm confused about how we're projecting -- how we're saying the sequester will impact the 2015 projection, and I would have thought on bullet point two there that the sequester would increase the size of the reduction, not reduce it. So I was confused by that. Am I wrong on the effect of the sequester?

MS. NEUMAN: You know what? The slide should read, "The sequester reduces payments beginning April 2013." So there's an extra word in there that's causing confusion.

DR. CHRISTIANSON: Yeah, reducing payments is what I thought the effect would be.

MS. NEUMAN: Exactly.

DR. CHRISTIANSON: Okay. Good.

MR. HACKBARTH: Round 2 comments? We'll start

with Scott and go down the row.

MR. ARMSTRONG: I, too, would just start by saying I think a really interesting topic and a great chapter handling a lot of information.

Generally speaking, I support the recommendations. Just a question. It's good to see the increase in the use of the hospice program, but $15 billion out of $600 billion still seems like a relatively small percentage of the total spend, particularly given what we know about how intense the consumption of resources is for people at the end of life, generally speaking.

And so I just wonder if we have done any analysis around -- I hate to say this, but like the return on our investment in expanding the hospice program. And it seems to me that the Medicare program could benefit overall if we doubled our spend on hospice appropriately. Frankly, I'd have a greater tolerance for double-digit margins for some of the providers if, in fact, I knew the Medicare program was getting that kind of return.

So in there is a question, and I think it really is have we tried to get a feel for some return or the implication of more people getting the hospice benefit who

otherwise would not have for the Medicare program overall?

MR. HACKBARTH: I was going to say a couple things. One, on the issue of what is the impact of hospice use on Medicare costs for curative therapeutic services, and there has been research on that. And, Kim, correct me if I've got this wrong, but my recollection is that we think the evidence is that for -- I don't want to use the term "short hospice stays," but ones that are not very long, use of hospice probably results in a reduction in Medicare costs for therapeutic services. However, when the hospice days are very long, then that may no longer be the case, and it may not reduce costs. It may increase costs. Did I get that right? So that's just sort of the state of the evidence.

The second point I'd make is that, of course, election of hospice is an individual patient choice and a very important individual patient choice, and I know you're not proposing this, but you don't want to squeeze out that element of individual choice. And so that's going to be something that you have to build your approach around.

The third point I'd make is that, you know, I do think that models like incorporating hospice within MA where

it can be integrated with the therapeutic care and potentially in the structure where patients don't have to make this choice, "Oh, am I going to give up therapeutic care in exchange for hospice?" that might be the best structure in which to have innovation that both improves patient satisfaction, gives them the outcomes they want, while efficiently using resources. So I'll stop there.

MR. ARMSTRONG: I just would add that my organization and I have been a strong advocate for folding the hospice benefit into the MA structure for the very reason that you just described. But it strikes me that -- and I know particularly around issues like this, patients need to be in control of these choices, but if there are ways in which through payment policy to providers or maybe even benefit design itself we could encourage a greater utilization of the hospice benefit so it's not just better for individuals but it's better for the Medicare program overall.

DR. REDBERG: And just related to that, because I was also thinking about, you know, when you were presenting the data on the percentiles and how a lot of people seem to be getting into hospice too late to enjoy the benefits of

the supportive care and the comfort at the end of life for hospice care, so certainly it has to be an individual choice. But I think there are a lot of data that a lot of patients don't make that choice because it was never offered to them. And so I think more programs that encourage physicians, like in my own specialty, congestive heart failure, where it's often, you know, a very end stage disease, we know that hospice care is really underutilized, it's thought of a little more in oncology. And I think there has been renewed discussion now about the kind of end-of-life planning discussions with primary care, because I think that could help promote more patients at least knowing what their choices are and then deciding if they do want to elect hospice care or not, because certainly I think more patients would choose, if they knew what the benefit was.

And then there's also this unfortunate distorted perception that hospice care means you're shut away and nobody cares about you anymore and you're just left to die, which, of course, we know is not true. And, in fact, I think some people are in there longer because they actually start doing better once you take away some medicines and do more supportive care.

MR. HACKBARTH: So let me see hands of people who want to build on Scott's point. Were you among -- no cheating.

DR. CROSSON: I'll wait.

MR. HACKBARTH: Kathy is a definite yes, and Mary is a definite yes on that. Okay, and Jack and Bill.

MS. BUTO: I was going to build on both Scott's and Rita's point. I think that something to look at in terms of increasing use of appropriate hospice care would be to look at those conditions where we think there's underutilization. It would be good to have -- I don't know how we analyze those data, but it's pretty clear that hospice care is not cost-effective if it is sort of a per diem payment for services that substitute for nothing that would not have been spent during that time because the individual really wasn't an appropriate candidate.

So rather than a blanket approach to looking at increasing hospice utilization, I think if we could identify some of those underutilized conditions where, whether it's education or something else, more outreach would actually help, that might be a great service.

MR. HACKBARTH: And there are the anecdotes

recently of disturbing cases where patients even in the final days of their life don't seem to be getting service from their hospice, which clearly is not a value-add sort of situation.

DR. NAYLOR: I want to align with Scott's and Rita's comments as we think about Medicare's investment in hospice going forward, 1.3 million, given Glenn's comments about choice and alignment with preferences and goals and values, but, you know, are we doing enough to maximize the use of this service given what we know from science, evidence, could be the return for people who make that choice, and especially in the last couple months of life?

I think there's some very good news in this report, I mean, meaning we're seeing increased number of decedents in the six months of time, and I think this reflects lots of things, like advances in understanding who's going to benefit most directly, and certainly seeing it across age groups that I think are really important, seeing some increases in racial and ethnic minorities but not enough.

So I think that, you know, I really do think -- support the recommendations but think this is, again, an

area that really we could delve into a little bit more to see why median lengths of stay are so low, why 10 percent have an average length of stay in hospice of two days or three days. This is something I think we really want to figure out as a program how we can target and get more people understanding the possibilities and making choices that align with their goals.

MR. HACKBARTH: Okay. So we're still following up on Scott's initial observations.

DR. HOADLEY: So this may not add a lot to what has been said, but it does seem like just even quantitatively you show on one of the slide 47 percent of decedents today using hospice, and obviously it never is going to be a hundred and shouldn't be a hundred between personal choice and just circumstances that people who die in sudden circumstances. But maybe there's studies out there or some sense of is there an optimal level, and also beginning to get us to the sense of where are the opportunities. Same thing with the short stays. I mean, again, some of them are -- it's just the pattern that life takes, and they sign up, and it's a short path to their deaths. But in other cases, they should have signed up

earlier, and I wonder if there's either literature or kind of analytic ways to look at those things and get some sense of what the size of the opportunity might be and, therefore, what steps and what investment in counseling and shared decisionmaking and other kinds of things that we kind of have a sense that would help.

The other one I was wondering about was the share inside Medicare Advantage plans, you know, does the fact that they have to sort of leave their MA plan mean that people are actually less likely to use hospice, or are they equally likely, they just have to go through this more complicated process? And I don't know if the data are set up in any way that we know the answer to that.

MS. NEUMAN: Yeah, the Medicare Advantage beneficiaries are more likely to use hospice, about five percentage points.

DR. HOADLEY: Okay. So it doesn't seem to be that it's deterring them from using it. It's just not taking advantage of some of the opportunities to potentially --

MR. HACKBARTH: Without that, it could even be higher.

DR. HOADLEY: Sure.

MR. HACKBARTH: You don't know what -- in fact, let me ask Scott. So you've spoken several times in various meetings about the importance of this. We know from prior conversations that your organization has invested pretty significant in shared decisionmaking. Do you know what percentage of your Medicare beneficiaries who die elect hospice?

MR. ARMSTRONG: Not off the top of my head. But--

MR. HACKBARTH: That's your assignment for the next meeting.

MR. ARMSTRONG: I don't want to publicly announce a number I don't actually know, but --

MR. HACKBARTH: Yeah.

MR. ARMSTRONG: I would just add, though, that we're in a unique circumstance being both an MA plan and actually the care provider of hospice as well as of the other services. So as much as anything, it's pretty continuous, but it's just a lot of administrative stuff that we have to handle.

MR. HACKBARTH: Yeah.

MR. ARMSTRONG: But I can find out what those percentages are.

MR. HACKBARTH: I don't mean to single out just you, but I'm trying to get a sense of what sort of an optimal rate might look like in an organization that is, A, committed to shared decisionmaking and educating patients about their options and also has the integrated delivery system structure and financial incentives. And that might give us sort of an idea what the target rate might be.

DR. HALL: So I just wanted to compliment you on this chapter. I think this is one of the most concise and informative things that I've read on this whole area of the development of hospice. It's really good. And particularly the last part of the chapter where you talked about the thoughts about quality assurance and some of the plans that CMS has throughout.

It sounds like, though, that things are still a little bit vague in the quality field. What was it, by 2017 you'd be using CAHPS scores to try to understand a little bit more about quality. Did I read you right on that? Actually, I'm reading it right here.

[Laughter.]

MS. NEUMAN: 2017 I believe is the target for the process measures that the hospices are reporting.

DR. HALL: Right.

MS. NEUMAN: I don't know if the CAHPS will be publicly reported by 2017 or not.

DR. HALL: All right. So I think that the development of the hospice movement is one of the most important medical advances in the last 50 years. It has in many ways begun to change the whole kind of nature of what we all have to face, and that is, death with dignity and comfort. It started out as kind of a missionary movement, and now has morphed into a more corporate structure, which is sort of the way things go.

I think your chapter points out very well that there are -- even Mother Teresa could maybe take a bribe, that we do need to have some surveillance and worry about fraud and abuse, although it's hard for me to think of people in hospice being guilty of fraud and abuse, but I guess there are some examples.

But I think as we move into quality, we're seeing the same pattern that's developed in many other areas. So we had two quality measures; now we have seven. These are mostly process measures. So everyone says, well, let's look at outcomes. Well, the outcome is always the same, isn't

it? You die. I mean, it's very different than other outcomes that we look at in anything we do.

And Scott has mentioned that we should be putting more resources into this program, and I couldn't agree more. But I think the contribution that maybe we can make at MedPAC here is to really ask some of the important questions about quality and what we're really trying to achieve. And I think that paradoxically Medicare Advantage may turn out to be the vehicle where these changes most easily can be made.

For example, if you take an older person who is in a nursing home and has a hip fracture, unequivocally, no matter what you do, that patient will probably be dead in a year -- 85, 90 percent sure. So they should have nothing done, right? They should be on hospice. Well, the point is that sometimes the only way you can really achieve comfort in that person is to actually fix the hip. You know they're never going to walk, they're never going to be doing anything else. But in many -- and there are a couple other examples. When people have an occlusion of a large artery in their leg, for example, which is relatively common, that has to be fixed not because the outcome is going to be that

they're going to be transformed into a 30-year-old again.

So it's getting very complex, but for us to really push this along, we really have to take a very hard and careful look at how we measure, and does the measurement not just conform to what we think works in other areas of medicine, but I think there's an opportunity here to really further develop the hospice movement. And I think MedPAC is exactly the right organization to take that on.

MR. HACKBARTH: So anybody else who's still building on Scott or -- I think maybe we're sort of going off in a different direction, so I'll go to Jay, who's flapping in the breeze, and then Craig.

DR. CROSSON: Yeah, I didn't want to have a buzzer go off. I will connect this a little bit to the prior discussion, because it seems to me that, you know, in the future, in order to, let's say, increase Medicare investment in hospice, given the fact that it's not clear whether in its current form, as it's evolving, the industry is evolving, it actually saves money or costs money; that in order to get, you know, more investment, more focus, as some folks have said -- and I agree with that -- getting back to kind of the original purpose of hospice might be an

important part of the evolution. And to the extent that the payment system can be used to do that, then I think that would be a good thing to be done.

But it raises to me then this fundamental process question, which is why I didn't raise it earlier. In terms of the recommendations, as we've gone through the day, in some cases and in some of the silos, we have added to the simple update recommendation previous recommendations that have a strong impact, perhaps even stronger impact than the nature of the number that we put up there. And it just seems to me in this case -- I'm not arguing for purity here, but it just seems to me in this case that, in addition to just calling for a zero update, would we not want to reiterate the fundamental recommendation -- a couple of fundamental recommendations, at least one, that there's something very wrong about the U-shaped profitability situation we've got, and particularly the broadening of the bottom of that U, which seems to be -- and that unless that's fixed, we may see the hospice benefit moving in a direction that it shouldn't be in, which would then preclude, you know, further investments.

And so it's just a question of when during the

year or in which update recommendations are not we choose to emphasize certain additional recommendations.

MR. HACKBARTH: So a mechanism that we have used to do that in what we refer to as "text boxes," where sometimes we will have, you know, a shaded box where we repeat a prior recommendation and the rationale for it. And I can't remember, Kim, if in this draft of the chapter -- I thought we did have a text box --

MS. NEUMAN: Yeah.

MR. HACKBARTH: -- on the U-shaped payment system and the rationale for that.

MS. NEUMAN: Right.

DR. CROSSON: Right, I mean, I understand that in terms of, as we often say, what's in the bold-faced recommendation versus what's in the text, and in the text box --

MR. HACKBARTH: Well, this is not just in the text. We try to make it stand out and --

DR. CROSSON: Okay. So maybe I'm getting purist, but in other areas, as we had earlier today, we repeated as a formal recommendation -- we intend to, anyway -- things that have been repeated before. Or am I missing something?

MR. HACKBARTH: Yeah. You know, I think we're almost splitting hairs here. So, we're talking about two different ways that recommendations are repeated. One, where the so-called packages include elements that relate to the current year update --

DR. CROSSON: [Off microphone.] Right.

MR. HACKBARTH: -- which is sort of the question at hand. And, then, we sometimes include in chapters references to other prior recommendations, often using this text box mechanism that says, you know, this is real -- we want to again reiterate, reemphasize that we think this is an important recommendation and here's the rationale for it. Then, there are still other prior recommendations that we very well believe in still, that we don't repeat them at all in the chapter. So, there are different levels. But, I think of the text box mechanism as a way, not necessarily the only way, but a way to accomplish what I think you're after.

DR. CROSSON: And, therefore, almost akin to the power of having a formal recommendation that would be voted on.

MR. HACKBARTH: Yeah. We're running it as a text

box to emphasize we still believe this and think it would be a good thing to do.

DR. MILLER: The other thing I might offer here is, you know, I'm thinking also of the Executive Summary, where you get kind of everything that happens in this chapter in one shot. I mean, the other thing we could do is add a single final paragraph that says, "And, we stand by the recommendations we've had in the past. Those are discussed in text box X," just to get a little bit more front-loaded to the reader who flips through and wants to see immediately where we stand.

DR. CROSSON: And, not to get fussy here, but I might even suggest saying something like, "And, if those recommendations were implemented, they could have a much more profound effect on Medicare financing -- on Medicare finances than this simple -- "

DR. SAMITT: So, this is a more unique discussion, I think, as it relates to hospice, because I feel like the discussion about the update is really disconnected from the means by which we strengthen the use of hospice. So, my view is very similar to Scott and Bill's and others, that we're underutilizing hospice and many Medicare beneficiaries

are not partaking of a very important comfort benefit, or even more concerning for me are the shorter-than-appropriate hospice length of stay to suggest that we're offering the benefit too late and the beneficiary wants it, but we haven't delivered it until close to end of life.

And, so, clearly, the margins are sufficient to support the viability and the strength of hospice. I would say that the dollars and the update should be used instead to encourage appropriate education and referral to hospice. So, the way that I think of it is should we be, as we think about quality incentives for providers, physicians and others, would we look at incenting referrals to hospice in an appropriate length of time -- I'd hate to think of it like a readmission penalty, but, in essence, when we're referring within five days of end of life, it's referring too late. So, would we ever think about an incentive to say, when we refer to hospice from the provider community, we should be referring sooner, and those who refer with an appropriate length of time in advance of end of life, they would be rewarded for those referral patterns.

So, just a thought. It's disconnected from the issue update, but I think perhaps incentives should be

directed elsewhere as a means of strengthening the hospice program.

MR. HACKBARTH: Are you concerned, Craig, that if the incentive is on the provider and they're rewarded or penalized, that some people might fear that means that the provider has a financial reason to foist their preferences on a patient that may not want hospice?

DR. SAMITT: Well, I think that's where the distinction between a referral to hospice or not, I would be worried about that perception. What I'm more focused on are these very short length of hospice referrals, that if the patient is going to be referred to hospice, it's a disservice to the beneficiary when it is so late in life. And, maybe there's no way to navigate around the risks of an incentive in this regard. I'm just wondering, how do we get at the imperative for providers to be referring sooner to hospice without it being a dysfunctional incentive.

MR. HACKBARTH: Yeah. A late referral could be a function of either the clinician's behavior or the patient's reluctance to let go. You know, one of the reasons I'm intrigued by the notion of not requiring that the patient abandon curative care is that, in fact, it may result in

earlier referrals because patients feel like, oh, I don't have to give up in order to get hospice services. And, it may accomplish the result you're seeking without raising the specter that providers are forcing patients into hospice.

Kathy.

MS. BUTO: I would just second that. I mean, Craig, that felt like a bounty system to me when you were describing it. I know that's not what you were intending, but I was wondering if, as we look at a U-shaped reimbursement mechanism, some of that incentive could be built into that mechanism. Although that's not the referring physician, some other way of getting a provider to want to reach out quicker than they might be otherwise. But, I'd be nervous about what I think of as more of a bounty system.

DR. REDBERG: So, just briefly, this goes back to the question I asked during clarifying, which wasn't clarifying, but anyway, that others have given this a great deal of thought and in part of the IOM recommendations and in many reports speak to just making sure that we let people know their choices. And, I think that that's a different approach than referrals and so on. So, we've talked about

this many times in other discussions around palliation and palliative and end-of-life care and the opportunities for combination, but -- so, I think there are ways to frame trying to get -- to be assured that people know what is available, what is accessible to them without pushing and the notion of referrals.

MR. HACKBARTH: Other hands on this topic. Alice.

DR. COOMBS: Thank you. I was thinking about Scott's question about the uptake, and I think the uptake has multiple lenses and one is the best reason for uptake in hospice is really the hospice programs. And, I think, depending on where you are, the hospice programs may be a Cadillac version or may be really inadequate. I just recently got a call regarding a hospice program where they did a phone call daily and would show up as needed. And, so, it makes a big difference, the quality of the program, in terms of the patient encounter.

I actually think there might be some advantage to a graduated approach in some patients in terms of being able to discuss palliation and then go on to hospice, but I'm not optimistic, and I'm really usually an optimistic person, only when it -- because of the workforce and the training of

individuals that I see that are not even comfortable with talking about DNR status.

And, I will tell you how many people I've seen in the ICU who have advanced stage cancer and I wind up having to do very aggressive measures. No one -- and they have four to five doctors on their team -- no one has even talked to them about resuscitation or intubation. And, I don't -- I see it as that front-end discussion has got to happen. I think it was the Society of Critical Care or ACCP, one of them did a study showing a video, a vignette of a patient on a respirator, just as an information, for FYI. And, when they showed that and the discussion followed subsequent to that for various reasons, patients decided that they didn't want all of the kind of aggressive measures. I think it's couched in a way where they see that and they say, "Well, that's not me, but if I should get to that point..." So, I think, culturally, how we do it is really important.

And, I see it as if someone is bold enough to discuss end-of-life decisions when it comes to DNR, resuscitation, intubation, defibrillation, I think that that is like -- that comes even first, before hospice. If you can get there, then you can get to hospice a whole lot

quicker.

MR. HACKBARTH: Okay. We are down to our last few minutes for round two. Are there any other round two comments on topics that have been raised or any new topic related to hospice?

[No response.]

MR. HACKBARTH: Okay. So, let's go to round three, and, I don't know, whose turn is it to start? Kate looks really eager to start round three.

DR. BAICKER: Are you ready?

MR. HACKBARTH: I'm ready.

[Laughter.]

DR. BAICKER: I support the recommendation.

[Laughter.]

MR. HACKBARTH: [Off microphone.] Warner.

MR. THOMAS: I also support the recommendation, but I agree with Scott that I think we need to continue to look at opportunities for resources to either be looked at, you know, how we can do more counseling and education around hospice, or -- not necessarily -- I mean, I agree with some of Craig's components, but we don't want it to be a bounty system. But, generally, I agree. I just think we need to

look at how we can increase utilization here, because I do think it's an opportunity to have overall savings in the program.

DR. COOMBS: Support.

DR. HOADLEY: I support the recommendation, you know, including the fact that we're reprinting the 2009, and I know the Medicare Advantage recommendation, I think, is going to be in the Medicare Advantage chapter and there seems to be a call-out to it, but that should be. And, then, I think maybe this is a topic where next year, we should be gearing up for having some kind of recommendation on appropriate education, take all the things we've been talking about and give us enough time to think through how to frame that in a useful way.

DR. CHRISTIANSON: I support the recommendation and I also hope that we would continue to work on trying to figure out a better payment system, in general, for hospice.

MR. ARMSTRONG: I support this, too, and I thought some of Jay's comments specifically around how to structure some of these points were really good comments.

DR. NAYLOR: I support this conversation.

DR. CROSSON: Yeah, I support the recommendation,

and again, just to say, I think there's evidence that the benefit is evolving in a way that is moving in an opposite direction from what we would like to see, and I think some continued work and perhaps some real pointed focus in that area might be useful.

DR. REDBERG: I support the recommendations and also increasing incentives for providers to talk to patients about end-of-life care.

MR. GRADISON: [Off microphone.] I support the recommendation.

MS. BUTO: I support the recommendations, but would like to see us take another look at the benefit, because this has been a benefit that has been -- is the subject of fraud and abuse in the past, a lack of clarity and so on, and maybe in light of the IOM report, we can take a look at whether it's really suited to end-of-life care options as they exist today. So, I'd like to see us look at that.

DR. SAMITT: I support the recommendation.

DR. HALL: I support the recommendation.

MR. KUHN: And, I also support the recommendation.

MR. HACKBARTH: [Off microphone.] Thank you, Kim.

Let's see. We now go to skilled nursing facility services.

[Pause.]

MR. HACKBARTH: Whenever you're ready, Carol.

DR. CARTER: Before I get started, I wanted to thank Anna Harty for her help with the chapter.

I'm going to start with an overview of the industry and then present information related to the update, and I am going to end with a summary of the Medicaid trends, which we are now required to report.

There are about 15,000 providers in this setting. About 1.7 beneficiaries or about 4.5 percent of fee-for-service beneficiaries use SNF services. Program spending in 2013 was just under $29 billion, and Medicare makes up about 12 percent of days but 22 percent of revenues.

Here is the framework that we have been using. I will go through the rest of the material quickly, but there is a lot more detail in the chapter.

Access is adequate and stable. Supply was steady between 2012 and 2013. Three-quarters of beneficiaries live in counties with at least 5 SNFs, and the majority live in counties with 10 or more. Occupancy rates were slightly

lower in 2013, compared with 2012, but remained relatively high at 86 percent. However, about one-quarter of SNFs have occupancy rates at or below 72 percent, indicating some capacity.

Between 2012 and '13, covered admissions and days declined, consistent with 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 stay increased slightly.

We continue to see a continued shift in the mix of days. The mix now is reflecting more and more the shortcomings of the SNF PPS. There has been a large increase in the share of days classified into therapy case-mix groups and within those into the most intensive groups. At the same time, the share of medically complex days has declined.

These shifts reflect three features of the current system. First, the amount of therapy, not patient characteristics, drives therapy payments. Second, therapy payments exceed therapy costs, making these services profitable. Third, payments for non-therapy ancillary services, such as drugs, are unrelated to these services'

costs, and I'll say a little bit more about that a little bit later.

Turning to quality measures, the risk-adjusted rates of discharge back to the community and potentially avoidable rehospitalizations show small improvement. The community discharge rate increased slightly, while the readmission rates during SNF stays decreased slightly. The readmission rates during the 30 days after discharge were about the same. These declines are likely to reflect a focus by both hospitals and SNFs to lower their readmission rates.

We use two measures to gauge the functional status of beneficiaries treated in SNFs -- the percent of stays with improvement across three mobility measures and the average share of stays with no declines in mobility. These measures are risk adjusted to account for the functional status of patients at admission and how much improvement they would be expected to make. We saw essentially no change in either. So despite paying for more therapy, we did not see improvement in these measures.

We also continue to see large variation in the risk-adjusted quality measures, and here, I have listed the

25th and 75th percentiles for four measures. The variation ranges from 1.5 times to more than two-fold, indicating large opportunities for improvement, to improve beneficiary care, realize program savings, and increase the value of the program's purchases.

In terms of access to capital, industry analysts report that capital is generally available and expected to continue during 2015. Some lenders are reluctant to lend to nursing homes, but this reflects uncertainties about the federal budget and lower volume in the sector, not the level of Medicare's payments. Medicare continues to be a payer of choice.

In 2013, the average margin for freestanding facilities was 13.1 percent, and that was the 14th year in a row with margins above 10 percent. Across facilities, margins vary almost six-fold. One quarter of SNFs have margins of 3.7 percent or lower, and one-quarter have margins of at least 21.7 percent.

There continue to be large differences between non-profit and for-profit facilities, with non-profits consistently having lower margins than for-profit facilities.

Compared to low-margin SNFs, SNFs in the highest margin quartile had considerably lower cost per day after adjusting for differences in case-mix and wages, and they had higher payments per day, in part reflecting their provision of more intensive therapy.

Hospital-based SNFs, which make up 3 percent of Medicare spending, continue to have very negative margins, negative 70 percent. However, as mentioned this morning, SNF units contribute to the bottom line of hospitals, allowing them to lower their inpatient length of stay. Prior work found that hospitals with SNF had lower inpatient cost per case and higher inpatient Medicare margins than hospitals without SNFs.

To estimate the average 2015 margin, we assumed that costs grow at the market basket between 2013 and 2015. We assumed that revenues will increase at the market basket minus productivity and the sequester, and we accounted for changes in the bad debt policy required by law. Also, in '14, there was a forecast error correction that lowered payments by a half a percentage point. The estimated average Medicare margin for freestanding SNFs in 2015 is 10.5 percent. If the sequester was lifted, the margin would

be about 2 points higher.

Each year, we look at efficient providers using three years of performance to identify SNFs with relatively low cost and high quality. In 2013, over 500 SNFs -- and that was about 7 percent of the almost 7,800 SNFs we included in the analysis -- were relatively efficient. Compared to the average, they had costs that were 7 percent lower, community discharge rates that were 20 percent higher, and rehospitalization rates that were 18 percent lower, yet they still had average Medicare margins of 20.6 percent.

Before we get into the 2016 update, I wanted to remind you of a two-part recommendation made in 2012. For the update year, you recommended that the PPS be revised, with no update. Then, in the second year, payments should be lowered by an initial 4 percent, with subsequent reductions made during a transition until payments are more closely aligned with cost. For those of you who were not here, I want to explain the logic of the recommendation.

With margins so high for so long, the Commission believed that Medicare payments needed to be lowered. However, we knew that the margins varied widely and reflect

systematic shortcomings and biases of the PPS. Most importantly, payments are driven by the amount of therapy furnished, and payments are not targeted to patients with high non-therapy costs, such as drugs.

In a joint paper with researchers at the Urban Institute, we show that over time, payments for both services have gotten more inaccurate, despite the many revisions to the PPS.

The overpayments for therapy services are larger, and current payments for non-therapy ancillary services are unrelated to these services' costs. The Commission believed that before rebasing began, this PPS needed to be revised to correct these systematic problems. The Commission first recommended revising the PPS back in 2008.

Without increasing total spending, the design would shift payments within the industry. We estimated that payments would decrease for SNFs that furnished a lot of intensive therapy and would increase 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 freestanding SNFs to hospital-based facilities and from for-profit to non-profit SNFs;

that is, from the highest margin providers to lower margin providers. And payments to rural SNFs would increase about 4 percent.

The second part of the recommendation stated that payments would be rebased, beginning with a 4 percent reduction. The Commission has reviewed many pieces of evidence that support a reduction.

First, the average Medicare margin for SNFs has been above 10 percent since 2000. Since the payment system was implemented in 1998, the industry has changed its practices, shifting the mix of days and therapy modalities to increase their revenues.

The variation of Medicare margins is related to the amount of therapies furnished and their cost per day. Large cost differences remain after controlling for differences in wages, in case mix, and beneficiary demographics. Our analysis of efficient providers show it is possible to furnish relatively low-cost high-quality care

Finally, we compared fee-for-service payments to MA payments for 5 publicly traded companies and found that fee-for-service payments average 22 percent higher. Our analysis of the differences between all fee-for-service and

MA enrollees in terms of age, risk, and functional status would not explain the differences in payments. In our conversations with MA plans, we have also learned that their enrollees tend to have shorter stays compared to fee-for-service enrollees.

The payment adequacy factors indicate that the SNF landscape has not changed since last year. The Chairman proposes to maintain the previous recommendation, with a discussion of why these changes are still needed. For 2016, this would provide a zero update while the PPS was revised, and in 2017, rebasing would begin with a 4 percent reduction to 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 2013. Between 2010 and '11, which is the most recent two years of data, the number of users increased slightly to 1.6 million. Spending is estimated to be $52 billion in 2014, and that's a 2 percent increase from 2013.

Non-Medicare margins for 2013, the average was negative 1.9 percent, and the total margin was a positive

1.9 percent. Both of these increased from 2012, reflecting in part an improvement in the Medicaid revenues for nursing homes.

The industry posits consistently that facilities lose money on Medicaid, and they need the high payments from Medicare to be viable. Using Medicare payments to subsidize Medicaid is poor policy for a number of reasons.

First, it does not target payments to the facilities that need the most assistance. Second, when Medicare raises or maintain its high rates, it could encourage states to freeze or lower their Medicaid rates. Finally, it diverts Trust Fund dollars to subsidize payments from Medicaid and private payers. If Congress wishes to help nursing homes with high Medicaid payer mix, then a separately financed, targeted program should be established.

And with that, let me put up Chairman's proposal, and I'm glad to answer questions you have and look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Carol. Well done.

Let's do Round 1 clarifying questions, beginning with Herb and then Bill.

MR. KUHN: So, Carol, thank you. This is helpful information.

If we could go to Slide 6 when you talk about the number of admissions decreasing. I'll wait until you bring that back up.

[Pause.]

DR. CARTER: You said slide?

MR. KUHN: Six.

So the decrease of 2.2 percent, you said that obviously correlates with the reduction of admissions in hospitals, but is there a way to even further refine that of how much might be attributable to observation days and the changes of patterns that are going on with hospitals there?

DR. CARTER: I would have to talk with the hospital guys. I have not looked at that, so I don't want to even venture into that territory.

DR. MILLER: And what I'll say is we presented some information, which I'm not going to be able to draw up in detail right now, on how many patients had three days in the hospital but not three days that allowed them to qualify for the SNF, and how many of them were actually referred to the SNF. And it ends up being a relatively -- that second

number ends up being a relatively small number, about 10- or 11,000 is what my recollection is.

I don't have quite the group here to -- oh, all the way in the back. Is that about right, Zach?

MR. GAUMER: Yes.

DR. MILLER: All right. They are supposed to be over here. What the hell is going on?

MR. KUHN: What happened?

[Laughter.]

DR. MILLER: So I wouldn't think that this would have a large impact on this, this number, but we can go back and parse through that. That would be my basic take, but I'll locate Zach and actually have that conversation.

MR. KUHN: Thank you.

And then on Slide 8, when you talk about discharge to the community and the rehospitalizations, are we seeing any geographic variation there, or are there certain parts of the country that are more problematic than others or some that are performing much better or higher level than others?

DR. CARTER: I have that data back on my office --

MR. KUHN: Okay. Thank you.

DR. CARTER: -- and I can shoot that to you, if

you want.

MR. GRADISON: On page 21 of the earlier report, it says that, and I quote, we found almost 600, that is, 7 percent freestanding facilities consistently furnished relatively low-cost higher quality care and had substantial Medicare margins and so forth.

That 7 percent that we identify as meeting our screening criteria working group to relative efficiency compares with 13 percent that we meant -- were brought up earlier today working group to hospitals and 17 percent that we'll be taking up next working group to the report on home health care. Are SNFs less -- are there fewer? It looks like there is about half of the universe of SNFs are identified by us are meeting these criteria as against hospitals and home health.

DR. CARTER: I will say two things. One is the share does vary each year. In some years, we have had 10 and 11 percent. This year, it is 7. I think the hospital definition has varied by a similar range. It's just been a little bit higher. So I don't know that this number would be the same next year.

The second is we are seeing that it's increasingly

hard for SNFs to meet all of the criteria; that is, to be low cost and high quality. We are seeing many more SNFs not getting into the pool because it's hard to do both.

We have seen non-profits tend to have higher quality, but they also have higher cost. They start from a higher cost base, and they have had higher cost growth. This year's sample, the non-profits are underrepresented, and I think it's because of their cost position and their cost growth, where they are not qualifying for these, by this definition.

We could expand the definition and get a higher share, but that would mean -- I don't know that this is excessively stringent. That would be loosening it, and we would see fewer differences between the efficient provider and other SNFs.

In the past, we have looked at alternative definitions, and we have talked about doing that in the future.

MR. GRADISON: Well, I am not suggesting that you do that. I was wondering whether this was sort of an artifact of using different definitions, so to speak, for each of these three siloes, but my takeaway from your answer

is that there is a difference, and that, at least this year, appears to be a significant difference. And it's harder to qualify right now at least for SNFs and for the other two categories as meeting our concept of relative efficiency, and that's a helpful thing to know. And thank you.

MR. HACKBARTH: So, Carol, help me out. Correct me if I am wrong. My recollection is that the basic structure of the criteria are consistent across provider group.

DR. CARTER: Yes.

MR. HACKBARTH: That includes a cost measure, and it includes quality measures, and you have to be in the top two-thirds on everything and in the top third on either quality or cost as the basic structure.

DR. CARTER: Right.

MR. HACKBARTH: The specific measures, of course, vary the quality measures because of the differences in the services provided, but that basic structure is constant across all the efficient provider tests.

DR. CARTER: Right.

And one thing I have looked at, even for the efficient providers, there are fewer of them, so fewer of

the 524, that are in the best third for cost and quality. They're in the best two-thirds, but it's hard to be in the top third on both of those measures, and that has -- it is a smaller group. They still meet the definition, but they are not in the best on all of the measures.

MR. HACKBARTH: Carol, you said the number meeting the test has sort of bounced around in a range. Did I hear that correctly? Has it bounced around, or has there been a consistent trend downward in the number --

DR. CARTER: It's been between ten and 11, but it was not a steady decline.

MR. HACKBARTH: Was not on a steady decline.

DR. CARTER: No.

MR. HACKBARTH: Okay. Clarifying questions. Jon.

DR. CHRISTIANSON: Carol, remind me of whether the measures that we used to reconstruct, how do they correspond to the measures that are reported by CMS on quality for SNFs, and do they overlap, and --

DR. CARTER: So, Medicare Compare reports for the entire nursing home. The measures are -- there are seven measures that focus on long stays and two measures that focus on short stays. And, the two short-stay measures, we

don't use because they don't -- they're, I think, something, share patients with severe pressure sores and, I think, pain medication. And, those are fine measures, but they're not really capturing the essence of short-term post-acute rehabilitation kind of care, and so we have used different measures.

In one of the announcements as part of CMS trying to overhaul the nursing home Compare data, they are going to move to having a rehospitalization, a readmission measure as one of their measures.

DR. CHRISTIANSON: So, right now, is there any overlap between our measures and theirs?

DR. CARTER: There is none.

DR. CHRISTIANSON: Okay. Thank you.

DR. CARTER: Right.

DR. HOADLEY: Question on Slide 20. I know this isn't our main focus, but the non-Medicare margin. So, here, you've got non-Medicare margin of minus 1.9, total margin of 1.9, whereas we had a Medicare margin of 13.1, and the spending totals you show here are $52 billion on Medicaid and you had on an earlier slide about $29 billion. So, it's not a huge discrepancy in -- so, I'm not sure why a

13.1 and a minus 1.9 leave us at a total margin of 1.9.

DR. CARTER: So, Medicare is about 22 percent of revenues.

DR. HOADLEY: Okay.

DR. CARTER: The -- so, does that help? I'm not absolutely sure what you're not seeing.

DR. HOADLEY: Okay. This spending is -- this is -- so, maybe it's the difference between, on this chart --

DR. CARTER: Yeah.

DR. HOADLEY: -- $52 billion is the Medicaid spending, but your margin is for all non-Medicare spending and there's a lot of other --

DR. CARTER: Right. And, you know, private is about 20 percent.

DR. HOADLEY: Okay.

DR. CARTER: Right.

DR. HOADLEY: So, it would be, effectively, if we looked at a private margin or something like that --

DR. CARTER: Yeah. We don't have, on the Medicare cost report which we use, we only have non-Medicare as the bucket.

DR. HOADLEY: Okay. That probably explains it,

then.

DR. CARTER: Yeah.

DR. HOADLEY: Thank you.

MR. KUHN: Could I follow up on --

MR. HACKBARTH: Yeah.

MR. KUHN: Carol, just to be sure that I'm clear, so it's 22 percent of their revenues, but it's only about ten percent of their patients.

DR. CARTER: About 12, right.

MR. KUHN: Okay.

DR. CARTER: Yeah.

MS. BUTO: Carol, could you explain a little bit more about the fact that your efficient -- it's harder and harder for SNFs to make it into the high quality efficient provider category. What is it -- is there anything in particular that they're not doing well on or continue to do worse on over time that you could point to?

DR. CARTER: We haven't looked at that in detail. I will say that staffing and the costs associated with staffing is closely related to facility performance in terms of quality. And, so, I would expect to see facilities with high costs doing well on the quality measure, but having

high costs.

MS. BUTO: The use of therapy services, is that another major factor in high cost versus --

DR. CARTER: Umm --

MS. BUTO: -- low cost, or not?

DR. CARTER: No, not -- no, since they are so overpaid. I mean, I think the costs increased for therapy, but the payments increase even more, and so it's true, the levels of intensive therapy might be different, but the payments are more than compensating for that.

DR. MILLER: The thing I do want to get into this conversation is I don't think we have established, and maybe it was just choice of words early on, trend here on the efficient provider. I think the most important statement to take out of it is the not-for-profits had a cost increase this year that, I think, made it -- and they tend to have better quality and that had an effect this year. Whether that's a trend, and I think once you answered the trend question, that's a lot less clear. We'd have to see this a few more times to see if this is a bounce or whether this is a trend.

MR. HACKBARTH: Any other clarifying questions?

[No response.]

MR. HACKBARTH: Seeing none, let's go to round two comments. Bill, then Kathy and Craig.

MR. GRADISON: When we were talking about hospitals earlier, I suggested that we make public in some form a list of the ones that we've identified as being efficient providers. I offer the same suggestion with regard to the list of SNFs that meet that measure, and while I'm at it, with the home health agencies that we'll be talking about later. It's the same idea and would seem to me appropriate to make all three of these available to the public.

MR. HACKBARTH: Kathy.

MS. BUTO: My comment is really more of a comment at this point, but I mentioned this to Mark earlier in looking at rehab to SNF, that transition in terms of site neutral. It struck me that SNFs are not on an episode-based payment, and I don't know whether the Commission has looked at that. It just strikes me that that's one way to look at this unfortunate incentive just to increase therapy services. If there's a way to bundle more of that into the payment, then I think we could change the incentive. But,

again, I don't know where you are on that and whether you looked at it.

DR. CARTER: So, when the PPS was first implemented, I think CMS was quite concerned about stinting, and so it did go to a per day payment system to try to mitigate that. In our work with the Urban Institute, we have a separate -- once we've looked at whether we could predict reasonably well or even better than -- it turns out better than -- the current payment system with a predicted prospective payment system based on patient characteristics, we looked at whether we could predict discharge-based payments, and so we've done a little bit of work on that, but not -- that was a couple of years ago. But, we did think -- particularly on the therapy side, we were trying to think, can you do as good a job or a better job predicting therapy payments over the episode as on a per day basis, and the answer was, you can do as good a job. But, we haven't looked at trying to predict over an entire stay and sort of how that would work.

DR. MILLER: There is also the thought that we have churning in the background of whether you can create a payment system that is for PAC broadly. So, you're talking

about SNF day, SNF bundle, whereas we have some work going on where we're trying to say PAC bundle, okay, and --

DR. CARTER: Right, and that's a required report that we have to do on that.

DR. MILLER: Oh, yeah. I had forgotten it was required.

[Laughter.]

DR. MILLER: It's not one we just -- yeah.

MR. HACKBARTH: [Off microphone.] Round two. Kate.

DR. BAICKER: Following up on that point, this seems like an opportunity to mention the difficulties introduced by the different payment silos and the harmonizing as well as the dovetailing with the interaction with inpatient payments and how these downstream payments are related. That doesn't change the update, but it warrants mentioning.

A small side note to think about as we're thinking about efficient providers, which comes up in all these different situations, and I think it's great to have a framework where we think of efficient providers as based on a two-prong test of cost and quality and that those quality

measures have to vary based on the silo we're looking at or the site of care we're looking at, and the one thing to be cognizant of in constructing those -- which, again, I don't think changes any of the analysis here, but one I'd like to keep in mind in thinking about refining quality measures, is that in some of the areas we're talking about, they are really closely tied to spending, and in other areas, they're more distant from spending.

And, obviously, it takes some spending to get quality, so it's never entirely divorced, but some things where there is a more tight one-for-one, or highly correlated relationship between spending and the quality measure, you're going to have mechanically fewer places in the overlap because you've built in a negative correlation, and so it's going to be pretty hard to populate that cell. And, so, we want to think about measures of quality that are not so tied to the spending that we're not creating a strange hybrid that we're looking for.

So, I would -- you know, as a silly example, I think it doesn't take so much extra money to avoid bedsores, but it takes so much -- it takes a given amount of extra money to get an extra person on staff. And, so, thinking

about the implications of those quality measures will help us think about how we define the benchmark of efficient provider. But, that's just a background question. It doesn't affect my views of the recommendation.

MR. HACKBARTH: [Off microphone.] Very helpful, Kate.

Scott.

MR. ARMSTRONG: Glenn, I'm just looking at the recommendation itself and the previous recommendation, and I don't know if we're going to talk much about this or not, but just given what we've looked at and some of the margins here, the recommendation to not have any update while the PPS payment structure is implemented, and then subsequent to that consider a rebasing by four percent and kind of moving forward on that, it seems contingent on a lot of things we don't control. Obviously, there's a lot of this we don't control, but -- and, it seems fairly conservative to me, and I was just wondering if we could spend a minute being reminded of kind of what we were thinking about when we kind of mapped that chain of events out previous -- in our previous recommendation.

MR. HACKBARTH: Well, I'll start, and Mark and

Carol can leap in. Actually, as I recall, I was at least one of the Commissioners who was insistent on the notion of revising the PPS before beginning the rebasing. And, to me, that seems like an important principle, that if you don't think that the money is accurately or fairly distributed and that some providers, whether it be SNFs or home health agencies or any other provider type, are already disadvantaged by the payment system and may have lower margins as a result, you don't want to pile on with that with a rebasing. And, so, the first step is try to improve the distribution of the dollars in the system to minimize the potential harm that could come to innocents by rebasing. So, that's the reason for that order.

Then, in terms of the four percent as the first step, I'm not remembering clearly off the top of my head how we arrived at the four percent. Can you, Carol or Mark? This has been a number of years now.

DR. MILLER: I can remember spending a lot of time on it.

DR. CARTER: Yeah. I don't really quite remember, either.

DR. MILLER: Yeah. Can we have some room to come

back to you on that?

MR. ARMSTRONG: Sure.

MR. HACKBARTH: But, that's the reason for the order, rebase first and then -- or, improve the case mix first and then rebase.

MR. ARMSTRONG: What do we know about the likelihood that this revised PPS thing will actually be implemented in 2016?

MR. HACKBARTH: This is actually something that I wanted to explore with Carol. To revise the case mix system, does CMS need additional authority --

DR. CARTER: No.

MR. HACKBARTH: Yeah. so, that was my recollection. That's within CMS's power. And, frankly, I've been both frustrated and surprised at how resistant they have been to our efforts to get them to improve this system. You know, I'm no expert, but it seems to me that the analysis that we presented is pretty compelling, and they have sort of tinkered around the edges, doing a little bit of this and that, sort of addressing some of the issues we've raised, but never coming to grips with it fundamentally.

DR. CARTER: Right. I don't think any of the changes have really altered kind of the backbone.

MR. HACKBARTH: So, I -- Carol, perhaps you can speak as to why CMS has been so reluctant to change. But, this is a case where it's not Congress holding things up. It is CMS.

DR. CARTER: I don't have a great insight on that. I've been surprised by it myself. They did study -- they have currently work ongoing to look at how to revise the therapy component, and then this fall said, we're going to expand that to look at the whole payment system. But, this recommendation has been out there for a long time.

MR. HACKBARTH: Yeah. It's, like, every year, there's a different rationale why they're not going to do it, and they're going to study new things and a new list of potential analyses to be done, so that's the history.

DR. MILLER: Yeah. I mean, it would, and this is not -- it would involve a different way to compute the payment, particularly in the non-therapy ancillaries in the therapy cases. But, we've even gone so far with the Urban Institute to develop a model, which we would assume they would develop their own version of the model. Well, we've

even gone and done that and said, you can have it if you want, that kind of thing. So, I think there is that.

I don't think you can discount entirely that the industry is aware of the effects of this, and they probably have things to say and at a minimum are saying, go slowly, if not, don't go at all. So, I don't think you can discount that entirely.

And, then, the third thing I would say is, they do mess around with the system, and I would characterize the changes that they make as in some ways trying to do what we're saying to do, but they just -- they don't get there.

DR. CARTER: Well, that's why I was so interested to do the work looking over time at whether, you know, there may be multiple paths to the same end, so I was interested to look at, over time, whether the changes in policy have actually improved the accuracy for therapy and non-therapy and it hasn't.

We have talked with CMS over the years about things that they didn't like about our proposed model. We revised our models reflecting some of those comments to try to address some of their concerns, but we haven't gotten much direction.

MR. ARMSTRONG: Well, so, behind my question, really, was, frankly, a sense of impatience. If the structure of our recommendation creates this big barrier to getting anything done early on, then I think that would just be worth some consideration between now and next month when we act on this.

MR. HACKBARTH: By the way, Carol, I was saying to Mark and Jim the other day that I admired how the language in each successive comment on the regulations, you've mastered increasing levels of frustration evident in our comments on their failure to act on this. It's very artfully done. Thank you.

DR. MILLER: All the while remaining polite.

MR. HACKBARTH: Other round two -- Bill.

DR. HALL: So, another very well done chapter. I would suspect, apropos of relatively effective providers, that we would find that the nursing homes that are going to do well, particularly as the PPS system changes, are those that have a strong affiliation with a health system or parts of a health system. The contrast to that would be, in New York State, when we are seeking SNF care for someone in the hospital, we're not allowed to give them a strong

recommendation. We have to present them with a list of available SNF facilities, to a family that doesn't even know what SNF stands for and they're supposed to pick the right one. Now, that rule is being lightly enforced.

But, I think that one of the influences we may be able to have on CMS is that in this prospective payment system, maybe one of the metrics ought to be, to what extent are you affiliated with a health system, so that a lot of the barriers that go back and forth between discharging patients, or, for example, if I'm worried about 30-day readmissions, I may look at SNFs in a very different light than if that potential penalty wasn't there. So, just another plug for relatively efficient systems and how we can --

DR. CARTER: That's an interesting comment, because I did notice that about half of the SNFs were efficient last year, but I haven't looked at whether -- and I'm not sure I have the data to look at systems.

MR. HACKBARTH: Other round two comments? Jack.

DR. HOADLEY: I was just going to follow up on Scott's comment on -- I mean, I don't know whether there's a difference from -- which year did we make this previous

recommendation? Was it --

MR. HACKBARTH: The rebasing.

DR. HOADLEY: The rebasing.

MR. HACKBARTH: Two thousand...

DR. CARTER: '12.

DR. HOADLEY: Anyway, you know, in the two or three years, whatever it's been, since we made that, three or four years, whether the sort of story on where margins stand and on sort of where the default update stands, I mean, right now we've got a sequester, right now we've got, you know, margins that are at maybe a different level than we were, and whether the meaning of what a zero update followed by 4 percent rebasing may look different, and whether that -- I mean, we don't necessarily need to go back and change the numbers, but whether that's at least worthy of some comment, as, you know, it actually might be more generous today than it would have looked in 2011.

DR. MILLER: I would say that --

DR. HOADLEY: Or less.

DR. MILLER: Yeah, more -- it looks pretty similar.

DR. HOADLEY: Similar?

DR. MILLER: We're talking about 13 percent margins here. The margins at the time were running, I'm going to say, 14 and then they jumped to 20 because of the coding thing, and then they came back down. I would say we're about in the same place.

And I would also say, without a hell of a lot of information but with Carol sitting right here, the spread between for-profit and not-for-profit, about the same, too. So I would say we're still in the same place.

MR. HACKBARTH: I sense we're winding down on this. Any final Round 2 comment?

[No response.]

MR. HACKBARTH: Okay. Seeing no hands, let's do Round 3, reactions to the draft recommendation. Mary, why don't you start?

DR. NAYLOR: I support.

DR. CROSSON: I support the recommendations.

DR. REDBERG: I support the recommendations.

MR. GRADISON: I do as well.

MS. BUTO: I'd like to see an alternative. I mean, I could support this recommendation, but if there's a way to accelerate the -- and maybe it's not no update but a

negative update, some way to put more steam behind the revision of the PPS and then a rebasing effort. I don't know if there are alternatives, but I would really encourage us to look at that.

MR. HACKBARTH: So let me just be sure I understand. So you're saying even before the improvements in the case mix system happen, do a negative update, a cut in the rates?

MS. BUTO: I'm not saying that's the right approach. I'm just saying it would be nice if we could figure out a way to sort of build a fire under that recommendation. It hasn't moved over the last two or three years.

MR. HACKBARTH: Yeah. Craig?

DR. SAMITT: I support the recommendation.

DR. HALL: I support the recommendation.

MR. KUHN: I support the recommendation.

DR. BAICKER: As do I.

MR. THOMAS: I support the recommendation.

DR. COOMBS: I support the recommendations.

DR. HOADLEY: I support the recommendations.

DR. CHRISTIANSON: I support the recommendation,

but I think I share Kathy's sort of misgivings about the recommendation hasn't really done the job in the past, and maybe there's some way of rethinking it.

MR. ARMSTRONG: Yeah, I'm with Kathy and Jon, too. I'd like a chance to talk some about how you could really get some traction on this.

MR. HACKBARTH: We did talk about where the responsibility lay for changing the case mix system. Of course, the rebasing of the rates piece is in Congress' hands, and so as we've discussed so often, you know, Congress works in mysterious ways, and it often will do nothing, do nothing, and then move dramatically into action. And I'm not sure that there's anything that little old MedPAC can do to alter that longstanding characteristic of the Congress. That one is sort of beyond our control.

Okay. Thank you, Carol. Good job.

[Pause.]

MR. HACKBARTH: Actually, we could give Bill that assignment. Bill could tell us how to move Congress into action.

[Laughter.]

DR. MILLER: Bill Hall, right?

MR. HACKBARTH: Evan.

MR. CHRISTMAN: Good afternoon. Now we're going to look at home health. This presentation is going to cover three areas. First, I'll take you quickly through some background on the benefit. We'll look at the payment adequacy framework for home health. And then I'll do a brief review of the mandated report. As some of you may recall, we completed this fall a mandated report on home health rebasing.

Medicare spent about $17.9 billion on home health services in 2013. There were over 12,600 agencies, and the program provided about 6.7 million episodes to 3.5 million beneficiaries.

Before we begin, I just want to remind you of some of the issues with the home health benefit. Home health is an important part of the continuum for serving frail community-dwelling Medicare beneficiaries. Properly targeted, it can be a tool for keeping beneficiaries out of the hospital or other more costly sites of care.

However, eligibility for the benefit is broadly defined and does not encourage efficient use. As I will note in a minute, there has been a rapid growth in episode

volume, which raises particular concerns in the current fee-for-service environment that rewards providers for additional volume.

The Commission recommended a co-payment for episodes not preceded by a hospitalization because the rapid growth and broad geographic variation we have observed suggested potential for overuse of this service in these instances. Post-acute users generally have more chronic conditions then community-admitted home health users, so applying the co-pay only to community admits shields the sicker population.

The benefit also has an unfortunate history of fraud and abuse, and there are many areas with aberrant patterns of utilization. The Secretary and the Attorney General have made a number of efforts to address fraud in the benefit, but many areas with aberrant patterns of utilization remain. The Commission has recommended that the Secretary continue and expand efforts to curb fraud.

Our recommendations also address a payment vulnerability in the PPS. The current PPS uses the number of therapy visits provided in an episode as a payment factor. More visits yield higher payments. We recommended

that CMS eliminate the use of the number of therapy visits as a payment factor to address this problem. 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.

The fact that home health can be a high-value service does not justify the excessive overpayments that Medicare has made for many years. As I will explain in a moment, Medicare has overpaid for this service since the beginning of PPS, and these overpayments did not accrue to the benefit of the beneficiary or the taxpayer.

As a reminder, here is our framework. It is the same one the other sectors have followed in earlier presentations.

We begin with supply. 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; 84 percent live in an area served by five or more.

Turning from access to supply, the number of agencies was over 12,600 by the end of 2013, and there was a net increase of 302 agencies. Growth is concentrated in a

few areas, such as California and Texas, and many of these areas also have higher utilization.

Next we look at volume. Episode volume in 2013 declined slightly. However, this decline comes after several years of rapid growth.

The number of users increased slightly, but the number of episodes per user decreased slightly. The share of fee-for-service beneficiaries using home health was 9.3 percent in 2013, a slight uptick from the previous year.

Though we have seen a recent slowdown in utilization and spending, over the 2002 through 2013 period you can see that all of these factors have increased significantly. Spending has almost doubled, and utilization increased by more then 60 percent.

Our next indicator is quality. 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 for transferring dropped slightly while the rates of improvement in walking increased slightly. Both rates are higher then the baseline year of 2003.

Hospitalization rates remained unchanged. The lack of progress in lowering the hospitalization rate was one of the factors that motivated the Commission to recommend a rehospitalization incentive for agencies with very high rates. This recommendation is discussed further in the paper, and I could address any questions you have during the discussion time.

Next we look at 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. But, overall, financial analysts have concluded that the publicly traded agencies have adequate access to capital, though perhaps not as favorable as previous years because of the payment reductions in the PPACA.

We have seen a recent uptick in acquisition activity in this sector, with two health care firms buying home health providers to expand their capacity in this sector.

For agencies not part of publicly traded companies, the continuing entry of new providers indicates that smaller entities are able to get the capital they need.

As I mentioned earlier, the number of home health agencies increased by over 300 in 2013.

Next we turn our attention to margins for 2013. You can see that the overall margin for freestanding providers is 12.7 percent. The margins are listed here for the different categories of providers, and the trends you see here in the distributions are similar to prior years. I would note that these margins include the effect of the sequester that began in 2013.

I would also note that these data rely upon the home health cost report. CMS audited a sample of 2011 home health cost reports and found that costs were overstated by 8 percent in that year. If reported margins were adjusted for this error, our home health Medicare margins for 2011 would have exceeded 20 percent. While it is speculative to apply the 8 percent to other years, the results suggest that 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 other agencies. Recall that we define relatively efficient providers as those that are in the lowest third of providers

in cost or the best performing third of providers for quality for consecutive three years, and never in the worst performing third on either measure. About 17 percent of agencies met this standard.

Relatively efficient providers had a cost per visit that was 12 percent lower than other agencies and Medicare margins that were about 41 percent higher. Relatively efficient providers were typically larger in size, providing about 21 percent more episodes in a year. They had lower hospitalization rates, and they provided about the same mix of nursing, therapy, and aide services to their patients, and they served similar numbers of dual-eligible patients, and their beneficiaries were about the same average age.

We estimate margins of 10.3 percent in 2015. This is a result of several payment and cost changes. There is a 3 percent add-on in effect for rural areas in 2010 through 2015. Payments in 2014 and 2013 were adjusted downward to reflect -- excuse me. Payments in 2014 were adjusted downward to reflect rebasing, and we assumed cost growth of less than 1 percent in 2013 and 2014, in line with historical rates of growth. These estimates include the

sequester. Without the sequester, the margins would be about 2 percent higher.

We are about to release the mandated report to Congress on home health payment rebasing. As a reminder, rebasing is a payment reduction for home health in PPACA designed to bring payments more in line with costs. Keep in mind that since PPS began operation in 2001, margins have averaged 17 percent a year. While PPACA intends to lower payments, we have been concerned that the reductions it requires are too low, and this table shows why.

Every year rebasing will bring payments down by about $81 an episode. However, this decrease will be offset each year by the annual payment update that will add back about $66. Across the four years, payments will decrease by about $58, or about 2 percent.

For some perspective, payments in 2013 averaged about $2,960, so these reductions will not significantly change average payments.

The PPACA required the Commission to assess how changes in payment under the law will affect quality and access. This slide summarizes some key findings from that report.

Since data that will allow us to directly examine the impact of rebasing is not yet available, this report examined how past changes in payment related to past changes in quality and access.

The intent was to use these trends as a model for what could happen due to the rebasing. Looking at this period, we found that the supply of agencies increased regardless of whether payments increased or decreased. Episode utilization increased in most years, too.

Recently there has been a slight decrease in utilization, but, again, as I noted, this comes after many years of utilization growth.

The trends for quality measures did not suggest that changes in payments had a significant effect. The rates of functional improvement -- walking and transferring -- rose every year regardless of the direction of payment policy; the rate of hospitalization was unchanged during this period. Overall, the Commission concluded that past reductions did not appear to have a negative effect on quality and access, and the relatively small size of the reduction suggests that it will also have a limited impact on financial performance.

Turning back to our framework, here is a summary of our indicators. Beneficiaries have good access to care in most areas. The number of agencies continues to increase. The number of episodes declined slightly after several years of rapid increases. Quality measures have not changed significantly. Access to capital is adequate. And the margins for 2015 are projected to equal 10.3 percent.

I would note that these are average margins, and our review of the quality and financial performance for relatively efficient providers suggests that better performing agencies can achieve better outcomes with profit margins that are 23 percent higher then other agencies.

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 and eliminate the annual payment update. We have also advocated that CMS use its authority to address fraud and abuse in the home health benefit. There are many areas of aberrant utilization that suggest investigation and enforcement efforts continue to be needed. We also recommended that CMS

eliminate the use of therapy visits as a payment factor. Finally, we have also recommended that Medicare establish a co-payment for episodes not preceded by a hospitalization or PAC stay.

This completes my presentation. I look forward to your questions.

MR. HACKBARTH: Let's see. Round 1 clarifying questions?

DR. CHRISTIANSON: A couple, Evan. One, I understand why no beneficiary cost sharing, it was in the context of trying to encourage use of, I assume, a lower-cost site of care as opposed to a facility. Are you aware of any other part of the Medicare program where beneficiaries have, I think almost quoting your chapter, unlimited -- can use an unlimited -- have access to an unlimited number of services with no cost sharing at all?

MR. CHRISTMAN: Well, I think in terms of the broad categories of service, the big one that everybody also talks about is hospice. But, you know, and there are some other things out there that -- smaller things, such as certain preventative treatments and things such as that. But I think people generally think, relatively speaking, as

home health kind of being the big one.

DR. CHRISTIANSON: Another thing that I was going to ask you, so Medicare has audited 100 cost reports out of 12,000 agencies. They did it once over a 14-year period. Is there a sense that -- has anybody articulated, you know, why this is the appropriate level of financial oversight for this area of Medicare?

MR. CHRISTMAN: Well, I certainly can't give you a good answer to that question. I can tell you that I think that, you know, of course, there's always the cost of doing the audit itself, its administrative costs.

The second issue that you sometimes hear -- and I'll simply repeat what I've been told and not pretend it may fully address your concern. It's just that back when CMS was paying on the basis of cost, you audited things regularly. And I think moving to prospective payment and having these fixed rates, part of the benefit to them, I think they saw they would get out from under the costs of doing these audits every year. But, obviously, as someone who is a heavy user of that data, you know, greater surveillance of it would be --

DR. CHRISTIANSON: Right. It makes it a little

more difficult for us to place a lot of faith in our margin calculations, I would think.

DR. MILLER: You know, my own experience -- and Herb and Kathy may speak to their own -- is at least in the administrative budget, when the dollars would start to get low, the priority is process the claim and, you know, the program integrity activities definitely moved to the back of the line.

DR. CHRISTIANSON: In this case, way back.

MR. HACKBARTH: It's program integrity spending. It's focused on things that are first-order problems, namely, you know, charges for services that were never provided and that sort of thing, as opposed to this, which is sort of a second-order issue that may affect assessment of future payment rates.

DR. CHRISTIANSON: Right, it does affect our business, I think.

MR. HACKBARTH: So other clarifying questions?

DR. NAYLOR: Thanks. My questions are from the report itself. Just help me to understand or reconcile what I read and can't figure out. 2010, CMS, you summarize their sense that the majority of home health services are provided

by home health aides. I'm reading your report.

MR. CHRISTMAN: Okay. I'm sorry. Well, that may be a misstatement, but what we were trying --

DR. NAYLOR: I'm sorry. Page 10.

MR. CHRISTMAN: What we were trying to say is that there is a share of episodes that -- there are a share of users that the majority of services they receive in an episode are home health aide services.

DR. NAYLOR: All right. And you said that, so you're talking about 9 percent of the episodes. Because I was trying to reconcile it against the Table 1 where we see massive changes in skilled care, et cetera. So I'm --

MR. CHRISTMAN: So the picture I want to paint for you is that overall the home health aide is about 20 percent of total visits, but that doesn't mean -- but what I would say is there are a lot of episodes that have almost no visits, and then there are a pocket of episodes that have an enormous number of visits, and that 9 percent is that pocket that is getting a large number of episodes -- a large number of home health aide visits. Does that help?

DR. NAYLOR: It does. It's just that the final statement about whether these standards are adequate remain

-- whether the home health benefit is applying the standard I think maybe just needs to be looked at.

The second, and this is clarifying, Table 4 on page 14. I think you answered this, but do we have 2013 data about what's happening in terms of first episode following hospitalization versus community enrollment?

MR. CHRISTMAN: I don't yet. The data that really allows us to do that doesn't become available until later -- or allows us to do it easily, let me say it that way. But the trend has been -- I guess I think as a percentage, it's kind of flattened out a little bit. It's sort of two-thirds of episodes not being preceded by a hospitalization and one-third being preceded by a hospitalization.

DR. NAYLOR: Thanks.

MR. HACKBARTH: It's flattened recently, but for a while the increase was pretty rapid, wasn't it?

MR. CHRISTMAN: It started about 50-50 in 2001, and we're now at two-thirds.

DR. CROSSON: I had two questions also from the text of the report itself. One had to do with the fact that the payments for the third and later episodes in a consecutive spell of home health episodes are paid at a

higher rate. I mean, I don't know whether that's counterintuitive or just not intuitive at all. What's the reason for that?

MR. CHRISTMAN: The point is -- what CMS found is that beneficiaries who have longer home health spells on average use more visits in an episode, and so they're essentially using the length of stay as a marker to kind of say on average you get about -- those episodes get about 23 visits per episode. Earlier episodes, first and second episodes, on average get 16 visits per episode because they reflect both users who are in the benefit for a short period of time and people who are very sick and going to be on for a longer period of time. And so they kind of -- they've got a bump in there that says since these visits on average have -- excuse me. Since these episodes have more visits, the payment system makes the increase.

DR. CROSSON: Just on the face of it, it seems like a little self-reinforcing.

The second one had to do with the Table 10, which is the numbers of average payment per episode, comparing the relatively efficient provider with all other providers, and what struck me looking at that was, compared to some of the

other areas we've looked at, the difference is only about 6 percent. It's about $150 out of $2,500, and that just seems -- maybe it's, again, hiding a variation difference there, but it just struck me as odd that this difference is so small.

MR. CHRISTMAN: Right. I mean, when we've looked in other settings -- excuse me -- another analysis, I think that it's reflected in this. The biggest difference between high- and low-margin agencies is their cost, not their payments.

If you look at the efficient providers in this table, they have lower cost per visit, and they provide slightly fewer visits per episode. So I think that that's probably the bigger contributor to their better financial performance.

DR. MILLER: Both the number of visits and the cost per visit --

MR. CHRISTMAN: Right.

DR. MILLER: -- are combining to make the effect, make a provider more efficient or less efficient.

DR. CROSSON: Right. It just doesn't seem like that big a difference is all I'm saying.

DR. MILLER: That's per visit.

MR. HACKBARTH: Yeah. So if you combine the lower cost per visit and the lower number of visits, where is that in the table?

MR. CHRISTMAN: So if you look at about mid-table, you will see that the cost per visit for the efficient providers were about $126 per visit and $144 for the other agencies, and it's about a 12 percent difference.

If you look at the visits per episode, you will see the less efficient providers provide about 1.2 episodes per visit -- 1.2 visits per episode more than the efficient provider. I guess the way I think about it is the efficient providers have lower cost per episode, and they get to lower cost per episode two ways. They have a lower cost per visit in those episodes, and they do fewer visits.

MR. HACKBARTH: But my point is you combine those two things, and you have a pretty significant difference between the relatively efficient agencies and the others that is, I think, even greater than what we saw for, say, hospitals between the efficient and the others.

DR. CROSSON: I see that.

DR. MILLER: Can I follow up on one thing that he

said? So this is a question that I don't know the answer to. So when he was saying there are more visits in the longer episodes and then you were saying that's a function of the payment system, is that that therapy visit threshold?

MR. CHRISTMAN: Nope. This is at a different threshold.

DR. MILLER: Okay.

MR. HACKBARTH: Okay. Continuing Round 1 clarifying questions, going around and around. Warner and then Jack.

MR. THOMAS: I just had a question on ¬-- did you study the best practice readmission rate, home health agencies, and is there a wide variation in financial performance between them? So if you kind of backed into the folks that really had the best readmissions to hospitals, then what's the variation, if any, in performance?

MR. CHRISTMAN: I think I have looked at something like that. I just can't recall it off the top of my head. We can take a look at that.

DR. HOADLEY: Can you help me understand? Since the recommendation here has a lot of moving parts in it, no update, but also reducing payments for the rebasing and

rebalancing, how is that ultimately going to compare with what's sort of the default under current law?

MR. CHRISTMAN: Okay. Working through them in order here, I guess what I would say is our recommendation would be to take the -- I think the best way to think about it is take out the payment update that agencies are going to get for 2016 and 2017, and that would mean that they would be taking on roughly a 6 percent payment cut if you just took out the payment update and left the existing rebasing reductions that are also already along, so that would be a cut.

The third bullet, rebalancing the payments, that was really -- the simplest way to think about it is you'd be taking out the per-visit elements of the current payment system. That would be redistributive within the case mix. Payments would go up for episodes that have relatively more nursing, and they would go down for some episodes that have relatively more therapy. That would generally move money from for-profits to non-profits and hospital base -- excuse me -- freestanding hospital base, which we didn't set it up this way, but as it plays out, that is generally moving money from higher margin agencies to lower margin agencies.

DR. HOADLEY: So that last element you're talking about would be budget neutral.

MR. CHRISTMAN: Right. Right, right, yes.

DR. HOADLEY: And where we stand now with the full rebasing, are we suggesting a different pattern than you have back on Slide 14 that CMS is currently implementing?

MR. CHRISTMAN: Well --

DR. HOADLEY: Or are we sort of implicitly accepting their pattern of rebasing?

MR. CHRISTMAN: I don't think we specifically crossed that threshold. We see their margins at 2015 as being at 10 percent. Take out another 6 points, it would be around 3, 4 percent, depending on what happens with costs, and I guess if it were possible to make some assumptions that they were going to be a little bit more aggressive about cost, maybe I'd take out a few more points. But I don't think we're really talked about this as a Commission.

DR. MILLER: Well, just a second. Was the question whether those are included in the calculation of the margin?

DR. HOADLEY: No. Really, it's -- so, when we say in our old recommendation that we'd be repeating, reduced

payments for a full rebasing, that adequately addresses excessive payments, so CMS has this particular rebasing in play now.

MR. HACKBARTH: But we say in -- if you look at the actual language of the recommendation, it's a two-year rebasing, which is --

DR. HOADLEY: quicker.

MR. HACKBARTH: -- way faster than that.

DR. HOADLEY: Okay. So that's what I'm trying to understand.

MR. HACKBARTH: Yeah.

DR. HOADLEY: And partly, we may just want to explain some of that more in the text, is to say under current law, this is the way things are set up and sort of play out, because it's hard for me to sort of understand without really understanding the guts of this payment system whether we're actually being more generous, less generous, at one point in time, over a couple of years, sort of how it plays out.

DR. MILLER: Than this.

DR. HOADLEY: Right.

DR. MILLER: Okay. We can certainly get language

to that effect, and I suspect we have it probably in two places, the report that is about to come out, which was our mandated report on, is this rebasing effect, and then maybe what we need to do is go back to when we constructed this recommendation and talk and kind of recover some of that. Things start to get into place, and we get more concise in summarizing in the report, but we can go back to some of the original language. Decidedly, we would be going deeper than those numbers at each step faster and --

DR. HOADLEY: Right. So it just seems like it would be important to help --

DR. MILLER: I got you.

DR. HOADLEY: -- both the policy decision but also your readers.

DR. MILLER: Your point is understood.

MR. HACKBARTH: Warner.

MR. THOMAS: I just had another question. In the presentation, you indicate the Medicare margin after the reductions. You have a projection of it here. I think it's around 10 percent, you indicated. Did you project the all-payer margin?

MR. CHRISTMAN: No, we don't project the all-payer

margin. Those margins run around 5, 7 percent right now. Medicare seems to be the more generous payer in this area.

MR. THOMAS: And did we project what that looks like post rebasing? Do we have any idea what the impact might be on that?

MR. CHRISTMAN: The all-payer margin, we don't project that.

MR. HACKBARTH: So our approach has always been to base our recommendation on Medicare, Medicare loan, and we talked about that and the rationale for that.

In the case of SNFs, there was a specific mandate that we report on all-payer margins, which we have complied with. That was in PPACA, as I recall.

The other sector where we have pretty regularly reported all-payer margins is for hospital, and I am trying to think of the other sectors. I think that's really the other major one.

DR. MILLER: Right. But I also think the thing that Evan is really pivoting on, unless I am missing something, is projecting, and we do the projection for the purposes of helping you guys think about the update, because the update you are being asked to recommend is 2016.

On the all-payer margin, which is not really our framework, we don't get in the projection game, I don't think anywhere.

MR. HACKBARTH: Yeah. We really wouldn't have any basis for that because that would require some understanding of what private payers are doing, and that's just really beyond our ability to project.

DR. MILLER: So we report it as we can get it out of the cost report in several places, but the projections don't occur, and I think that's what you were saying. And I think that's what you were answering.

MR. THOMAS: I was just reflecting on the hospital discussion this morning where we talked about the all-payer margin, which was significantly higher. We had the Medicare margin, which is negative for hospitals. Here, we have a reverse situation. I'm just wondering how we look at that in this case versus the hospital case.

MR. HACKBARTH: Any other clarifying questions?

Jon.

DR. CHRISTIANSON: Yeah. This is probably a quick one, Evan, but on page 30 and 31, you talk about the Commission's recommendation 8-1 from the March 11th report,

and part of the recommendation is that the Secretary should implement new authorities to suspend payment and enrollment of new providers in areas where there seems to be significant -- I guess my first gut reaction is, if I was somebody under investigation for fraud, I would love that second recommendation because that would protect any new competitors from coming into the market while I am being investigated.

Can you sort of reflect on what the thinking was at that time about that recommendation?

MR. CHRISTMAN: Well, I think there has always been the concern that, yes, the moratorium, it doesn't help you when the bad actors are already in the program, but what brought about the moratorium is there were a couple of areas. And Miami, unfortunately, was really just kind of the poster child for this. They were adding 5-, 600 new agencies a year, and the thinking was that there are just some areas where it's just so bad that they're not -- whatever we're doing on the enforcement side is not deterring them, that we can at least do this, have a moratorium on enrollment.

But I also think, yes, it was envisioned as part

of a -- that it would have to be part of a larger strategy that would go into areas and go after agencies that are already in the program and taking advantage of it.

DR. CHRISTIANSON: So is the Miami recommendation.

MR. HACKBARTH: Jon, I definitely see your point and can see how it could play out that way.

Sort of another angle on this is that there are limited administrative resources devoted to oversight and these things, including enrollment of new providers and making sure that they're legitimate and the like. So part of the thinking here is, where you've got a problem area, before you bring in still more people that you have to oversee with a fixed amount of resources, focus on the ones that you've got and see if you can clean up the operation. It could have the unintended benefit, if you will, of protecting a bad actor from competition.

DR. CHRISTIANSON: So it does raise the issue, of course, then about the whole sort of process anywhere in the country. I mean, if you don't have a process that can sort of screen out folks going in, that's true all over, not just Miami. It sort of really is a comment on the ability of CMS to make any kind of determination about whether some

organization is going to be a good provider here.

MR. HACKBARTH: Well, and it's also a comment on the Congress' willingness to appropriate necessary funds for administrative action.

I know you know there is the entitlement spending portion of the program, which is automatically funded, but all of the administrative activities of the organization are funded through an annual appropriations, which have been very tightly managed, shall we say, by the Congress.

And Herb and Kathy can talk more about this than I, but I remember Herb saying at one point that the count, the FTE count in the agency as a whole today is lower than it was in --

MR. KUHN: Well, I guess that was back on 2010.

MR. HACKBARTH: Yeah.

MR. KUHN: It was lower than it was a decade before.

MR. HACKBARTH: Yeah.

DR. CHRISTIANSON: Not the recommendation to actually help with that.

MR. KUHN: So with many new laws passed and thousands of new regulations they have to implement,

including the new Medicare Part D program.

DR. CHRISTIANSON: Yeah. So we don't have anything here that is a strategy for helping with that. I mean, there's nothing to --

MR. HACKBARTH: We have made -- I don't know -- probably a half-dozen times at least -- recommendations that have said you need to give CMS more funds to do this job well, with not much to show for it.

DR. CHRISTIANSON: So we've given up?

MR. HACKBARTH: Yeah. Yeah. I just don't think that's a fruitful use of our time, not only because it's been ineffective, but also because the committees of jurisdiction that we work with are the committees that govern the entitlement portion of the program, not the appropriations committees. We don't have those relationships, and that's where the administrative funding decisions are made.

DR. MILLER: The other thing I would say, Evan, the new authorities given to the Secretary included the ability to do like an enrollment, a provider enrollment re-up, where you could say, "I'm going to require people to come back through the certification process."

MR. CHRISTMAN: I believe -- I'm not sure it was specifically in PPACA, but on occasion, the program has sort of done sort of a recertification where they say, "We're going to go back into this area and make sure there is somebody actually there," and things like that.

DR. MILLER: And I would say that we have been trying to address things in program integrity. You do see some program integrity recommendations that ride along with the updates in some of our payment redesign recommendations, and here on this, even though it's shorthand here in the chapter, the kind of thing you would be looking for in Miami, as you say, okay, no new enrollment and force people back through the re-up, so that you can kind of try and rescreen for the people who are clearly fraudulent. That would be the kind of activity that we'd be looking for.

And what we're trying to do with this recommendation, as the Secretary was given the new authorities to do this, and at the time, we were concerned that years were passing, more people or providers were rolling into Miami and places like that, and no action was being taken. And so we wanted to kind of focus the attention of the world or whoever listens on the notion that

there were new authorities here that the Secretary could take, again, within the resources that she had, and that is an ongoing issue and ongoing issue across the government, really, when you think about it.

MR. HACKBARTH: Okay. We are on to Round 2 comments. I see Jay. Anybody else want to get in the queue here? Mary. Point of exhaustion --

DR. CROSSON: This is a point of mathematics. This is a mathematics update.

MR. HACKBARTH: Okay.

DR. CROSSON: Regarding my previous brain freeze between payment rates and costs, I actually calculated the cost difference, and it's 19.7 percent between the efficient providers and the rest. Thanks.

MR. HACKBARTH: Yeah. And that's consistent with what Evan said about the efficient providers would have margins in excess of 20 percent. Yeah.

Mary, you had your hand up.

DR. NAYLOR: So I think this is replay, but first of all, a good Round 3, that I support the recommendations, but I want to continue a thread around how high-value home care targeted to the right population really can contribute

to beneficiaries' better experience with care, better continuity, better health benefits, and reduced costs. So I hope that we will continue our conversation about how this benefit has migrated from something that is not preceded by hospitalization to really focusing on particularly beneficiaries, making the journey from hospital to home. And when 66 percent of our users do not have home health care preceded by hospitalization, I just wonder if we are doing the best we could in terms of program investment to target it back to the group that really needs it and will benefit from it.

[Pause.]

MR. HACKBARTH: Anybody want to run with Mary's ball? You got into -- go ahead.

DR. COOMBS: So, I remember the discussion from, I don't know if it was two years ago or last year, just regarding the copay and the potential for some default decision making by providers if it is connected with a primary care doctor, say, who has -- is fraught with a choice of going to a SNF versus a home health management and that the copays become problematic in some situations where the choice may be made that this is maybe onerous for the

patient, although we do know that there are those patients who have their copay supplemented. But, I would just be concerned that at the 10,000-foot level, that the decisions might be made for an easier path, for more expensive care.

MR. HACKBARTH: Evan, correct me if I am wrong here, but our copay recommendation, as I recall, was for post-hospital -- or, admissions from the community, rather, as opposed to post-hospital. The SNF are, by definition, post-hospital. And, so, the scenario that you are saying is a patient coming out of a hospital and the question is, do I give them home health or SNF. The home health copay would not apply in that case.

DR. COOMBS: [Off microphone.] Right. There are some situations where they are discharged and without support systems and it's later discovered that this person is just not going to fly at home. And, so, it might be a difference in scenario with that type of situation where it's not realized. So, I don't know what the timing is in terms of hours.

MR. HACKBARTH: A beneficiary coming out of the hospital, the home health will be the lower-cost --

DR. COOMBS: Right.

MR. HACKBARTH: -- option in all cases. And, so, the physician won't face this issue of do I send them to a higher-cost home health option as opposed to SNF. There is no home health copay for a patient being discharged. It only applies to home health admissions from the community, the way we'd structured it.

DR. COOMBS: Right, and I thought that we also discussed, like, looking at admissions rates from home health aides. Like, for instance, we talked about the emphasemanous patients or the chronic bronchitic patients who may have some interventions early on to keep them from being admitted to the hospital in the first place. Say, they are having some problems. The primary care doctor sees this patient is on the fence, they're really marginal, and how can I keep this patient out of the hospital. So, I mean, there's that scenario, as well.

MR. HACKBARTH: And in that case, there would be a home health copay if the physician says, well, the way I want to try to keep them out of the hospital is admit them to home health. The copay is a pretty modest one, and Evan, you can describe that in more detail. But, our thinking was this is not a free resource. Once the patient is admitted

to home health, we're talking about a $3,000 bill for an episode, and that's a significant sum of money and people ought to be looking for alternatives. You know, a patient can go to a number of office visits for way less than $3,000, and if a modest copay causes people to think, well, it's better that I schedule a series of office visits to keep a close eye on this patient, that would be cheaper for Medicare.

Evan, why don't you describe the level of the home health copay.

MR. CHRISTMAN: Sure. We talked about a $150 copay, which comes out to a touch over $10 per visit for a typical episode, and I think that for the community-dwelling home health beneficiary that doesn't have a prior hospitalization, even with the copay, cost sharing being what it is in home health, paying the $150 copay in many instances is going to be cheaper than just about every other alternative. It'll be cheaper than what they incurred if they went to the hospital. It'll be cheaper than what they incurred to get 20 office visits. It'll be cheaper than what they would get for any -- a SNF stay that lasted more than 20 days.

It is a new -- it would be a new burden on them compared to the current program, but relative to the -- you know, I think, frankly, a piece of what motivated us to think about this copay was sort of the angle Jon was going down. It's just that right now, it's absolutely free, even though we charge something for less expensive services. And, so, we worry that people aren't weighing the trade-off. We want people to use home health when it is appropriate, but right now, we're worried that the incentives are not balanced in the right way and the copay is an attempt to balance that.

DR. COOMBS: So, I actually agree with that. But, we were talking earlier about ambulatory-sensitive conditions and I'm just wondering if there's some middle ground just for those conditions that we talked about earlier.

MR. HACKBARTH: We should talk more about that. That's an important issue, and I don't want to give a glib answer to it. But, just one last thought on the home health copay. The general thinking about the utility of patient copayments is that you want to reduce out-of-pocket costs for the patients on non-discretionary services that have

high cost and you want some patient copay on services that are more subjective and may be discretionary. And, for me, home health admits from the community are often quite discretionary. There are alternatives. And, it is, for me, almost the poster child of a service for which you want to have at least some patient copay. And, again, we're talking about a modest one.

MR. THOMAS: So, just a comment, going back to Mary's point, because I, obviously, came in late to this whole discussion and the analysis of home health, and it's hard to basically disagree with anything that's in the report. I think the only comment I would make is the concept of home health as a cost reducer in the overall health care field is still a good one. I just worry that there's a lot of good folks out there that kind of get caught in an industry that has obviously over-utilization or challenges in it. I just have that as just something I think about as we look at the rebasing and the overall approach, so --

MR. HACKBARTH: And, Scott has frequently reminded us of this, and I agree wholeheartedly that properly used, deployed home health, integrated into a system of care, is

usually beneficial service that not only reduces cost, but can really be vital for patients. The problem that we have in Medicare historically is that it is not integrated, it is not properly overseen, and, therefore, it is often used in circumstances where it just isn't integrated with care. That's one problem. The second is that for every episode, we're paying 15 percent above costs. And, even if it's a great service, you can pay too much for it.

DR. MILLER: Yeah, and just -- I know what you're saying, because we have people who come in from the industry and talk to us. I mean, there is this really strong statement that this is about avoiding hospitalizations, yet for a decade, the hospitalization rate out of home health has not budged.

But, then to say something positive, which I know you don't expect coming from me, but we've also had a lot of conversations more recently around the ACO activity, and there, you suddenly have all these conversations where the ACOs are saying, well, we've really been engaging with our home health agencies and figuring out how to use that benefit to keep the person out of the hospital. And, it's kind of, like, well, you know, and it's really true. In the

fee-for-service environment, just a lot of that doesn't go on. You shift things a little bit and people start talking to each other.

The other thing I'd say about the copayment and the difficulty of -- you know, the Commission didn't just talk about this and say, okay, let's do it. There was a lot of back and forth for a long time on this. But, keep in mind this. Ideas now are coming -- now, I'm not going to say this is industry-wide, but out of the industry, where they're going to Congress and say, limit the number of episodes, because we recognize there's parts of this country that's out of control. And, I think, sometimes when a Commissioner is faced with this notion of an absolute limit versus give the beneficiary some play in this, I think they tend -- I'm speaking for you guys, so you can disagree, but tend to come down on the side of let the beneficiary have some operational choice there. But, those kinds of ideas, if spending and the patterns continue here, I mean, those kinds of ideas are making their way to Congress.

MR. THOMAS: And that's where I come back to. If you have organizations that are performing well from a readmission perspective, you know, is there additional

analysis or insight that we can gain there, and should there be -- you know, how should they be paid differentially based upon the fact that they may have a significantly better readmission rate for the folks that they're taking care of. So, I know there's wide variation in that, quite frankly, from home health agencies, because we've done our own analysis of who we use and have basically gone to just a few. So, I just put that out there as a comment. I know you've vetted this for months and months and months. I just wanted to be -- just wanted to point that out.

MR. CHRISTMAN: I think I hear two pieces in your comment, Warner. And, one is, there's variation among providers who are doing a good job and some doing a poor job, and at a very micro level, we have a rehospitalization recommendation to try and begin to make those distinctions in Medicare's payments to home health agencies, that there are people who do a good job at this.

But, I think that the second piece of it is, frankly, the longer pole in the tent, is just sort of identifying or getting people to properly target the benefit and hit those patients that are at risk for the hospitalization that you can grab at the right moment, and

that's something where we see a bunch of people doing different things. I'm not sure anybody really has a definite single answer to that question yet, I guess.

MR. THOMAS: The only other comment I would make on this is more of a regulatory versus a payment issue, is that, you know, there are limitations out there about how closely hospitals can work with home health agencies and make certain recommendations, and I would just encourage the Commission to look at that, as well, because, frankly, we have some limitations about who we can recommend, or can we recommend, and there are better agencies than others and I think that would be something that ought to be considered, as well.

MR. HACKBARTH: And, Bill Hall raised this a few minutes ago in the context of SNF, and I leaned over to Mark and said, we talked about this issue a couple meetings ago and I'll be damned if I can remember exactly what the context was. You know, the bottom line is that I agree with Warner and Bill, that to say to providers, your role is to give beneficiaries a list without any commentary, if, in fact, that's what the current regulation requires, that's just crazy. And, it's especially crazy in the context of

when hospitals are being held accountable for things like readmission rates.

And, so, I think that is something that we need to pursue. Maybe somebody here can remember the context in which you were discussing that.

MR. GLASS: It was ACOs.

MR. KUHN: Yeah, it was part of the ACOs, and I think where we took it is that there is kind of an implied effort right now by a lot of providers, hospitals, for -- maybe it was Carol or someone dubbed it soft steering --

MR. HACKBARTH: Yes.

MR. KUHN: -- where they --

MR. HACKBARTH: That's the term that we --

DR. CARTER: [Off microphone.] Private sector initiatives --

MR. KUHN: Right, where hospitals would array the ones at the top of the list to let folks move, and then we talked about a lot of options through there.

MR. HACKBARTH: Yeah.

MR. KUHN: So, right, it was two meetings ago that we did that.

MR. HACKBARTH: Right. Thanks for the reminder.

So --

MR. THOMAS: Can I just come back to -- I mean, I understand not saying, well, we use one home health agency and that's it. But, if you basically have relationships with two or three so there is some option, but they are folks that you know are going to work with you around readmissions and have a more collaborative relationship, I think that needs to be considered as part of this.

MR. HACKBARTH: Yeah. Yeah. And, so, we did use that term "soft steering" to suggest that, in this case, an ACO ought to be able to say, you know, we think this is a really good one that would give you the best care, but if you want the full list of Medicare participating agencies, here it is. So, we'll come back to that at some point.

Jack.

DR. HOADLEY: I just want to add for the record that I'm one who's not a fan of the copay approach. I mean, I hear a lot of the arguments, obviously, in this case, and I think if we were completely revisiting this issue, part of what I would argue is that if we're going to add this copay, let's do it together with taking off something on the less discretionary kinds of services, the kinds of discussion we

had under benefit redesign, or dealing with the out-of-pocket limits or some of the other kinds of things. And, the idea of just sort of adding this by itself is part of what concerns me about it.

MR. HACKBARTH: So, for the new Commissioners, in two separate conversations, two separate sets of recommendations, we recommended a copay for home health, and then I guess it was before that, or after that --

DR. MILLER: After.

MR. HACKBARTH: -- after that, we also did a review of the whole Medicare benefit package and recommended a restructuring of that, which, in the aggregate, would not increase beneficiary out-of-pocket costs. So, it was a restructuring, not an increased beneficiary cost sharing in the aggregate, proposal, and that's the approach that you're saying you favor.

DR. HOADLEY: Again, I wasn't here when we had that -- I wasn't here for that discussion, either, and, like, I might have different approaches to how to do it, but the principle of --

MR. HACKBARTH: Yeah.

DR. HOADLEY: -- doing it on a -- budget neutral

is not the right word there, but cost neutral to the beneficiary, and figuring out where you can add cost sharing on one thing and take it away on something else to keep it balanced is what I would strongly prefer over just sort of saying, okay, as part of looking at home health, let's add a copay, even though there are some reasonable justifications for how it was designed here.

MR. HACKBARTH: Yeah. Okay. Anybody else want to get in before we move to our final step here and close up shop for today?

[No response.]

MR. HACKBARTH: No? Jon, why don't you lead off on round three.

DR. CHRISTIANSON: Well, I support the recommendation. I wish that there would be something stronger in the program integrity area that could be here than just simply identifying an area where there seem to be problems and then stopping new agencies from entering the area. That seems like pretty small potatoes to me in terms of a very big program integrity problem here, so -- but, given that there's nothing else on the table, I'll support the recommendation, even with that qualification.

DR. HOADLEY: And, obviously, you know, given my comment a second ago, I mean, given our principle that we're just reprinting recommendations and stating them as that, I mean, I think there's nothing wrong with doing that. This one seems harder to get to for both the reasons I raised and the reasons Jon raised, that maybe there's parts of this that are looking like they're not as appropriate to the moment as -- and there's some sentiment to revisit, but, you know --

MR. HACKBARTH: Your views on the copay are at least on the record, so -- Alice.

DR. COOMBS: I support the recommendations that are on Slide 17.

MR. THOMAS: I support the recommendations with the comments that I made earlier around the steering issues and also around just understanding the value of this program and the overall Medicare program.

DR. BAICKER: I support the recommendations and I am more in favor of copays than it sounds like Jack might be, but I think it is important to have the beneficiary and provider incentives aligned with people valuing the care they're getting.

MR. KUHN: I support the recommendation.

DR. HALL: I support them, as well. I think we also ought to note, this was a very intensive discussion on this topic and we came out, I think, in favor of home health care, so we're all on the same page.

[Laughter.]

DR. SAMITT: I support the recommendations, as well, and I would echo Warner's stress point. I don't know if it's conceivable to underscore the discussion we had two meetings ago when we make these recommendations, as well, that we want to offer some degree of freedom, at least to ACOs, to be able to refer to higher performer, or at least to highlight higher performing home health agencies or SNFs, to give greater degrees of freedom than perhaps is offered in fee-for-service today.

MS. BUTO: I support the recommendation.

MR. GRADISON: [Off microphone.] I do, also.

DR. REDBERG: I support the recommendations.

DR. CROSSON: I support the recommendations.

DR. NAYLOR: I support.

MR. ARMSTRONG: Me, too.

MR. HACKBARTH: Okay. We are done. Thank you,

Evan.

We'll have our public comment period, and let me see who would like to make comments. Please line up at the microphone.

[Pause.]

MR. HACKBARTH: Okay. So we have three. Let me briefly review the ground rules. Please begin by introducing yourself and your organization. When the red light comes back on, that signifies the end of your two minutes.

And as always, I remind people this isn't your only and certainly not your best opportunity to contribute to our work. The best opportunity is to talk directly to the staff. Another is to communicate with Commissioners by mail. A third is to use our website to lodge comments.

So two minutes.

MS. UPCHURCH: Thank you. My name is Linda Upchurch. I'm with Next Stage Medical, and I'm here today to speak about home hemodialysis.

Home hemodialysis is a modality consistent with the congressional mandate to expand home-based therapies, one clearly linked to life-changing clinical benefits in the

published literature, and one for which there is an astounding lack of beneficiary access due to inadequate payment for training to send patients home.

Home hemodialysis has demonstrated the ability to deliver on CMS and Congress' goals for safe, highly effective, patient-centered care while significantly enhancing the patient experience and quality of care.

Home hemo patients feel well enough to contribute and are passionate about ensuring that other dialysis patients have access to the therapy that has made them feel so well. That is why literally hundreds of them have taken time to write, call, and visit CMS to ask that they continue to remove barriers to home dialysis access.

Despite the fact that most physicians and nurses would choose this modality for themselves if faced with kidney disease, the modality is shown to lead to longer lives, better clinical outcomes particularly in the cardiovascular arena, higher quality of life, and improved rehabilitation, today only one in six dialysis centers even offers home hemodialysis training and fewer routinely train patients to go home.

CMS knows about this. They've recognized it in

their rulemaking process communications for many years, and yet their own cost report data, which shows that their payment for training at $50, grossly underestimates the $290 actual cost per training session. This remains an unfixed arena.

With payment for training, centers would invest in a training nurse. Without appropriate payment, the vast majority choose to not. This is clearly important to patients. In fact, in the 2014 rulemaking cycle, over 95 percent of the public comments to the proposed rule stressed the imperative to reform this payment. Again, the problem remains unfixed.

Additional data to support these statements will be submitted to the website. However, we really look forward and appreciate your support on this critical issue.

Thank you to staff, particularly Nancy, for their hard work on this. Thanks.

MR. THOMAS: Hi, my name is Peter Thomas. I'm here on behalf of the Coalition to Preserve Rehabilitation. We sent a letter to the Commission last week, tried to submit it. Just so you know, the link to submit comments is down, couldn't submit the testimony all week. Tried to get

in touch with some of the individual members. Very difficult to contact you all.

So I have testimony here that I'd love to not go into in depth, and instead just ask you to take a quick look at it. It actually involves site-neutral payment between IRFs and SNFs, which you'll be talking about first thing in the morning.

The Coalition is comprised of the Brain Injury Association and the United Spinal Association and the REEF Foundation and many others, about 30 groups, mainly beneficiary organizations and rehab and clinician organizations. And we're very concerned about site-neutral payment, and we lay out a whole set of reasons why. But ultimately we believe that site-neutral payment, the way it's conceived of thus far, really creates financial disincentives to place the patient in the proper setting of care based on their own individual needs. And we feel that that's wrong, and we feel that ultimately that could wind up really blurring the lines between an inpatient, intensive, coordinated setting for rehabilitation and other settings of care to the detriment of beneficiaries.

So we would just ask that you would take a look at

this before taking the vote, and we appreciate the opportunity to comment.

MR. HACKBARTH: I apologize for any communication difficulties. I think there is a copy of your letter here.

DR. MILLER: There is. We put the letter out, and we changed our Internet service and cable this week, and there have been a couple of issues. But they'll be resolved.

MR. THOMAS: Thank you.

MS. EDELMAN: My name is Toby Edelman. I'm an attorney with the Center for Medicare Advocacy. The Center is a nonpartisan, not-for-profit public interest law firm that works to assure fair access to the full range of health care services under Medicare for older people and people with disabilities. We are a member of the Coalition to Preserve Rehabilitation that Peter just mentioned, and we strongly oppose the recommendation to equalize payments between IRFs and SNFs.

Our opposition is based on two key factors:

First, they're not the same. They don't provide the same level of comprehensive, intensive rehabilitation and nursing services to their patients, and as a

consequence, the outcomes for their patients are not the same.

Medicare beneficiaries who are able to participate in the intensive therapy that IRFs provide do better on virtually all measures. They have shorter lengths of stay in institutions, better health outcomes, better outcomes in activities of daily living, fewer emergency room visits, and many have fewer rehospitalizations. They live longer and at home.

Paying IRFs the same as SNFs means lower rates for IRFs, and inevitably the result will be fewer IRFs who are available to provide care to Medicare patients. We want to preserve the IRF option for people who need it and can benefit from it.

Our second basis for opposing site-neutral payments is our belief that providing care to patients in SNFs is very likely far more expensive than providing care to patients in IRFs when all costs to Medicare and Medicaid are considered. We know the primary motivation for the site-neutral recommendation is saving money, but I don't think the facts support the assumption that the government will save money by shifting patients to snfs.

Many years ago, I represent a statewide class of nursing home residents in California who sued the state when it refused to implement the nursing home reform law, and I worked with an expert witness, John Fitzgerald, a practicing physician and medical school professor in Indiana, who looked at the treatment of patients with hip fractures before and after the prospective payment system in hospitals, the DRG system. He found that after the DRG system, patients -- before the DRG system, patients with hip fractures received their rehab in the hospital and then they went home. After the DRG system was implemented, hospital lengths of stay declined from 22 days to 13 days, and the percentage of patients discharged to SNFs increased from 38 to 60 percent. The expectation was that patients would get the same rehab in the SNFs that they had received in the acute-care hospitals but at a lower cost. But that didn't happen.

After PPS, the researchers found that for various reasons -- and this is their language -- rehabilitation therapy within the nursing homes was less effective than inpatient therapy before PPS.

Moreover, instead of getting therapy and returning

home, patients were more likely to be in the nursing home a full year after their hip fracture. They found a 200 percent increase in the rate of nursing home residents after PPS.

MR. HACKBARTH: Excuse me. Your two minutes is up. We'd be happy to look at any written material.

MS. EDELMAN: Okay. I did try to submit it all week, so I will do that again. Thank you.

MR. HACKBARTH: Thank you.

MR. BERGER: Thank you very much. My name is Eric Berger. I'm here on behalf of the Partnership for Quality Home Health Care. The 12 provider groups that comprise the Partnership constitute about 16 percent of the care provided to the Medicare beneficiaries.

I do want to speak to the mandated report, but briefly just want to first talk about co-pays. We are, to Dr. Miller's point, one of the organizations that has been advancing program integrity reforms. We continue to do so because we think that that is the optimal solution to a program in which there is a persistent but fringe fraudulent element. We think that that should be targeted rather than the broad spectrum of ethical compliant providers and, of

course, the innocent beneficiaries that they serve.

Co-payments are particularly troubling to us. As we all know, of course, there used to be a home health co-payment in Medicare. Congress saw fit to repeal it in 1972 precisely because it did prove to be counterproductive, in large part because the population it served is a particularly vulnerable one.

According to the most recent federal data that we asked Avalere Health to analyze, a Medicare home health beneficiary is twice as likely to be over age 85, 50 percent more likely to have four or more chronic conditions, three times as likely to be disabled, and nearly 50 percent as likely to be poor. And this is, of course, a homebound population, to the Chairman's point about ambulatory ability to go to a physician's office and the like. There is no Medicaid coverage for the home health co-pay, of course, because there is no home health co-pay. There is one for SNF. So home health co-pay, until such time as state Medicaid programs catch up, would make home health less cost-effective to seniors than SNF care, which we don't think is the intended outcome. So we would ask for continued consideration of co-pay policy.

As it relates to the mandated report, we are concerned about certain methodological issues, and we're really appreciative of staff time and Commissioners' attention to a letter that we submitted. We are concerned about the application of the market basket update against the rebasing cut because then that leave the increased market basket costs without an offset. From a provider standpoint, it's six of one and half a dozen of the other. The impact would be the same, and it would be deep.

The margins as well, we did do an all-payer margin analysis. I believe it was mentioned earlier. I will submit it to the Commission for your consideration, which we'd appreciate.

We asked Avalere Health to go to the Securities and Exchange Commission and find the independently audited filings that the large publicly traded providers submitted to the SEC, and found that the four largest publicly traded providers had all-payer margins of 1.3 percent.

Finally, the last comment as far as the mandated report. We are troubled by the lack of data concerning 2014, and we cite CMS, which in the final rule for HH PPS stated, and I'll quote: "Sufficient claims data for

calendar year 2014 is not available for analysis." Consequently any analysis such as is mandated by the ACA on the impact of rebasing can only be an assumption-based projection until such time as claims data is analyzed.

We, therefore, respectfully suggest that Congress be asked for an extension on this report --

MR. HACKBARTH: The report has already been submitted. Thank you very much. We talked about this several meetings ago, so your comments are not timely.

MR. BERGER: My apologies. I wasn't aware of that. Thank you for your time.

MR. HACKBARTH: Thank you.

Okay. We're adjourned until 8:00 a.m. tomorrow.

[Whereupon, at 5:04 p.m., the meeting was recessed, to reconvene at 8:00 a.m. on Friday, December 19, 2014.]

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 19, 2014
8:01 a.m.

COMMISSIONERS PRESENT:
GLENN M. HACKBARTH, JD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
FRANCIS “JAY” CROSSON, MD
WILLIS D. GRADISON, MBA
WILLIAM J. HALL, MD
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, RN, FAAN
RITA REDBERG, MD, MSc, FACC
CRAIG SAMITT, MD, MBA
WARNER THOMAS, MBA

AGENDA PAGE

P R O C E E D I N G S [8:01 a.m.]

MR. HACKBARTH: Okay. Good morning. We have three sessions today, beginning with one on payment adequacy for inpatient rehab facilities and then, combined with that, site-neutral payments for select conditions.

DR. MILLER: The machine was down [off microphone].

MR. HACKBARTH: Oh, okay. Everything okay?

DR. CARTER: Yes.

MS. KELLEY: Yes.

MR. HACKBARTH: All right. Great.

MS. KELLEY: Good morning.

As you know, the Commission has been discussing a possible site-neutral policy for IRFs and SNFs. Today I am going to first present our analysis of payment adequacy for IRFs and the Chairman's draft update recommendation. This recommendation would apply to IRF cases that are paid under the IRF PPS. Then Carol will review the findings of our site-neutral analyses and present the Chairman's draft recommendation on site-neutral payment for some conditions treated in IRFs and SNFs.

After illness, injury, or surgery, many patients

need intensive rehabilitative care including physical, occupational, or speech therapy. Sometimes these services are provided in IRFs. In 2013, Medicare spent $6.8 billion on IRF care provided in almost 1,200 IRFs nationwide. There were about 373,000 IRF stays in 2013, and on average, Medicare paid slightly more than $18,000 per case. Medicare accounted for about 61 percent of IRFs' discharges. Since January 2002, Medicare has paid IRFs under a per discharge PPS.

To qualify as an IRF, a facility first must meet Medicare's conditions of participation for acute-care hospitals. In addition, IRFs must have a medical director of rehabilitation and a preadmission screening process to determine that each patient is likely to benefit significantly from an intensive inpatient rehab program.

An IRF also must demonstrate that it is primarily focused on treating conditions that typically require intensive rehabilitation. To that end, IRFs must meet the compliance threshold, known as the 60 percent rule. Under this rule, at least 60 percent of all patients -- not just Medicare patients -- who are admitted to an IRF must have one of 13 conditions, specified by CMS. These include

stroke, brain or spinal cord injury, hip fracture, and neurological disorders. If an IRF does not meet the compliance threshold, Medicare pays for all its cases on the basis of the inpatient hospital PPS rather than the IRF PPS.

You may recall that CMS tightened enforcement of the 60 percent rule in 2004. IRFs responded by changing their mix of cases, shifting towards those that count towards the 60 percent rule.

To qualify for a covered IRF stay, a beneficiary must be able to tolerate and benefit from intensive therapy and must have a condition that requires frequent and face-to-face supervision by a rehabilitation physician. Beneficiaries also must need at least two types of therapy.

As always, we reviewed payment adequacy for IRFs using our established framework. We consider beneficiary access to care, examining supply, capacity, and volume of services. We also consider quality of care. We assess providers' access to capital. And, finally, we analyze Medicare's payments relative to providers' costs.

So let's start with access to care. In 2013, there were 1,160 IRFs nationwide, with more than 38,000 beds. Each state and the District of Columbia had at least

one IRF. As you can see in the facilities column on the chart, only 21 percent were freestanding facilities. The vast majority of IRFs were distinct units located in acute-care hospitals. However, because hospital-based units tend to have fewer beds, they accounted for 53 percent of Medicare discharges from IRFs in 2013.

Overall, 28 percent of IRFs were for-profit entities. As you can see in the last two columns, over time the number of hospital-based and nonprofit IRFs has declined while the number of freestanding and for-profit IRFs has increased.

This slide shows the number of IRF cases on a fee-for-service basis. Beginning in 2004, as I mentioned, tighter enforcement of the 60 percent rule resulted in a substantial drop in IRF volume. The decline in the number of hip and knee replacement cases was particularly steep. But since 2008, you can see that use of IRF services has been very stable.

This year, to assess the quality of care furnished in IRFs, MedPAC staff worked with a contractor to develop risk-adjusted outcome measures. Our first two measures look at improvements in beneficiaries' motor function and

cognition during the IRF stay, given their level of function at admission.

Motor function and cognition at admission and discharge are measured using the scores tallied from the motor and cognitive items on the IRF-PAI assessment tool. To measure gains in function, the admission scores are subtracted from the discharge scores. The numbers you see here show the average risk-adjusted gain, at the facility level.

In 2013, the mean gain in motor function during the IRF stay was 23.1 on a 91-point scale. The mean gain in the cognitive score was 3.8 on a 35-point scale. We see nominal change between 2012 and 2013. We will continue to track these measures over time to observe trends.

We do use caution when interpreting these particular quality measures. Remember that payment is based in part on patients' functional status at admission, with higher payments associated with lower functional status. So providers have a financial incentive to score patients with a low FIM score at admission. As a result, reported gains in motor function and cognition may be overstated.

We also worked with a contractor to refine our

measures of risk-adjusted community discharge and readmission to the acute-care hospital. Our refined measure of community discharge does not give IRFs credit for discharging a Medicare beneficiary to the community if the beneficiary is subsequently readmitted to the acute-care hospital within 30 days. Our analysis found that the risk-adjusted community discharge rate was 75.9 percent in 2013, a small improvement from 2012. We also looked at risk-adjusted rates of discharge to SNF; these remained fairly stable between 2012 and 2013 at 6.7 percent.

Our refined hospital readmissions measures reflect only those readmissions that are potentially avoidable with adequate care in the IRF setting. We found that the rate of risk-adjusted potentially avoidable readmissions directly from the IRF was 2.5 percent in 2013. The rate of risk-adjusted potentially avoidable readmissions within 30 days after discharge from an IRF was 4.5 percent. You'll note how low these rates are compared with those we see in other settings. But to some extent, we shouldn't be surprised by this. IRF patients are selected because they can tolerate and benefit from intensive therapy, which means they tend to be less frail than some other patients in other post-acute-

care settings. And IRFs are themselves certified as hospitals.

The IRF measures we examined varied somewhat across providers, indicating some opportunities for improvement. For example, looking at the discharge to SNF line in the middle of the chart here, the IRF at the 25th percentile had a risk-adjusted rate of discharge to SNF of 4.3 percent. That's half the rate of the IRF at the 75th percentile. There was similar variance in readmission rates.

Turning now to access to capital, about 80 percent of IRFs are hospital-based units, which would access needed capital through their parent institutions. As you heard yesterday, hospitals maintained adequate access to capital markets in 2013 and 2014, and the share price of publicly traded hospitals has increased substantially in 2014, indicating that the capital markets continue to see hospitals as a profitable investment.

Hospital construction has recently shifted away from inpatient and towards outpatient projects, but we note that about 20 new hospital-based IRFs were opened in 2013.

As for freestanding IRFs, one large chain

dominates the freestanding IRF market, accounting for 40 percent of all freestanding facilities in 2013. Continued acquisitions of other post-acute providers and expansion of capacity through construction of new IRFs reflect good access to capital and positive financial health for this chain. Market analysts we spoke to echoed this conclusion.

Most other freestanding IRFs are independent or are local chains with a small number of facilities. The extent to which these providers can access capital is less clear.

In 2013, the Medicare margin remained steady at 11.4 percent. This estimate includes the sequester that was in effect for part of 2013. As you can see, financial performance varies across IRFs. The aggregate margin for freestanding IRFs, which accounted for 47 percent of IRF discharges, was 24.1 percent. Hospital-based IRFs had an aggregate margin of 0.3 percent. There was a similar spread between for-profit and nonprofit IRFs. Of course, these two categories are highly correlated. Most hospital-based IRFs are not-for-profit.

So what accounts for the difference between hospital-based and freestanding margins?

First, we see higher costs across the board in hospital-based IRFs, with the biggest difference in routine patient care costs. We don't believe that allocation of overhead is much of a factor in hospital-based IRFs' higher costs. In fact, as a share of their total costs, hospital-based IRFs have lower indirect costs than freestanding IRFs.

When we standardize IRFs per case costs to control for differences in wages and case mix, hospital-based IRFs continue to have higher costs. However, there could be unmeasured differences in complexity and severity that we can't control for. We have noted some differences in hospital-based and freestanding IRFs' mix of cases, and I can talk more about that on question if you'd like.

Economies of scale likely explain a good deal of the difference in costs between the two provider types. Hospital-based IRFs tend to be much smaller and have fewer total cases. Their occupancy rates are also lower.

Despite the comparatively low margins in hospital-based IRFs, these units appear to make a positive financial contribution to their parent hospitals. Acute-care hospitals with IRF units have slightly higher margins than hospitals without IRF units.

When we sorted IRFs into quartiles based on their standardized costs, we found both hospital-based and freestanding IRFs among the lowest cost group, shown in the middle column here. You can see that hospital-based IRFs in this group of low-cost IRFs had standardized costs per case of about $12,000. This lowest-cost quartile had a median Medicare margin of 26.2 percent compared with minus 26 percent for IRFs in the highest-cost quartile.

You can see here that IRFs with the lowest costs tended to be larger. The median number of beds was 44 compared with 17 in the highest-cost quartile. IRFs with the lowest costs also had a higher median occupancy rate (70 percent compared with 47 percent for the highest-cost quartile. Forty-one percent of the low-cost group were hospital-based units.

We estimate that IRFs' aggregate Medicare margin will be 12.6 percent in 2015. This margin projection includes the effect of sequester. If the sequester were not in effect for 2015, the projected margin would be almost two percentage points higher.

To arrive at this estimate, we considered payment policies effective in 2014 and 2015. These include

statutory updates and changes to high-cost outlier payments that will more than offset the effects of the sequester. In addition, we assumed a historical rate of cost growth that has been below market basket levels.

So, to summarize, we observe capacity that appears to be adequate to meet demand. Our risk-adjusted outcome measures are stable or increasing nominally for the brief period we examined. Access to capital appears adequate. We estimate that the margin was 11.4 percent in 2013. And we project a margin of 12.6 percent in 2015.

The Chairman's draft recommendation reads as follows: The Congress should eliminate the update to payment rates for inpatient rehabilitation facilities for fiscal year 2016. Eliminating the update for 2016 will reduce spending relative to the expected statutory update. We do not anticipate this recommendation would have any adverse impact on beneficiaries or on providers' willingness and ability to care for patients.

Now Carol will review the findings of our site-neutral analyses and present the Chairman's draft recommendation on site-neutral payment in IRFs and SNFs.

DR. CARTER: In November, the Commission continued

its discussion of site-neutral payments, extending the concept to payments between IRFs and snfs. Because both settings furnish rehabilitation services to patients recovering from a hospital stay, they are another example where program payments should not based on where beneficiaries get their care but on their characteristics.

I want to remind everybody that the requirements and intensity of services furnished are different in the two settings. We went over this material in November, and it's in our June chapter, so I won't repeat it now.

Despite these differences, some of the patients and their outcomes are similar. So the two settings are ripe for site-neutral payments for select conditions.

The Commission has taken a deliberative approach to identify services and conditions most appropriate for site-neutral policies. It has consistently used criteria to evaluate candidate conditions and services. These include: the condition is frequently treated in SNFs, as a way to ensure that this setting safe; the patients have similar risk profiles, and their outcomes are similar.

In June, we reported on our analysis of five orthopedic and three stroke conditions. In last month's

discussion, we discussed the large variation in stroke patients, and the stroke conditions were put aside for now.

We also discussed 17 additional conditions. The 22 conditions under consideration -- that's the 17 new ones plus the five orthopedic ones we reported on in June -- are a mix of orthopedic, pulmonary, cardiac, and infections. Together, they comprise 30 percent of IRF cases and spending, and I want to point out that number is a revised number.

Let's look at the first criterion: conditions are frequently treated in the lower-cost setting, SNFs. Given that many markets do not have IRFs, we looked at the frequency of IRFs and SNFs and their use in markets with both types of facilities. Given the majority of conditions are treated in SNFs, we thought the conditions would be ripe for site-neutral payment. If you looked across all markets, the shares of patients treated in SNFs would be even larger.

On a per stay basis, Medicare payments to IRFs are considerably higher than those made to SNFs. For example, for the 17 conditions we reviewed last month, the IRF base rates that exclude the add-on payments are 49 percent higher than SNF payments.

The next criterion is comparing risk profiles. We found that for each of the 22 conditions, the patients treated in IRFs are similar. Their risk scores are similar, both their averages and we looked at the overlap in the distributions. And, on average, SNF patients tend to be older.

Most comorbidities were either more common among SNF users or comparable between the two settings. To the extent we find older, more complex patients in SNFs, we conclude that SNFs are capable of treating the patients currently treated in IRFs, and in markets without IRFs, they already do. From CMS's PAC demonstration, we know that the patients admitted to the two settings for all conditions had similar functional abilities at admission.

Turning to outcomes, we report mixed outcomes in part because not all the measures are risk adjusted. Ideally we would compare risk-adjusted outcomes, but often this information is lacking; and even when it is available, we cannot fully control for selection.

From CMS' demonstration, we know that across all patients, IRFs and SNFs had similar risk-adjusted readmission rates and changes in mobility. The changes in

self-care were higher for patients treated in IRFs.

We found that observed mortality rates were higher in SNFs, in part because their patients are older and sicker. Differences between the two settings would narrow with risk adjustment, but we would expect some of the differences to remain. Because patients admitted to IRFs have to be able to tolerate three hours of therapy a day, we would expect their mortality rates to be very low.

We also looked at program spending in the 30 days after leaving the IRF or SNF. We found that IRF stays continued to have higher spending in the 30 days after discharge compared with SNF stays. Although IRF stays had much lower spending associated with readmissions, their spending on additional PAC services is considerably higher.

The SNF-IRF site-neutral policy you've discussed has several components.

First, for selected conditions, IRFs would be paid the average SNF payment per discharge as the IRF base rate.

Another component of the policy is that all add-on payments for IRFs would remain the same.

DR. CARTER: For qualifying, IRFs would get relief from certain regulatory requirements regarding how care is

furnished, such as the intensive therapy requirement and the frequency of face-to-face physician visits.

It is likely that the threshold compliance on threshold would need to be revised to remove site-neutral conditions from the compliance calculation. Otherwise, the conditions would count towards IRF compliance but be paid at SNF rates.

In terms of program spending, a site-neutral policy would lower payments to IRFs by almost $500 million, or about 7 percent of their spending. The impact of the policy is dampened by two factors. First, the majority of IRF cases are not affected by the policy; and second, the add-on payments would remain for site-neutral cases.

Kathy, you asked about whether the estimate includes an offset for the higher readmission rates for SNFs. Factoring in those costs associated with higher SNF readmission rates would assume that the site-neutral cases would shift to the SNF, but we think many IRFs will continue to treat these cases. And if cases did shift to the SNFs, we would expect their readmission rates to be lower because they are younger and they have fewer comorbidities compared to the typical SNF patient.

Further, since SNF patients are less likely to use subsequent PAC use, an estimate would need to include the post-discharge spending as well. Because we do not know how IRFs will respond to this policy, we did not model these possible offsets, and our estimate assumes no behavioral changes.

The estimate also assumes the payments under the current PPS, but as we discussed yesterday, we have recommended that the SNF PPS be revised. We don't think the aggregate impacts would vary very much because this revised design, we propose to be implemented in a budget-neutral way.

Let me say a bit more about the possible responses from the IRF industry.

The policy relieves IRFs of some of their regulatory requirements for site-neutral conditions. IRFs can lower their costs and reduce the intensity and mix of their services. The extent to which they make these changes will depend in part on their cost structure, and remember that Jeff's work has shown that the variable costs make up the lion's share of at least hospital costs.

We think many IRFs will continue to treat these

cases. As we've discussed in this SNF update presentation, the SNF PPS is very profitable. The SNF payment rates may still cover the patient care costs in IRFs and might be preferable to an empty bed, especially since the average IRF occupancy is 63 percent. We think IRFs will modify their service mix and cost structures.

On the other hand, IRFs may decide to no longer treat these cases. In this case, the industry may shift their mix of cases and even contract. While this is what happened when the compliance threshold was enforced, we think this policy's impact will be different because IRFs will have the flexibility to change their cost and their service mix.

Kathy, you asked about the changes in beneficiary liability that would result from the policy. We think that the impacts would be small. For the patients who continue to be treated in IRFs, the liability would not change and is detailed in the first part of the slide. They would still have an inpatient deductible, which they meet with their prior hospital stay, and they would have copayments for the very long stays on the inpatient setting. And they would have copayments for any subsequent PAC use and outpatient

care.

Patients who are shifted to SNFs will incur the same hospital deductible and copayments. Their SNF copayment will depend on whether their stays extend beyond 20 days. IRF patients' average length of stay is 14 days. So if they stayed that long in the SNF, there would be no copayment. If their stays extended beyond 20 days, they would face a daily copayment.

Since most beneficiaries have supplemental coverage, either private or Medicaid, even for beneficiaries who shift site of service, we expect the impact would be quite small.

This leads us to the Chairman's draft recommendation. It reads, "The Congress should direct the Secretary of Health and Human Services to eliminate the difference in payments between inpatient rehab facilities and skilled nursing facilities for select conditions."

Note that the recommendation does not specify conditions. The discussion below the bold text -- face recommendation would describe using a set of criteria, similar to the factors we used, to identify conditions.

It would also discuss setting the IRF base rate

based on the average SNF payment per discharge and retaining the add-on payments for IRFs. It could also discuss a transition as a way to mitigate the impacts.

In terms of impacts, the recommendation would lower program spending relative to current law. For providers, payments to IRFs would be lower. SNFs may see an increase in volume and their program spending for the select conditions if this volume shifts.

For beneficiaries, we do not anticipate negative impacts. We expect many IRFs will continue to treat these conditions, minimizing the impact on them. We do not see significant differences between the two settings in terms of readmission rates and mobility improvement, and the majority of these cases are already treated in SNFs.

And with that, I look forward to your discussion.

MR. HACKBARTH: Okay. Thank you, Dana and Carol.

So we have two distinct recommendations here, the update for IRFs and then the site-neutral draft recommendation. What I'd like to do is separate the discussion of those two. I think the discussion around the site-neutral recommendation is probably longer and more complex. So what I'd like to do is -- let's see. We have

about 50 minutes left for this, and my target would be to do a quick discussion of the update recommendation, maybe, hopefully, in around 10 minutes, and then have the balance of the time, 40 minutes, for the site-neutral. So that would be my objective.

I'd like to begin with the IRF update, and what I envision here is like two rounds, one, a very quick, focused, clarifying question round. And then the second, we'll go around the table and give people a chance to say whether they feel comfortable with the draft update recommendation or not. Okay? Sound like a plan?

So clarifying questions on the update recommendation? Bill.

DR. HALL: These are terrific reports.

I just want to make sure I understand the difference between Medicare and non-Medicare recipients of IRF and SNF services. Is everything in here limited to Medicare recipients, or are some of the data aggregating for anyone who might end up in one of these facilities?

MS. KELLEY: All the information about volume and spending --

DR. HALL: Right.

MS. KELLEY: -- is all Medicare-specific.

DR. HALL: Okay.

MS. KELLEY: There's nothing about other beneficiaries in there.

DR. HALL: Right.

MS. KELLEY: We do have an analysis in the chapter that looks a fee-for-service versus Medicare Advantage patients.

DR. HALL: Right.

MS. KELLEY: We have assessment data for managed care -- for Medicare managed care payments.

DR. HALL: Yeah.

MS. KELLEY: And so that allows us to do that comparison in the mix of cases and case mix. But generally, this is strictly limited to Medicare fee-for-service.

DR. HALL: Okay. So, particularly, when we looked at outcomes, functional state, those are Medicare --

MS. KELLEY: The measures that I -- the risk-adjusted measures that I reported today are Medicare fee-for-service only --

DR. HALL: Thanks.

MS. KELLEY: -- and I believe all the work that

Carol did.

DR. HALL: Thank you.

MR. HACKBARTH: Other clarifying questions? Jay.

DR. CROSSON: Just a quick point on Slide 13 of that. The difference in profitability between the lowest cost and highest cost is quite dramatic, as we've seen in other areas.

You said that you thought that perhaps economies of scale was the most likely reason for that. I would agree with that, but there's two different economies of scale here. One has to do with the number of licensed beds, and the other has to do with the occupancy rate. It would seem to me, since most of the high-cost IRFs are hospital-based, that they have most likely underlying costs that are not that different from the lowest cost IRFs, since those are licensed as acute care hospitals as well, whereas the occupancy rate would spread the cost over a different number of patients.

In terms of economies of scale, it might be helpful to say in which of those two measurements are you talking about economies of scale, and I would guess that the occupancy rate is more of an issue than the number of

licensed beds.

MS. KELLEY: I suspect it's some of both. I mean, we've seen much higher costs in the hospital-based IRFs, even beyond the indirect cost. The routine care costs are 70 percent higher in the hospital-based IRFs than they are in the freestanding. So I suspect it's some of both, both a lower number of patients, a lower number of patients in general, to spread the costs across, because of the lower occupancy rates and because of the -- I mean, the difference in -- I mean, you're looking at a huge difference there when you combine the number of beds with the occupancy rate in terms of the number of patients they're spreading their costs across.

I'm not sure what else to say. We do see some differences in the types of patients that are being admitted to hospital-based and freestanding IRFs, so there could be unmeasured case-mix differences there. There could be a richer mix of staff in the hospital-based IRFs, simply because they're in hospitals and the availability of staff that is in a hospital, but whether that's because that's needed because of the patients or whether that's sort of an overflow from more of a hospital -- you know, acute care

hospital setting, I can't say.

DR. CROSSON: [Speaking off microphone] -- surrender.

DR. CHRISTIANSON: Most of the analysis, it seems to be based on 2012 Medicare claims data, but there are a couple of analyses based on 2011. Do you plan on -- are you working on updating that, or is it just considered to be not needed?

MS. KELLEY: The claims analyses, the claims were from 2013.

DR. CHRISTIANSON: I'm looking at Table A6 and A7, which is 2011 Medicare inpatient hospital claims analysis in the report.

MR. HACKBARTH: What's the heading of the table?

MS. KELLEY: Which report?

DR. CHRISTIANSON: The appendix, Table A6, Share of Cases Treated by Severity Level in Markets with Both Types of Facilities, and A7, Analysis of Paralysis --

DR. CARTER: Right. So that's on the site-neutral work.

DR. CHRISTIANSON: Yeah.

DR. CARTER: Right. That was all done using '12

data.

DR. CHRISTIANSON: It says 2011 data on the table, so I was wondering if you had updated that analysis to 2012.

DR. CARTER: I'll check, but I think it's '12.

DR. CHRISTIANSON: Okay.

MR. HACKBARTH: Other clarifying questions? Rita.

DR. REDBERG: Yesterday, we heard about differences when CMS audited costs that were reported by some other facilities. I'm wondering if there has been similar audits for the IRFs.

MS. KELLEY: I don't know the answer to that, but I can look into that.

MR. HACKBARTH: Dana, can I ask about the IRF PAI scale? After all these years, I should remember more of this, but I don't. Could you just briefly describe that?

In your presentation, you mentioned that there is an incentive to scale at the lower end on admission. Just sort of elaborate more on how the scale works.

MS. KELLEY: So the case-mix groups, the IRF case-mix groups are first based on condition type, so there is stroke, neurological disorders, hip, lower extremity joint replacements. And within those categories, patients are

delineated by functional status and age for the most part and then with some additional specified comorbidities, also, moving patients up or down in payment.

So the functional status is measured using the IRF PAI, and on the 18 items, cognitive and motor, patients can score from zero to 7 on each particular item.

So lower scores indicate lower functioning, and patients with those lower scores in most, if not all, of the CMGs will move up into a higher payment category.

So there is an incentive to code or to assess patients as being more rather than less functionally impaired at admission.

MR. HACKBARTH: And how objective are the steps within each of the scales? Could you give an example about how they're structured and how they're --

MS. KELLEY: Yeah. So the -- I think I have one right here. I believe it's on a zero-to-7 scale, and I believe the measures are based on how much burden on the caregiver that particular item is. So how much assistance the patient needs is measured by how much the caregiver needs to help the patients. So you would score zero -- the zero would be if there's no performance of the activity at

all; 1 would be the caregiver completely assists in the activity; moving up to 7, where it would be complete independence.

MR. HACKBARTH: Okay. So, in the middle, it sounds like there's probably a fair amount of subjectivity, whether you score a patient a 4 or a 5 or a 6.

DR. CARTER: There probably is some room for differences. It is a rating system that was tested and found to be reliable within a rate of reliability.

MR. HACKBARTH: Okay.

DR. CARTER: And I believe assessors have to go through training too. So it helps try to minimize in a rate of reliability, but it is one of our concerns that there's still some opportunities for differences, really, in how the same patient could be assessed differently by a different assessment.

MR. HACKBARTH: Yeah. And I'm not necessarily suggesting anything nefarious. It's just that different people experience different things with patients and observe different things. Okay.

DR. MILLER: Or even peculiar to this area, I mean, we have assessment instruments in other areas.

MR. HACKBARTH: Right.

DR. MILLER: And they all have some of this characteristic.

DR. CARTER: That's right.

DR. REDBERG: Related to that, but similar, has there been any studies that have assessed -- observed a variability in those evaluations? Like if two people evaluated the same patient, would they get the same scores?

DR. CARTER: I think so. This isn't a space I work in actively, but I'm pretty sure that before the scale was adopted, there was.

MR. HACKBARTH: Jon.

DR. CHRISTIANSON: Yeah. Given the kind of provocative results that you got from your '12 interviews, do you have any plans or do you see any need to expand that, or did you get what you needed out of just the 12 people?

DR. CARTER: Well, we really did this -- so that's about the site-neutral work, and we really did that work focused on stroke evaluation to try to shed more light on what we were -- trying to understand how stroke patients are placed, and once we heard quite different situations and sort of the decision-making that goes on, last month you all

decided to put that aside. So we don't have any plans to follow that up.

MR. HACKBARTH: Okay. So I'd like to complete the discussion of the update recommendation, and so, Bill, why don't we start with you. Bill Hall, your view on the draft update recommendation?

DR. HALL: I'm generally supportive of the recommendation. I still have a certain amount of nervousness that we are using nomenclature of inpatient rehab and SNF, and it's still not entirely, in my mind, patient-specific enough.

Having said that, I don't have any particular suggestions as to where we go, but I think Jon's question of really making sure that we have a pretty good idea about the various functional differences and the scales that are being used -- but I think we're moving in the right direction.

MR. HACKBARTH: Okay. We will come back to the site-neutral discussion. So let's just focus on the IRF update in this round.

Herb?

MR. KUHN: On the update, I'm generally supportive.

MR. HACKBARTH: Kate?

DR. BAICKER: I support the update.

MR. THOMAS: I support the update.

DR. COOMBS: I support the update.

DR. HOADLEY: I support the update.

DR. CHRISTIANSON: I support the update.

MR. ARMSTRONG: So do I.

DR. NAYLOR: As do I.

DR. CROSSON: For it.

DR. REDBERG: I support the update.

MR. GRADISON: So do I.

MS. BUTO: I support.

DR. SAMITT: Same here.

MR. HACKBARTH: Okay. So now let's turn to the site-neutral draft recommendation and begin with clarifying questions on site-neutral. We'll go this way, Kathy and then Mary.

MS. BUTO: So, thanks for the work. I think the more I delved into this, the more complex it seemed to me, and I really admire your ability to navigate.

I tried to do something, because I couldn't find it anywhere, and it may be somewhere in the documents, which

was I crosswalked the 13 compliance condition categories to the 22 conditions, and then I tried to layer on top of that the conditions that MA plans use predominately, or seem to gravitate toward, in using IRFs, because at least the discussion in the paper was that they've been more discriminating and they tend to really refer and focus on certain high-severity patients. So, I was trying to figure out, what's the convergence of those things?

And, so, my sort of clarifying question to the two of you is, in my analysis, which is quite crude, the overlap between the 13 and our 22 revealed to me, I think, that only four of our 22 really are included in the sort of 60 percent group, two amputation conditions and two lower extremity, or, I guess, it's hip and knee fracture -- fracture and revision, or something like that. So, really, four out of the 22 would overlap into that 60 percent group, because I know one of the issues we're going to be talking about is whether that gets adjusted if we do site neutral.

So, I just wanted to verify that that's true, and then, secondly, that in the MA list, that stroke was the most -- it jumped out at all of us, I think, as the one where MA plans tend to use IRFs more than fee-for-service.

And, then, I guess some others not necessarily out of line with fee-for-service where there is use, is lower extremity fracture and brain injury are two other categories that I noticed.

So, I just wanted to make sure that analysis was correct, or were there more conditions that we've identified in the 22, which I think is in one of the papers, a list of the 17 in addition to the orthopedic, that those four are the ones that would overlap. Is that right, or were there more?

DR. CARTER: You're thinking about this correctly, but my count's a little different-

MS. BUTO: Okay.

DR. CARTER: -- and it's only because some of what you're counting as one condition is really a collection of DRGs. So, if you said that, like, hip fracture is really -- is one, but hip and femur procedures was three, and joint replacement was two. So, my count -- and the categories don't perfectly align, so I appreciate your feeling like, I think I'm doing this right, but my count is more like nine of the 22 --

MS. BUTO: Okay, and that includes the two

amputations?

DR. CARTER: Yes. Yes.

MS. BUTO: Okay. That's helpful.

DR. CARTER: And, I think, Dana, that's right, that the MA plans are -- have -- a higher share of their patients are stroke patients.

MS. BUTO: Okay. And, what I was trying to get at there was some understanding of which, just from a layperson's perspective, which conditions seem to lend themselves to intensive rehab of the sort we're talking about in these IRFs, versus septicemia and other conditions, respiratory conditions, which I think many of us realize are not only handled in many cases by SNFs, but that may even be the first choice rather than an IRF.

So, if you look at the conditions, there were what I call medical conditions, which are of the septicemia variety and respiratory infections, cardiac valve recovery, et cetera, and then there are these more physical, the amputation recovery and knee and hip kinds of procedures. So, anyway, I just wanted to clarify that. Thanks.

DR. CARTER: And, the only thing I would add to that is the Commission in a couple of the comment letters on

the proposed IRF rules over the last couple of years has commented that we think that some of the conditions should be narrowed in the same way that the joint replacement condition was more specific about the types of joints. And, we think that that could -- and, we're not clinicians, so this is -- kind of get beyond our expertise, but some of those conditions are very broadly defined.

MS. KELLEY: And, I'll just add to that that CMS is going to be moving towards a more narrow definition of the arthritis conditions that count.

DR. NAYLOR: [Off microphone.] It doesn't directly build onto that --

MR. HACKBARTH: That's a good --

DR. NAYLOR: That's a good thing.

MR. HACKBARTH: Well, no, a good catch. I should ask, does anybody else want to pursue Kathy's question further or something closely related to that?

Okay, Mary. The ball is yours.

DR. NAYLOR: So, Slide 8, and to help make sure I understand, in that slide, you talk about relief from the provision of three hours of therapy. And, so, to get into an IRF now, you must be able both to tolerate and benefit

from three hours of therapy. For the 22 conditions, you are recognizing that there will need to be relief from that provision. So, does it change both, both tolerate and benefit from, in terms of screening who comes in? So, theoretically, could older, frailer people come into IRFs now with those 22 conditions if they're no longer in a threshold?

I'm just trying to say, does it get us to a position -- the reason I raise it is you raise the comment that mortality rates are higher in SNFs right now and you didn't expect them to change with this new. But, we could have a mix, a different mix of people, and if we don't have the same kind of therapy, we could end up with higher mortality rates. So, I was just wondering how you were thinking --

DR. CARTER: So, we were thinking that that kind of relief for both aspects of the intensive therapy requirement, but also things like the pre-admission assessment by a physician and then the post-admission evaluation and the requirements for more physician face-to-face visits during the week. So, we were thinking about the things that really affect the way patient care, and,

therefore, facility costs, we were thinking of relief from all of those.

MR. HACKBARTH: So, just to follow up on Mary's point, which, I think, is a good one, so you could see in IRFs, if this change were made, more frail patients who would not have been candidates before because they couldn't withstand the intensive therapy. And, so, the IRF mortality rate could go up as a result of that. Conversely, you may see an influx into SNFs of more lower-risk patients who would have been in the IRF in the past because they could withstand the intensive therapy and not pull down the SNF mortality rate.

DR. CARTER: That's right.

MR. HACKBARTH: Jack.

DR. HOADLEY: Yeah. This follows on this line of conversation. I mean, you've said that your estimates are assuming no behavioral change, but you had a good discussion, it seemed like, of some of the potential dynamics that could lead to some behavioral change, and what we're talking about here is more of that. Is there a sense, for example, that -- it was implied by this conversation that some existing SNF patients might end up in IRFs if

those regulatory rules are changed so that those no longer would run into those restrictions. I mean, it's still probably reasonable to, if you don't have a lot of evidence on what direction to expect changes, to say, well, okay, for the purpose of estimates, we're not going to assume any behavioral change. But, is there any more insight into what's reasonable to expect in terms of movement around?

DR. CARTER: I mean, I think what you've outlined is possible. We just don't really know.

DR. HOADLEY: Yeah.

MR. HACKBARTH: On this general topic of behavioral response and shifting of patient types as a result of site-neutral policy, so, IRFs are paid on a per discharge basis. For these patients, then, they would now be paid on the SNF per day, or we'd stay with --

DR. CARTER: No. So, when we thought about how the new base rate would be calculated, we calculated a discharge rate based on the SNF length of stay. So, in that sense, they would still be thinking about their costs and their payments over the entire stay.

MR. HACKBARTH: Okay. Alice.

DR. COOMBS: So, there was a mention about

prorating the pay, because the length of stay of the IRFs is considerably shorter than the SNF in the document, so I just wanted to mention that.

But, one of the things that Mary said, and I think that when you set the bar for the three hours of rehab and we say, okay, let's be a little lax on that, or to take away that as a bar, I only worry about to what extent some IRFs might have labor stresses in the area, and actually the ones that should have received the three hours no longer -- you know, there might be a little bit of laxity with giving appropriate intervention or rehab to the ones that really, really need it for those minimal criteria.

I actually think about the other way in which IRFs begin to look like SNFs in their function and in their action plans. They may have robust action plans, but the implementation of those action plans are not carried out. So, I was thinking along those lines rather than the opposite.

And, I think, you know, if we could just reiterate in the chapter really strongly this whole notion of the mortality being greater at the SNFs, it's okay because the decision is made at the provider level, you're leaving from

the acute care hospitals, that this patient belongs at this appropriate facility because of, maybe, discussions with families about resuscitation status and maybe more of a custodial care rather than an intervention and an aggressive rehab. And, I think that when you change the selection based on appropriate sites of care for patients and their comorbid conditions, that's very different than saying that it's stinting or selection that's in operation here. It's really looking at the general picture of the patient and saying that this is an appropriate place for this patient.

So, not to introduce this -- you know, we can introduce selection and stinting in different places in our chapter, but I think right here, we need to really say that if I, as a clinician, if I see someone who has five comorbid conditions and they have a poor prognosis, then I'm going to try and put them in the right clinical site that's going to be best for them and their families.

MR. HACKBARTH: I think that's a good point, that clinicians will still be key decision makers here, in conjunction with families, and they could decide to use SNIRF -- SNIRFs --

[Laughter.]

MR. HACKBARTH: I was actually bringing up the SNIRF point, is that we're potentially talking about a new sort of middle category that is the SNIRF --

[Laughter.]

MR. HACKBARTH: Where is Evan? I heard that he also came to the SNIRF term. Anyway, there is potentially this middle category, and the decision on whether to use it will be a clinician and patient decision.

Now, that brings me to what I think is a related question, and that has to do -- so, the payment rate would be at the SNF level, and that raises the question of whether for these 22 conditions we know whether SNFs are profitable. We know SNFs are very profitable on average. Do we know anything about these particular 22 conditions for SNFs?

DR. CARTER: We don't, but we know that the high rehab patients are highly profitable.

MR. HACKBARTH: Yeah. Kathy.

MS. BUTO: Glenn, I wanted to follow up on your point. You asked earlier about whether payments would be set at a discharge level versus a per diem level, and I think that's true for IRFs. But, to the extent these patients shift to SNFs, they're paid on a per diem level,

correct, and there, could the costs -- I don't think the costs would necessarily approach the level of payment per discharge at the IRF, but they could go up for a given case, right, because of the per diem nature of SNF payment and the fact that rehab services play such an important role, at least under the current system, right?

DR. CARTER: Well, I don't think they would increase compared to current SNF payment. Those incentives are already there --

MS. BUTO: Right.

DR. CARTER: -- to increase the length of stay. I would expect these patients to be slightly -- you know, they're younger and they tend to have fewer comorbidities, so I would think they'd actually have shorter stays and be less expensive --

MS. BUTO: Okay, but --

DR. CARTER: -- than the current SNF population.

MS. BUTO: Okay, because I would just point to -- there's one, I think it's fractures of hip and pelvis without MCC, where the SNF payment is roughly 15 percent above what the IRF payment is --

DR. CARTER: Mm-hmm.

MS. BUTO: -- and your feeling is it would never get to that point in a SNF because of the relative youth and mobility of the IRF patient, you think.

DR. CARTER: That's my --

MS. BUTO: I'm just wondering --

DR. CARTER: Yes, that's my sense.

MS. BUTO: -- how big a difference there might be in just the per diem payment versus a per episode kind of thing.

DR. CARTER: Right. But, in our SNF estimate, we've included current SNF practice.

MS. BUTO: Okay. So, you tried to -- you've just assumed that current SNF practice would govern the treatment of these patients.

DR. CARTER: Yes.

MS. BUTO: Yeah.

MR. HACKBARTH: So, did I see another hand? Was it on this immediate issue?

DR. CROSSON: [Off microphone.] It's on rural --

MR. HACKBARTH: Let me come back to you, okay. We'll just continue down this side for a second. Clarifying questions? Any more clarifying questions? Warner.

MR. THOMAS: I'm just trying to kind of put together a couple different facts here. So, in the -- when we did the payment update, you were looking at the high-versus low-cost facilities, and 95 percent of the high-cost facilities are hospital-based. Then, looking at the number of IRFs, about 80 percent of the IRFs are hospital-based. And then if you look at the payment update information from yesterday, if you look at hospital-based SNFs, they run a negative 70 percent margin, based on what I saw yesterday.

So, I'm trying to put those three components together and see what impact this site neutral would have, kind of given those three different points of information, because it seems like we'd be taking 80 percent of the IRFs that are hospital-based -- and I understand they're the higher cost because they're running a lower occupancy, and I don't know what that's all about. I guess we'd have to try to understand that better. But, I'm just trying to understand what the impact would be to moving hospital-based IRFs to a hospital-based SNF rate that runs a 70 percent negative margin. So, am I, like, not putting this together right?

DR. CARTER: No, everything you said is true. I

guess we don't know that the patients are going to leave IRFs, so let's start there, and it's true that hospital-based SNFs have lower margins. I'm almost -- you could have replaced SNF for some of what Dana was talking about in terms of the cost differences between hospital-based SNFs and freestanding SNFs. Their cost structures are just higher.

And, I haven't looked at the hospital-based occupancy rates to see how much excess capacity there is there. So, some of what you're talking about, I guess I would need to know a little bit more -- I would need to do a little bit more work to know, do hospital-based facilities have the capacity if the patients were to then move out of hospital-based IRFs and into -- but hospital-based SNFs are three percent of payments, five percent of facilities. So, that's not where most of them are going to go, because my industry is 95 percent freestanding.

MR. THOMAS: But, 80 percent of the IRFs are hospital-based.

DR. MILLER: [Off microphone.] It's about 50 percent of the cases.

MR. THOMAS: Right.

DR. MILLER: The hospital-based are a lot smaller. So, 80, 50, depending on what you're talking about.

MR. THOMAS: Because, basically, all the freestandings are larger. They're going to be larger facilities. They're running a -- so, I understand. They're going to run -- be able to run leaner, because they have scale. So, I get that. I guess I'm trying to understand of the -- you know, if there's 80 percent of these hospital-based, they're smaller facilities, can they -- what happens? I mean, should they not be there? Is there an alternative, so they shouldn't be there? That's why they're running lower occupancy? Or is it they need to be there and that's the only kind of volume of patients they have, and if they've got to rehab in a SNF and the SNF is running a negative 70 percent margin, how does that work by shifting the --

DR. MILLER: I guess the way I would think about this is there's going to be -- I mean, we're kind of back to all of the behavioral response questions that have come up, in a way, and in some ways, unless I'm missing your question, and you should redirect, you're sort of asking it in the context of the hospital-based setting.

So, I think there will be a set of decisions that the providers will have to make. They'll either look at the set -- and, I don't know quite the distribution of cases that we're talking about here and how they fall across the two different actors, which would be relevant here. They'll have to decide whether, okay, at this rate, it's still profitable. Now, we know when you look at it under the SNF rates and the hospital-based, there's this huge negative margin. But, we also know that having a hospital-based SNF includes your overall -- increases your overall margin by a point, and hospital administrators -- I can't believe I'm having this conversation with you -- have told us that the way they think about the hospital-based SNF is not as an operation in its own right but how it helps them with their overall operation. You, obviously, may have --

MR. THOMAS: No, I understand. I mean, I totally understand that.

DR. MILLER: And, so, here, they would have to decide whether, given the mix of cases, I'm going to stop putting these cases in my hospital-based IRF, and in that case, the case moves out to the SNF and we have that conversation, or they still look at, even at a SNF rate, it

somehow contributes to the patient margin or the overall margin of the hospital and they decide to make that decision. Exactly how all that ripples through depends probably on the current mix and the very behavioral responses that I think are a bit unclear here.

MR. THOMAS: And, do we understand, or do we have any idea how many of these hospital-based IRFs, also, they have SNFs, or vice-versa? Do we have any idea about are they running both, or do we know?

DR. MILLER: That's a knowable thing, but I doubt anybody has it right on them.

MR. HACKBARTH: Just the raw count. How many hospital-based IRFs are there?

MS. KELLEY: Nine-hundred-and-some-odd.

MR. HACKBARTH: And how many hospital-based SNFs?

MR. LISK: [Off microphone.] A little over 500.

MR. HACKBARTH: Okay.

MS. KELLEY: I did just want to say, we do know a little bit about the patient mix in hospital-based IRFs versus freestanding IRFs, and it does differ. For example, up here on the slide, hospital-based IRFs have a much bigger share of stroke patients than freestanding IRFs do. So, the

impact on the different types of IRFs is going to be different, depending on their case mix.

DR. MILLER: And, part of this -- and, so, they would be less affected, all other things being equal.

MR. HACKBARTH: Okay. Clarifying questions? We need to move on to Round -- oh, go ahead, Jay.

DR. CROSSON: So if you could go back to Slide 24, we haven't discussed this yet, but the last bullet point there, the potential need to revise the 60 percent rule. In the text you mentioned, appropriately, that that would be necessary because you would eliminate the site-neutral payment patients from the numerator. Therefore, it would be harder to qualify.

That then raises the need to have a discussion about what the new percent should be, which seems to me to be a complicated and potentially controversial issue.

Did you look at -- this is another math problem -- simply eliminating those cases entirely from the numerator and the denominator?

DR. CARTER: We thought they should be removed from the numerator and the denominator.

DR. CROSSON: Okay. I'm sorry. It said it a

little differently in the text.

DR. CARTER: We'll work that out, but yes, definitely.

DR. MILLER: Yeah, I think what we were trying to -- because I remember we went over this.

DR. CROSSON: Then if they were eliminated entirely, would you have to change the 60 percent rule?

DR. MILLER: Probably change the 60 percent [off microphone].

DR. CROSSON: Okay. I'm not -- I'm having a lot of math problems in this meeting. I'm not sure why you -- if they just were taken out entirely, why would you have to change the 60 percent?

MS. KELLEY: Because the 60 percent rule is 60 percent of all their cases, so it would have to be these certain diagnoses. So if we removed those cases from --

DR. MILLER: Are you okay?

DR. CROSSON: No. But that's the denominator. If you just pretended they didn't exist at all, right, take them out of the numerator and the denominator, then the criteria would stay the same for the other patients and the 60 percent rule theoretically --

DR. MILLER: I tell you what --

MR. HACKBARTH: Let me approach this is a very non-mathematical way.

DR. MILLER: Or we could do it by e-mail.

MR. HACKBARTH: Yeah, you can resolve that by e-mail. You know, if you look at the draft recommendation, we're not going to try to resolve all of the details of this in our recommendation. We can point out issues and discuss them in the text. I think this is -- however important it might be, it's not something that's going to influence how we characterize the recommendation itself. And so I'd like to move on. We're sort of running out of time here.

DR. MILLER: And, Jay, we'll get something to you.

MR. HACKBARTH: Yeah. Now, before we start Round 2, let me kick off with just a question about how we frame our draft recommendation. Would you put up the draft recommendation slide?

Now, in the paper and in the course of the presentation, you mentioned the possibility of a transition on this. Remind me whether we have -- when we've done other site-neutral recommendations, whether we've included language in the recommendation itself about transition.

DR. CARTER: I don't think so.

MR. HACKBARTH: Okay.

DR. CARTER: Ariel can talk about it.

MR. WINTER: You made a recommendation in 2012 to equalize payment rates for E&M clinic visits and OPDs and physician offices. It might have been in the recommendation text for a three-year transition, or it might have been in the language that, you know, described it. I don't recall for sure, but we can look.

MR. HACKBARTH: What about with the LTCH recommendation?

DR. MILLER: I thought the LTCH was in the -- actually --

MR. HACKBARTH: Okay. I think my point is simple. You know, I think transition is an important issue when you're talking about a significant change in the level of payment for a fairly large number of patients, and we're on a path of doing a lot of this site-neutral stuff, and I think we need to sort of have some consistency about how we handle that, because if we don't and we include it sometimes in bold face and sometimes just in the text, people can infer things that we may not intend about the importance of

transition. So I'll leave it there.

MS. KELLEY: I think we're learning that it was in the hospital recommendation last year in the bold-face language.

MR. HACKBARTH: That was my recollection. So we just need to clean that up and have a systematic way of addressing transitions.

MR. ARMSTRONG: A related question. On the recommendation, we're very general about selected conditions being identified; whereas, in the analysis we're very specific about different kinds of conditions and so forth. And my recollection was we were much more specific about which kinds of care or codes we would treat as comparable in terms of our payment policy, where this is so general and I wonder what the thinking is behind that.

DR. MILLER: What we've generally done is said there's a set of criteria that we used, and so, for example, when we did the ambulatory stuff, we said, you know, most of the time done in the physician's office, same risk profile, you know, we had five criteria and said we ran through the data and this is what we found.

And so I think what we're trying to say to the

Congress and the Secretary is more this is the criteria and how to approach it. Here is what we found. If they want to use that, they can use that. If there's some other way that they want to approach it, then it's more the principle that we're trying to say. But I don't think in the recommendations we've ever said these particular conditions.

MR. HACKBARTH: And we need to look at past recommendations. My inclination would be not to specify conditions for the reasons that Mark mentions, and over time, you know, the conditions may change that could meet the test, and so you wouldn't want to say, well, we have to do a new recommendation to add to the 22. If, in fact, the characteristics show up other places, we want the Secretary to have the authority to do site-neutral payment.

MR. ARMSTRONG: Thank you for that, and I support that. I just, first of all, thought it was inconsistent with our past recommendations.

MR. HACKBARTH: Yeah, so we need to clean that up.

MR. ARMSTRONG: And, second, we've spent a lot of time really looking at specific conditions and ruled several out. And it was really for that reason that I thought we were pushing for that kind of specificity. But if that's

how we've done it in the past, then I'll --

MR. HACKBARTH: And just for the record, the LTCH recommendation did in the bold-face language have transitions, so we'll need to work that out and clean that up.

So I'm ready to start Round 2, and I think, Craig, you had your hand up awhile ago? No? Then we'll go Kathy and start working our way around.

MS. BUTO: I actually would favor some specificity around the conditions, and the reason for that is while we have criteria, the criteria may be flawed in some way. I think we took stroke a little bit off the table last time because, although it met the criteria, there was at least some degree of unease about including stroke at this point. There was some ambiguity in the data, or we don't have enough specificity, et cetera. So I'd be in favor of that.

Similarly, I'm very much in favor of the site-neutral policy, but I have misgivings about a couple of the conditions that I think lend themselves to more intensive rehab services, which is the two I mentioned, the two that actually would invoke the 60 percent rule: amputations and not the full boat of all of the knee and hip procedures, but

the ones that, again, CMS has specified down to a level involving people with, you know, comorbid conditions and so on.

So I would actually -- my own thinking at this point is that there's some justification, particularly when you look at the outcomes in relation to self-care, better ability to perform self-care, and mortality rates for those two, because I think fractures have a very high mortality rate period post-hospitalization. So those outcomes in relation to those procedures which, for whatever reason, when they designed the benefit, they decided that those were amenable to more intensive rehab, such as that performed by the rehab hospital.

Now, clinicians here, if you're comfortable with moving those without regard, that would be another thing. I mean, I'm just, you know, really operating on instinct.

The other misgiving I have is that the SNF -- I don't believe these patients are going to stay in IRFs. Particularly if the denominator includes these procedures and we narrow the criteria, the IRF will have an incentive really to try to get as many of the patients who still meet the criteria of the whatever percent rule, and those

patients -- these patients, even if they keep them, will be subject to potentially a lower level of service.

So I'm not at all confident they won't move to SNFs, and, again, I don't think we have good enough data to know whether the treatment in terms of intensive rehab is going to be the same for these categories of individuals.

MR. HACKBARTH: Kathy, I'm just trying to make sure I understand. So let's stipulate that there are two conditions that may be amenable to more intensive rehab that are on the list. Now, there are significant portions of the country where there are no IRFs, and so patients that need more intensive rehab and can benefit from it are, in fact, treated in SNFs.

MS. BUTO: Right. But are we saying, Glenn, that we don't see any justification for an IRF in that case?

MR. HACKBARTH: No. I'm talking about the payment rate. Those patients are receiving more intensive rehab at the SNF rate. This is not a judgment that they shouldn't get more intensive rehab. It's a question of how much we should pay for.

MS. BUTO: And I don't know what the difference in outcomes is between -- and maybe we have that, SNF-only

patients in those two categories and patients who receive IRF treatment. But if they are the same, that's fine. I'm just saying I don't -- I have a misgiving about that. I don't feel confident looking at the papers that we really know the answer to that question. My feeling is why not move ahead with those conditions where -- you know, I think there'd be less controversy around whether intensive rehab would actually make a big difference in the outcome for the patient. That was my only point.

And then the last point was really about the SNF payment system, if they do move, if some of them move, that we find so flawed, that, you know, we're talking about essentially $500 million. Are we comfortable -- and I wouldn't advocate waiting until you fix the SNF payment system, but we are going to be moving that into a per diem and out of a per episode --

MR. HACKBARTH: Well, as Carol pointed out, the flaw in the SNF payment is that we tend to overpay for rehab services.

MS. BUTO: Right.

MR. HACKBARTH: And so if -- the concern is that patients who are going to move to SNF and benefit from

rehab, that's where we pay most generously for SNFs. It's the medically complex patients where we fear we underpay the SNFs.

MS. BUTO: Right, but I think we want to fix that.

MR. HACKBARTH: We do.

MS. BUTO: Don't we?

MR. HACKBARTH: We do.

MS. BUTO: So, anyway, my only point is we're dealing with a system which we're not particularly happy with now, trying to move some patients in just based on a payment rate -- or not move them in, but move them to the same level of care. Are we confident that that level of care will produce the same outcomes? That's my only point there.

And so I just prefer per episode payments generally to any kind of per diem or per fee system. So that was it.

MR. HACKBARTH: Okay.

DR. REDBERG: Just to build on that point, I would be assured that the outcomes aren't very different -- I mean, that we've looked at between SNFs and IRFs. And, you know, you can give the same patient the same amount of

therapy, and they get different benefits -- I mean, different patients get different benefits. Different patients put different efforts into it according to how they feel and how they're doing. And I think what you learn from interviewing the neurologists, there's just very different criteria. You know, we certainly want to be very patient specific and offer patients what they can do best, but I think the site-neutral patient proposal accommodates all that within the proposal.

I'm more interested in knowing more sort of about some of the outcomes for these 13 conditions, because some of these I think are going to have poor outcomes no matter what the -- you know, knee replacement and so on whose body mass index is greater than 50, you know, no matter how much rehab you have, that's pretty rough. And the same for that kind of thing over 85 years old. And I wonder if we have those kind of data on outcomes in those specific groups, because I worry they have very poor outcomes no matter how much rehab they're getting.

DR. CARTER: We don't have that kind of level of detail on outcomes.

MR. HACKBARTH: Okay. Continuing Round 2.

DR. HOADLEY: I'm just trying to think about this question, how much specificity we're getting into within the recommendation. I mean, obviously we're going to have all this analysis presented, so, you know, the world is getting the benefit of us thinking through and having reactions to stroke versus some of the other categories and the criteria. And, you know, obviously we can look back at the other times we've done these to see, but, I mean, it seems like we've -- the level of specific categories, the exact 22 categories is not where the recommendation would be because there's these issues of do we have it quite right, and if we thought about it more, maybe we'd take these two out or put these two in, or something like that.

The general criteria, I don't know if in other cases we've written the general criteria into recommendations or whether we simply present that sort of directly below and above the recommendation to say, And here is our thinking of how you would go about that. But it seems like that's the kind of level where we're the most comfortable that we have generally -- but even there, as we've pointed out, the conditions led us to include stroke, and then we looked more at it and said, well, maybe not.

But it seems like the main thing is we present all that argument. How much of it's in bold, how much of it's in non-bold right underneath and right before is more of a technical question.

DR. MILLER: I didn't interject because I wanted to keep you guys talking, but that was also what I wanted to say out loud. There is this fundamental choice of whether at the most extreme you write all 17 conditions into the recommendation, which we haven't done in the past and I would recommend against or suggest against, and more, presented all the information in the text, as you've said, and, Kathy, some of the concerns that you had raised, you would see a notice and comment period where some of this might get raised. So say the Secretary goes forward with 17 or 20, and ends up with 15 or 17, that kind of notion, as opposed to us litigating it at this level is, I think, some of the thinking. And that's what you're saying, but I just wanted to hit it.

DR. BAICKER: Yeah, I very much agree with that. I very much agree with that line of thinking that we want to illustrate that it's possible. Just saying, oh, you should find ones where it's reasonably comparable on these

dimensions and we're sure they're out there is not very helpful. Saying we've looked at these, here are some illustrations and suggestions for things we think would work, but not putting that in the recommendation -- because in some sense we don't actually have a strong view on exactly which ones should be in and which ones shouldn't. There should be lots of comment on that and lots of dialogue, as we did illustratively with stroke to say, well, maybe, maybe not. I'm sure there would be lots of that, and not having that in the text of the recommendation to me makes it clear that the recommendation doesn't hinge on those specific conditions but, rather, they show they're proof of concept and they're our suggestions, but that the recommendation is strong with or without any one of those particular conditions.

DR. COOMBS: We actually had a really good discussion, I think, the last time, and it was very comprehensive. We actually focused on three different entities. And I think because of that, many of us around the table actually felt like we were getting close to some place, especially with the hips and joints -- I mean the hips and knees. And I had mentioned that some of the

orthopedic surgeons were actually in a really abbreviated rehab period where even some patients would go home with interventions at home, and that was really a poster child for maybe not even having an IRF kind of PAC stay.

So I think with that discussion, I came away from the table saying, okay, we're honing down, and then we have the other conditions as well, we're honing down and we're going somewhere. But I wonder what the impact would be just by putting selected conditions. Does that leave us at a weak place where this could mushroom into something else later? And that's what my apprehension is about leaving it broadly. Or the other issue would be to -- you can have selected conditions, but in an appendix or some kind of an added footnote say that the Commission discussed these entities at length and the consensus was X, because we all -- I mean, not everyone, but I think there was a growing consensus about stroke and the heterogeneity of stroke, and we talked about at this time we didn't have a consensus about the post-operative care, so that if you left it with selected conditions, you might include stroke later on. And stroke, I think the Medicare Advantage plan has it right. They send most of their strokes to IRF, and there's a

reason.

So I think with that discussion, my impression I walked away with a more focused kind of targeted approach to site-neutral payment.

MR. HACKBARTH: Well, let me approach this from just a little different angle. The draft recommendation is a recommendation to the Congress, and so that implies legislation. And I think that's a relevant consideration. I don't think you want the Congress to write into statute a specific list of conditions, because the legislative process, as we've discussed so often, you know, sometimes it moves fluidly and sometimes it doesn't move at all. And you don't want to encase potential misjudgments in legislation. You want the Secretary to have the flexibility to do notice and comment, rulemaking, collect data, and change relatively quickly.

So to the extent that we're recommending to Congress a legislative change, it needs to be broadly stated, in my view.

DR. MILLER: And I just want to give Alice some comfort. It won't be a footnote. Right following that set of words, all of the conversation on the stroke, the 17, our

criteria, the list, all that will be there. So it's not like there will just be the selected conditions and it's left to the imagination. All that discussion we went through will be right following the -- or leading up to the recommendation.

MR. HACKBARTH: I see a couple hands. Is it on this particular point?

MS. BUTO: Yeah. I just wanted to follow up and say that I'm much more comfortable, now that I've heard the discussion, with Jack's and I think Alice's point and Kate's that we leave the specificity out. I was misled by the discussion on stroke. We spent so much time on that, I thought we were putting specific conditions into the recommendation. And if you read the papers, we talk about dollar amounts and so on that imply that there's -- and we associate that with the 22. We might want to just look at that language to make sure that we, you know, appropriately make sure that it doesn't imply that we've picked out specific conditions. But I think that would work.

And I would just add, Glenn, to Rita's point, if we could get something in the report that would also recommend that we look at or that Congress look at the 60

percent rule and whether that's the right set or -- you know, I think that's appropriate, too, because we haven't really gotten into that. But that's very tied up in this whole discussion.

DR. SAMITT: I have just one reservation. I'm generally supportive of the recommendation, and it's consistent with our prior discussions about site-neutral policy and our philosophy around that. It's clear to me that the freestanding, for-profit IRFs would have the capacity to absorb the financial implications of this shift in payment. I would just suggest that we concentrate and pay attention to the hospital-based IRFs here. I'm worried about a death by a thousand cuts phenomenon here. There may be less capacity to absorb this payment shift. So what I'd be interested in -- and I know that you reviewed the statistics that show that fewer of these conditions are cared for in the hospital settings versus the for-profit settings, especially orthopedic. But I think we should just be very careful and cognizant of the financial impact to the least profitable IRFs as presented in the prior deck. I'm not sure they've got the capacity for this in addition to all other changes in an already low margin setting in that

sector.

MR. HACKBARTH: I want to make sure I didn't miss anybody over here. Warner, do you have any comment on this? And we heard from Kate. Anything more, Kate? Herb.

MR. KUHN: Just a couple thoughts here as we look at this. One is I continue to wonder about this issue of the behavioral changes. Kathy and others spoke to them, but in two dimensions. One is our recommendation from yesterday for the SNF payment to rebase at 4 percent. So we're talking about lowering that payment. Do we think that's going to materially impact some of this activity here? I'd like to hear more discussion how that was considered as we thought about this policy of those two interrelated.

And then the second thing is I do wonder about access issues. So we know what we've heard today is that the IRF occupancy rate is around 60 percent. We know the SNFs are above 80 percent. So if you do have any kind of behavioral change and movement to the SNFs, they're pretty full. Could this create some access issues? And so I wonder about the need for some kind of narrative in there that talks about an appropriate surveillance program through the transition period to make sure that we are monitoring

access as well as quality as part of this process would be something to think about.

And then, finally, this might be too much in the weeds, but I'm really interested in how ultimately the compliance would be on this and how IRFs would really be able -- would they be able to fully differentiate which cases are there? And what I worry about is creating new audit opportunities or new opportunities, I hate to say it, for recovery audit contractors where they would come back and second-guess some of these decisions, whether this patient should have been an IRF patient or should they have been a SNF payment in an IRF facility, and create a whole new set of issues that we might have to deal with in the future.

So I'd like to at least think about that a little bit more, if there's anything we could add to that conversation to make sure that this would be a bright line and the differentiation would be a little bit easier to deal with.

DR. MILLER: So, in the discussion, you're looking for is if identified by condition -- in your second point, you're saying if identified by condition, is there play or

inaccuracy in how a patient could be coded to be moved out of these -- in or out of these categories as --

MR. KUHN: That's correct.

DR. HOADLEY: I just had three quick points. I'm speaking in favor of the recommendation.

One thing I think we agree on here, in terms of looking at rehab services, we want the right care at the right place and at the right price. I mean, no one is arguing about that.

Secondly, the reason we're having this struggle is that our only way of keeping score is on the basis of diagnoses, which really don't, in most cases, in older people, reflect the real reason they need rehab. It has to do with a functional decline associated with another illness, and we're not going to solve that around this table.

An example, Kathy, you mentioned sepsis and what's sepsis got to do with rehab. It turns out that it is a disease that has such a tremendously deleterious effect on the muscle and cognitive function that it's probably one of the main reasons that we send people to IRFs now, if we can shoehorn the diagnosis properly, because that's exactly the

place where they need the care.

So I think the wording, particularly "selected conditions," does give us, particularly with the discussion following, it really just says that there has to be some authority for common-sense decision-making by qualified clinical personnel, just the writ large, and I think the recommendation does allow that to happen. But we're going to argue till the cows come home whether we say, "Well, does stroke versus a knee qualify one way or another?" It gets there part of the way, but it doesn't really -- the technology for assessing function is still in its relative infancy, but I think we're moving in the right direction.

DR. HOADLEY: Just a quick comment, taken from your comment earlier, Glenn. The recommendation does not speak to the regulatory issues in the language, and it looks like I'm reading in the chapter that, for example, the 60 percent rule is in statute, or at least it says here it was capped at 60 percent.

DR. CARTER: Yeah.

DR. HOADLEY: So, to the extent that some of these regulatory things are in statute, we may want to think about whether, therefore, when we are directing the Congress, we

need to raise that or. again, whether it's in the bold or below, but just think about how those things play out.

MR. HACKBARTH: Okay. So I'd like to do a quick round now with people's current thinking about the draft recommendation. I know we've got a number of issues that we've raised in this conversation that are still hanging and not completely resolved, but if I could just get, very briefly, your current thinking -- and nobody is bound by this; we'll all be talking about it between now and January -- starting with Craig.

DR. SAMITT: I suppose the recommendation. I would like to see additional information on the impact on the least-profitable IRFs, especially the hospital-based setting, but at this point, I can support the recommendation.

MS. BUTO: I support the recommendation, given the discussion that we've had about not specifying and making it clear that we have looked at conditions, and there are some appropriate conditions.

I'd also like, back to Jack's point, to sort of challenge the 60 percent rule and the conditions that are in there and ask that Congress sponsor or have sponsored a

reassessment of whether that set of conditions is the most appropriate for rehab facilities.

MR. GRADISON: I support the recommendation.

DR. REDBERG: I support the recommendation. I would like to see, perhaps related, if we had data on the distribution of those 13 conditions that make up the 60 percent rule, like what percent are each, and also the outcomes in those conditions after rehab.

DR. CROSSON: I support the recommendation.

Similar to Kathy, I would like to perhaps have some more discussion about the 60 percent rule and how that might work out, because I think -- well, I just think, perhaps, if we're going to mention that in the text, that we ought to explore it a little more deeply.

DR. NAYLOR: I support the recommendation, see it as totally aligned with the Commission's work to try to get the right payment to the same population, regardless of where they're served, and think this is not an easy path but a necessary path.

I encourage the use of transition, and maybe if one recommendation in the text -- others have said it -- thinking about the behavioral responses in IRFs, what might

it mean to have more SNFs in SNFs, what might it mean to have more IRF patients.

MR. ARMSTRONG: I support the recommendation and actually would like to pile on a little bit to Mary's point and just say that I think we're worrying too much about a lot of pieces that payment policy actually can't control, and if anything, I think we should remember that -- or at least my point of view is that this is a step consistent with policy we have applied in a lot of other areas that is actually just a step to much bigger ideas around post-acute care bundling and other concepts that in no way take away the responsibility from the care delivery system, individual care plans for patients, and discretion about facilities and services. This is just payment policy.

So I think, actually, I worry we're getting bogged down too much in too many things we actually can't control through these recommendations.

DR. CHRISTIANSON: Yeah. I think this is a good idea for the reasons that Mary and Scott just articulated.

DR. HOADLEY: I'm comfortable with the recommendation. Again, but the possibility of some of the regulatory items maybe belonging in it, maybe not, but at

least being clearer in some of those other things.

DR. COOMBS: I support the recommendations with the understanding that there is a discussion that is included in the text.

And one of the other questions I had with some of the other concerns, we've done recommendations before, and then we've had a direction for the Secretary. I'm wondering if some of the issues that we talked about could be directed to the Secretary of HHS.

MR. THOMAS: I have some reservations about the recommendation. I would agree with Scott and Mary's points around the idea of bundling more on a post-acute basis, and I think we have a lot of siloes there, quite frankly, that we need to break down.

I am concerned with the hospital-based component and the points that Craig brought up, and I would like to understand more about that before rendering a final view.

DR. BAICKER: I support the recommendation.

MR. KUHN: And I would say I understand the recommendation, and I understand what we're trying to achieve here. I just want to be a little bit more comfortable with the narrative that we have behind this

before finally coming to a final conclusion on that, because there's been so many things talked about today. I just want to see how it all knits together to see the bigger picture.

DR. HALL: I'm supporting the recommendation.

MR. HACKBARTH: Okay. Thank you all. Thanks, Dana and Carol. Well done.

So now we move on to Medicare Advantage. It is part of our charge from the Congress to include a status report in March each year on Medicare Advantage.

[Pause.]

DR. HARRISON: Good morning. I'm going to present analysis of current plan enrollment and plan bids for 2015. Carlos will then update you on plan quality performance. And, finally, Carlos will discuss CMS's presentation of premium information.

Due to the tight time frame here, this material will be compact. There's more detail in your mailing material, and we will be happy to take your questions and requests for additional information to be included in the chapter.

Strong growth in MA enrollment continued in 2014. Since 2006, enrollment has more than doubled to the current

16 million enrollees. Plans project continued growth for 2015. Overall growth in 2014 was nine percent, with HMOs growing at seven percent and enrollment in both types of PPO growing at double-digit rates. Trends vary by plan type. HMOs have grown steadily each year over this period, but their market share declined between 2006 and 2008 as private fee-for-service plans grew rapidly. Later, enrollment in private fee-for-service declined due to legislated changes in their requirements, and enrollment in both local and regional PPOs began to grow. Currently, hence, since 2008, about two-thirds of MA enrollment is in HMOs.

In 2015, Medicare beneficiaries have a large number of plans from which to choose. MA plans are available to almost all beneficiaries; one percent of beneficiaries do not have a plan available. Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2014.

I want to highlight three changes for 2015. Private fee-for-service availability continues to decline consistent with expectations. Forty-seven percent of beneficiaries will have access to a private fee-for-service

plan in 2015, down from 53 percent. The number of average plan choices declined from ten to nine per county because of the decline in private fee-for-service plans. Finally, fewer beneficiaries will have zero premium plan with drugs available in 2015, declining from 84 percent to 78 percent. But, as the value of extra benefits provided by plans has not declined, I think this may be an indication that insurers are more willing to charge premiums for plans that include extra benefits.

We estimate that in 2015, MA benchmarks, bids, and payments, including quality bonuses, will average 107 percent, 94 percent, and 102 percent of fee-for-service spending, respectively. These figures continue the overall decline in payments relative to fee-for-service since legislated benchmark reductions started in 2011.

For 2015, the base county benchmarks, which do not include quality bonuses, declined 5.5 percent. Plans also faced additional benchmark reductions due to the end of the quality demonstration. The benchmark effects on overall plan payments, however, are mostly offset by changes in the risk adjustment calculations and risk coding intensity. I will say more about the coding intensity adjustment on the

next slide, but those factors do not affect the ratios that we present on this slide.

In any event, the decrease in benchmarks may have exerted fiscal pressure on MA plans and encouraged them to better control costs and to restrain the growth in their bids. The average bid did not increase between 2014 and 2015.

Although plan bids average 94 percent of expected fee-for-service spending for similar beneficiaries in 2015, because the benchmarks average 107 percent of fee-for-service, Medicare pays an average of 102 percent of fee-for-service for beneficiaries enrolled in MA. Note that HMOs bid lower than other plan types. Also, employer plans bid much higher than the average plan, and recall that we had a recommendation last year to address that.

One finding not on this page is that excluding quality payments, MA plans would be paid at 100 percent of fee-for-service in 2015, assuming that risk differences are properly accounted for, which brings us to risk coding intensity.

Plans have incentives to have their providers code more completely or intensely so that the risk scores of

their members, and, thus, their Medicare payments, will be higher. Thus, we undertook a new analysis of coding differences between beneficiaries in fee-for-service Medicare and those enrolled in MA plans. We explain the analysis in the chapter, but let me summarize what we found.

Beneficiaries in MA had more growth in risk scores than beneficiaries who remained in fee-for-service, and those differences grew the longer the enrollees stayed in Medicare Advantage. On average, the Medicare Advantage enrollees' risk scores grew about eight percent faster than scores in the fee-for-service population. Those differences in coding are larger than the current 5.16 percent coding adjustment mandated by law. If CMS raised the coding adjustment by about three percentage points, the aggregate level of coding in the fee-for-service and MA sectors would be roughly equal. Otherwise, it would be appropriate to add three percentage points to all the figures on that previous slide.

So, to summarize our payment findings, given the presence of uncorrected coding differences in MA, payments are 105 percent of fee-for-service for 2015. The 105 percent includes the 102 percent that we estimate using the

methodology that we have traditionally used that assumes that CMS's risk and coding adjustments properly adjust for differences in the MA and fee-for-service populations, plus the additional three percent that we found should be added to the coding adjustment. Still, the benchmark bids and payments continue their decline relative to fee-for-service.

At the same time, beneficiaries also receive an average of $75 in extra benefits. That $75 rebate for non-employer, non-SNP plans is unchanged from 2014 and 2013, but I should note that the $75 figure includes the plans' administrative costs and profits.

These results suggest that plans are doing well financially and continue to be able to offer benefits to attract enrollment. Some plans have demonstrated their ability to provide the Medicare Part A and Part B benefits for less than fee-for-service Medicare.

Carlos will now carry you through the rest of the material.

MR. ZARABOZO: In comparing this year's quality results to last year's, we found that a number of measures improved, a few declined, and most remained stable.

As you know, MA has a quality bonus program based

on a five-star rating system. Plans that achieve an overall rating of four stars or higher receive bonus payments. Only a subset of the measures we traditionally examine are included in the star rating system, and the majority of those measures improved. However, for plans that had star ratings in both years, the enrollment-weighted average star rating is essentially unchanged between this year's star ratings and last year's. This is in part due to higher thresholds that plans needed to meet to achieve a four-star rating in certain measures that did not have a predetermined threshold and other changes to the star rating methodology.

One point about the measures that declined is that they are all mental health measures, except for one patient experience measure on the timeliness of access to care. Given that the majority of measures included in the star rating system improved, one potential way of promoting improvement in the mental health measures, which have been declining over the past several years, is to include the measures in the star rating system.

Something that we want to call attention to is the practice of some organizations that move their MA enrollees from lower-rated plans not eligible for bonus payments to

plans rated at four stars or higher. This occurs during what CMS refers to as the crosswalk process of contract consolidation, where one contract is subsumed under a different contract. In 2015, nearly 400,000 beneficiaries are being moved from non-bonus status to bonus status through this process. Although contract consolidation may be desirable from an administrative point of view, it does have the effect of increasing program expenditures if there are consolidations of this nature.

We have been examining an issue that has received a great deal of attention, which is whether or not there is a systematic bias against certain types of plans in the star rating system. Representatives of plans serving Medicare and Medicaid dually-eligible beneficiaries through special needs plans, or D-SNPs, maintain that the health care needs and the social and assistive services needs of this population make it difficult for plans to achieve results at levels comparable to plans not primarily serving the dually-eligible population.

As this slide indicates, there is clearly an association between D-SNP status and star ratings. Under the newly released star ratings, 59 percent of enrollees are

in plans with four stars or higher. However, if you look separately at D-SNPs and non-D-SNP plans, you see that plans at four stars or above have 63 percent of their enrollment in non-D-SNP plans, while only 14 percent of the enrollees in contracts that have 50 percent or more D-SNP enrollment are in plans with four stars or above.

This difference has persisted for many years. CMS recently issued a request for information, or RFI, asking plans and other parties to submit information about the cause of these differences. CMS is still evaluating the information they received.

In past reports, the Commission has noted that not all D-SNPs perform poorly in the star rating system. There are plans that are 100 percent D-SNP plans which still can achieve star ratings of four or 4.5. However, our analysis has found that an important factor is the proportion of enrollees under age 65. For both D-SNPs and non-D-SNPs, the greater the share of enrollees under age 65, that is, those entitled to Medicare on the basis of disability, the lower the star ratings.

This slide shows that there is better performance among both non-D-SNPs and D-SNPs that have enrollment of the

under-65 that is low, at 30 percent or less. For plans that have enrollment of the under-65 that exceeds 30 percent, both plan categories have lower star ratings, but D-SNPs perform better than the non-D-SNP plans. This suggests that in looking at differences in performance across plans, it may be appropriate to use the under-65 population as a basis for stratification of enrollees or for purposes of peer group designation among plans.

To summarize the issues in quality in the star rating system, consistent with the Commission's past statements, the star system should continue to emphasize outcomes, which has been the case over the past several years. If the star system is intended to be an indicator of how well plans are performing and whether there has been improvement, that objective is made difficult because of the shifts in the threshold for achieving a particular star rating and because of movement of enrollees among plans through plan consolidations.

And, on the question of whether certain plans are disadvantaged in the star system, we are not providing an explanation of why some plans appear to be better than others, but we are pointing out that a factor that

influences plan performance is the share of under-65 enrollees that a plan has. Nearly half of Medicare beneficiaries under age 65 are dually-eligible beneficiaries, but their status as disabled beneficiaries may have a greater effect on plan performance than their dual status, as we infer from the differences among D-SNPs based on their proportion of enrollees under the age of 65.

The next issue we're going to talk about concerns the tools that beneficiaries are given when they're deciding among different MA plans using the Medicare.gov Plan Finder website. The issue we will discuss is how beneficiaries learn about plans that reduce the Part B premium.

Reducing the Part B premium for enrollees is one of the options that plans have for the use of rebate dollars when a plan bids below the MA benchmark. Currently, the premium information at the Plan Finder website is not displayed in such a way that a person could immediately determine their total premium obligation in joining an MA plan. Because what is highlighted is the plan's premium, plans offer a zero premium at the plan level and tend not to offer beneficiaries additional premium savings. Instead, plans use rebate dollars to provide other benefits, such as

reduced cost sharing or Part D drug benefit enhancements.

Some of the rebate dollars are used to provide extra benefits, such as dental care and routine vision care. Offering more generous benefit packages is the only way plans can differentiate themselves when they have reached the level of the lowest premium level that is salient to beneficiaries, which is a zero plan premium.

In using rebate dollars to finance extra benefits, the value of such extra benefits equals the plan's cost of providing those benefits, including administration and profit or margin. However, this valuation of the benefit may not equal a beneficiary's valuation of the benefit, and a beneficiary may place a greater value on having a reduced Part B premium. But, in the current system, a beneficiary is often not given the opportunity to choose between a lower premium versus extra benefits.

This slide shows the initial display for a Part B reduction plan. The presentation does not contain -- does contain much of the information that a beneficiary needs to know, including expected out-of-pocket costs resulting from a plan's premium, cost sharing levels, and extra benefits. However, the total plan premium is shown as zero and there

is no indication of a Part B premium reduction nor any reference to the status of the Part B premium. And, just to clarify, the large portion of the slide does show the premium information that is blown up and it does show the out-of-pocket costs as one of the elements that is included in that portion, the initial screen that you see in looking at plans.

In order to see whether or not there is a Part B premium reduction plan, the beneficiary has to select a plan to examine or select a set of plans to compare. This slide displays three actual plans in Miami that are being compared. Two of the plans reduce the Part B premium. The one on the left reduces the standard Part B premium to zero. The one on the right reduces it by $60, to $44.90. And, for the plan in the middle, a beneficiary must pay the full Part B premium. Each of these plans has a plan premium of zero.

At the bottom of this particular screen at Plan Finder, there's also a statement of total expected out-of-pocket costs for a beneficiary joining each plan.

What would make the actual premium costs more salient is to show more detailed information about the plan premium at the initial display of the plan premium and other

information. In the possible display shown on the right in this slide, the status of the Part B premium would be clearer and there would be a statement of the total Part B premium and total premium by joining a plan.

Of course, a beneficiary must consider all costs and benefits when selecting a plan. When using Plan Finder, a beneficiary can choose to see information based on health status. Continuing with the example of Miami and looking at the two Part B premium reduction plans selected for this illustration, you can see there's a difference based on health status. For a person who selects "in good health" as their health status, the plan that fully reduces the standard Part B premium is the least expensive plan, with total expected out-of-pocket costs in the year at $1,030. However, selecting "in poor health" yields a different result. The benefit structure of each plan is such that the least expensive plan is not the plan fully reducing the Part B premium, but instead it is the plan that has only a partial Part B premium reduction. That plan would have an average out-of-pocket cost in the year of $1,970, making it less expensive by $200 than the plan fully reducing the Part B premium, which has expected yearly out-of-pocket costs of

$2,170.

So, to address the issue of how premiums and other cost sharing are presented at the Plan Finder website, we suggest that Plan Finder be improved to provide clearer information about total expected cost sharing and the total monthly premium.

This concludes our presentation and we look forward to your discussion.

MR. HACKBARTH: Okay. Thank you.

So, clarifying questions for Scott and Carlos. Kate.

DR. BAICKER: There was a lot of really helpful information about the risk adjustors and the potential coding issues. I wonder what the implication of the three percent coding difference between MA -- beneficiaries in MA versus beneficiaries in fee-for-service implies about the remaining level of risk selection in MA plans and the implication for differential payment based on profitability of patients versus an across-the-board listing of coding.

DR. HARRISON: So, the difference is eight percent that we found, on average. And, we found -- but, CMS already takes five, so the five isn't included in the eight.

Okay. So, one thing is things may be getting worse.

We did a different analysis and looked at cohorts of people coming in and we tried to purify them basically by saying, okay, they had one year in fee-for-service, so they had scores based on fee-for-service, and then we followed them through. So, for those people, what happened in the first year they were in MA, their codes jumped by an extra six -- I think it was six percent in the early years, and last year, it actually jumped ten percent. So, one year of sitting in MA got your code up ten percent higher than if you stayed in fee-for-service.

So, it's getting worse. It's big. There is some -- also, the coding adjustment also increases by a quarter-point for the next few years. That's probably not enough, depending on your -- you know, new people come in and they're not over-coded because they're new. So, probably the sooner we act, the better.

Now, another way to do this is not by an across-the-board thing. It would be by making sure that the process for collecting codes is more similar in MA than it is in fee-for-service, because the model is based on fee-for-service. So, if you could limit the way the codes are

collected to the way they're done in fee-for-service, you may also have some success. CMS actually had put a proposal like that in the proposal letter last year, but it was taken out in the final version.

DR. MILLER: Kate, so, did you get your question answered, because I felt like you were almost asking an additional point than this one.

DR. BAICKER: Right. It's not all that well posed, so I was letting it go, but, yes, I still have some remaining question about the favorable selection of risks.

DR. MILLER: That's what I thought. To that part of the question, what I would have said is, "I'm not sure this informs favor" --

DR. HARRISON: I could also give you one other point.

DR. MILLER: Did you get that?

DR. BAICKER: No.

So tell me why.

DR. MILLER: Okay. The way -- this is the wrong person to answer the question. Why don't we start here? What the hell. Okay.

What I think could be happening here is coding is

a different issue than whether you are selecting, and so when you initially asked your question, I thought you were asking does this really inform selection. I think, in some ways, it could or could not, but the coding I think of is kind of a different phenomenon.

If you could have a completely average risk but still be coding more --

DR. BAICKER: But what I'm concerned about is that that coding puts you in a different risk adjustment bucket, and so the payment changes. And so what I'm wondering is -- my impression was that initial -- in the early years of MA, when the risk adjusters were just based on some basic demographics, there was lots of room for selection, and then introducing the more detailed HCC risk adjustors damp down on the potential for selection, and this seems like an important piece of evidence in suggesting the ability to risk-select within HCCs, because you have the potential to then change the coding.

But I wasn't -- it's fuzzy in my mind how the differential coding then plays out, and if it's sort of uniform, we just mark down more stuff in general. That's a different story about selecting within versus between HCCs

than if plans are differentially able to take some people who could get higher payments if they were more intensively code, and thus, there's more opportunity for risk selection than we might have thought.

DR. HARRISON: All right, so two things. Traditional selection is, "Are healthier people coming in?" Yes, healthier people are coming in.

When people first enter, the risk scores are about 10 points lower than people who stay in fee-for-service, but, in a sense, that's okay because we have a risk adjustment to take care of that.

The other thing is I think the coding is going on at all levels. I'm not sure that it's restricted to the upper risk scores.

Now, I think you do see the plans try to get the sicker populations. I mean, there are C-SNPs, and there are also other plans. There's more money to be made when you get sicker people because there's more you can save, and Carlos' margins, the last time, showed that higher risk score plans tend to have higher margins. So there may be some of that going on, but the other thing is it's hard -- this would be pretty hard, I think, for plans to select

within HCC.

MR. HACKBARTH: So let me just ask what I think is a related question to Kate's.

So early on in the program, when we had just demographic adjustors, the fiscal risk to Medicare was that plans would select better risk and get overpaid for the risks they actually had, and we used a richer risk adjustment system to combat that problem.

With the more complex risk adjustment system, you now get another type of problem, which is the potential for up-coding, and we see empirical evidence of that. I wonder whether we made a good trade here, a cruder risk adjustment with more potential for a risk selection versus an increased potential for coding, up-coding, and gaming the system that way. Was it a good trade that we made?

DR. HARRISON: Well, you could look at it as the incentives are now for plans to seek out the less well. They are not avoiding the sick anymore.

MR. HACKBARTH: Yeah.

DR. HARRISON: So I think that's a good thing.

MR. HACKBARTH: Yeah.

DR. HARRISON: Otherwise, I guess it's all in the

numbers and what we can find.

MR. HACKBARTH: But do you remember asking you what the numbers --

DR. HARRISON: I don't think we can answer that question yet.

[Laughter.]

MR. HACKBARTH: Sure.

MR. ZARABOZO: My opinion is that -- and this is my opinion -- I think it was a good tradeoff. I think it was a good tradeoff.

The selection that was going on before was huge, and this is 3 percent is a problem, but it's a smaller problem than the extent of selection that was going on before.

MR. HACKBARTH: That would be my instinct. I just wanted somebody --

DR. REDBERG: Sicker people have higher payments.

MR. HACKBARTH: But he doesn't think so. Okay.

DR. MILLER: Just for the record, I'm sorry I clarified Kate's point, number one.

[Laughter.]

DR. MILLER: And number two, I know Kate and Glenn

know, but also, in addition to the HCC, there's the annual enrollment, which probably dampened some of the selections, too, with just selections.

MR. HACKBARTH: Okay. Now that we clarified that, other clarifying questions? I have Alice and then Jack.

DR. COOMBS: For the private fee-for-service, is there a geographic distribution? I was just wondering. It seems like it's dropping every year, and under what -- have you been able to actually look at what circumstance the --

DR. HARRISON: So the general theory is they're only supposed to exist in places where there aren't two or more other kinds of plans. They can continue to exist in areas with other plans if they provide a network. I don't believe we can tell whether they are there because they have a network or because it's the two-plan rule, but what you do find is that they are now more in rural areas than they -- more concentrated rural areas than in urban areas.

DR. HOADLEY: So on Slide 9, on this question of the cross-walking of members, is this only happening when an organization discontinues a plan, or are they able to do this kind of cross-walk, even if they keep the lower rated plan?

MR. ZARABOZO: I think both ways. It could be a plan under a contract going to another contract and still retaining some of the -- you know, there are multiple plans under a contract, so I think they could do that. A portion of a contract could be moved, I think.

DR. HOADLEY: Interesting.

On Slide 15, when you are looking at the bottom row of numbers on the total estimated annual cost -- this is Slide 15 -- those are including the Part B premium?

MR. ZARABOZO: That's everything.

DR. HOADLEY: Everything.

MR. ZARABOZO: Right.

DR. HOADLEY: And so it's initially confusing because, obviously, these plans have other -- through other factors, other than premium, different estimated cost, and the premium is just a part of that.

MR. ZARABOZO: Right. It's premium, cost sharing, and It includes some benefits.

DR. HOADLEY: Right.

MR. ZARABOZO: You know, what is the cost of certain benefits.

DR. HOADLEY: And that's based on the health

status that --

MR. ZARABOZO: Right, that you choose the default health status as good health.

DR. HOADLEY: Right.

And on the risk coding stuff, have we ever spoken on the risk coding issues in terms of any kind of recommendation in previous rounds?

DR. HARRISON: I believe we have not.

DR. HOADLEY: Okay.

DR. MILLER: Not as a bold-face recommendation. I don't believe we have. I think there's been discussions of it in previous reports, but I don't think a bold-face recommendation.

DR. HARRISON: And this is the first time we've tried to quantify it.

DR. MILLER: Yeah. And Ariel can scan the website and make sure that that statement is true and correct it momentarily.

DR. CHRISTIANSON: Remind me whether you guys in previous analysis kind of looked at the impact of the home visits on the coding uptick and tried to tease that out.

DR. HARRISON: That was what I mentioned last

year, that CMS had put into the letter. We do not have a way to do that. You would need encounter data.

DR. CHRISTIANSON: Okay. I knew that. Right.

DR. HARRISON: And you might even need more than that. I'm not sure. Because I think plans can submit codes that are not -- I know plans can submit codes that aren't attached to individual encounters like that, so --

DR. CHRISTIANSON: So we don't know how much --

DR. HARRISON: We don't know.

DR. CHRISTIANSON: -- we should worry about the fact that the attempt to eliminate codes generated through a home visit --

DR. HARRISON: Right.

DR. CHRISTIANSON: -- has now been withdrawn --

DR. HARRISON: There was a --

DR. CHRISTIANSON: -- and still using those codes?

DR. HARRISON: There was a private consultant last year that thought they were worth 1 to 2 percent in additional coding.

DR. CHRISTIANSON: Based on what? Access to encounter data?

DR. HARRISON: I'm not sure what they had.

DR. CHRISTIANSON: Okay. Thanks.

DR. REDBERG: Thanks very much for the chapter. It was really helpful.

My question was sort of related to Table 2 in the mailing materials where we talk about beneficiaries change plans to have lower premiums. I know plans can cross-walk beneficiaries according to their star ratings, but do we have any data of beneficiaries select plans according to their star ratings?

MR. ZARABOZO: There was one article that suggested that, yes, star ratings make a difference; beneficiaries look at star ratings in choosing plans. But we had been talking to brokers, and that doesn't seem to be the case in most markets.

And the other point about the star ratings is that they provide bonuses, and what attracts beneficiaries are not necessarily the star ratings, but the fact that they have bonuses and can provide extra benefits that differentiate them from other plans.

DR. REDBERG: So they're choosing more on the basis of their pocketbook than on the stars?

MR. ZARABOZO: Yes, I think so. Yeah.

DR. CROSSON: With respect to the absence of mental health measures in the star rating program, do you know if that was a conscious decision based on some concerns about the quality of the available measures, or has it just simply not been done for some unspecified reason?

MR. ZARABOZO: There may be an issue of numbers that would fall under the measure, because I asked NCQA, actually, about adding additional measures for mental health, because Medicaid plans have some more measures that would seem to be appropriate, and they said that the numbers are too few in the Medicare population to be adding those measures. So there may be a similar issue with respect to the mental health measures, but I have not asked specifically why they were not included.

MR. HACKBARTH: Clarifying questions over here? Warner.

MR. THOMAS: Did you look at all at the impact or have you received any information on impact of shortening the enrollment time period at the end of the year, and has there been discussion or consideration of how that's impacted the population? Should that be evaluated or looked at?

DR. HARRISON: So the time period has been shortened.

MR. THOMAS: Yeah.

DR. HARRISON: Right. Well, enrollment has been growing pretty well, so I don't know.

We tend to think a lot of things slip through the cracks. So even though you are supposed to enroll by, I think it is, December 7th, if you look at the monthly enrollment, things tick up quite a bit from February to January, and you're not quite sure whether everything got through the system. So my guess is there are some issues, but beneficiaries seem to be enrolling pretty steadily.

MR. HACKBARTH: There are two distinct issues here. One is the length of the annual open enrollment period and whether it's long enough, which I think is what you were getting at, Warner, and then the second issue, of course, is confining enrollment to a fixed window, whatever duration. And as Mark was indicating, I think there is some empirical research suggesting that having a fixed annual open enrollment period has helped to deal with selection issues.

Kate is nodding her head.

MR. THOMAS: And I can understand that. I guess I'm thinking, I mean, inevitably, you would think that with more and more folks becoming Medicare-eligible, I think there is generally some, I think, confusion around the options and whatnot, and I didn't know if there's any sort of impact as we see more and more people becoming Medicare-eligible, whether they have enough time, did they understand it, that sort of thing.

DR. HARRISON: So one of the interesting things we found this summer when we looked at new people coming in is people coming in to sign up for Medicare Advantage right away, but we found a lot of people seemed to wait until there was an open enrollment to do it. So I think they used the information in the open enrollment period, and I think they do take advantage of it.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: So let me kick off with a Round 2 question/comment.

So, with the Affordable Care Act and its reduction in benchmarks over time, there were initially fears and even CBO projections, as I recall, that that would have a

detrimental effect on enrollment, and to this point, we don't see evidence of that.

Now, there have been some confounding factors like the CMS Quality Bonus program that for a period of time helped inject more money into the system, beyond what was envisioned by the Affordable Care Act, but that has now expired, and enrollment growth continues to be robust.

I wonder whether we couldn't make a contribution to this debate, as opposed to just focusing on the annual, which happened annually with the benchmarks and bids and payments, do something of a time-series look, so focus on bids, for example. What has been the year-by-year change in bids in response to reductions and benchmarks? I know the trend has been downward, and frankly, that's what I predicted when this was all being debated and in subsequent hearings on the Hill when Members would say to me, "Oh, this is going to be a catastrophe." I said, "I believe in markets. I think the plans will respond to the new payment environment and do things to hold down costs," and I think declining bids is consistent with my hypothesis, even if it may not prove my hypothesis, so I think some time-series information on that.

Now, a legitimate response to that is, "Well, bids have come down, but other things have happened as well, and plans may be charging higher premiums, or plans may be offering less in terms of additional benefits, or plans may be tightening networks." And I think it would be useful for us to actually go through the information that's available on those things and sort of evaluate them from a policy perspective. What has happened to the premiums charged by plans? Benchmarks have come down. What's happened to the additional benefits? The networks, I think is probably difficult to characterize in any sort of a summary measure, but my basic point is let's sort of evaluate what the impact of the Affordable Care Act has been over a period of time.

DR. HARRISON: So there are reports out there that track premiums, but premiums are a little difficult to track in terms of value because you don't know what's in the benefit package that they're charging for. And so I think our best measure would be the rebate dollars, and so I can give you a time series of the rebate dollars. I think that's the safest thing --

MR. HACKBARTH: Yeah.

DR. HARRISON: -- to get as a proxy for plan

value.

MR. HACKBARTH: Just one last thought that I personally would include in this sort of commentary is let's stipulate for the sake of discussion that maybe premiums have gone up and some of the added benefits have been cut back. Personally, I have no problem with that. I don't think there should be an entitlement to benefits above the Medicare benefit package financed by taxpayers, not by plan efficiency but by taxpayers, and if that goes down, I don't have any problem with that. And I don't think as a matter of policy, the Medicare program should have any problem with that.

The networks issue is actually a very interesting one. I assume that there has been some tightening of networks. I'd say that is a positive development. That is not a negative development. In fact, that is the mechanism by which Medicare Advantage can contribute to improvement in their health care system. It's the one thing that traditional Medicare cannot do, which is steer patients to higher performing providers, and we have abundant evidence that not all providers are created equally.

And so to improve our health care system, we need

a mechanism to steer patients to higher performing providers, and if networks are tightening, that at least creates the possibility that that mechanism is starting to be activated. And it didn't -- it wasn't activated when all the Medicare Advantage growth was through private fee-for-service plans. So I consider tightening of networks, if in fact it's happening, to be a great sign of progress.

So much -- and I'll stop my speech in just a second, but so much of the debate about Medicare Advantage, I think is just focused on absolutely the wrong things, and it's all our benefits going to be cut -- or the number of plans participating for this program to help Medicare get better, we need competition, lower bids, tightening networks. And I'm delighted with what's happened since the Affordable Care Act. It's working.

Craig.

DR. SAMITT: I mean, every indication that I've seen is that there actually has been a preservation of benefits, and there hasn't been necessarily an escalation in premiums, which then raises for me sort of my important monthly desire to understand encounter data, because the cost controls or the harmonization of payment between fee-

for-service and Medicare Advantage should instigate additional innovation and cost control in the MA space, and we should be watching where those innovations occur, so all the more reason now to begin to understand how are the practice patterns in the MA plans now beginning to differ from fee-for-service. I think there will be a lot that we can learn from that for all the points, for all the reasons that you've described.

MR. HACKBARTH: Okay. We're into Round 2.

MR. ARMSTRONG: Just a quick question following up. Perhaps to put Craig out of his misery, where are we with the encounter data?

[Laughter.]

DR. MILLER: We are still working with the agency. They have the data, and they are assembling it and cleaning it. It's just not quite come to us in, you know, an official capacity. My sense is movement, but I can't give you a clear date of when it's all going to be available to be analyzed. Jim, is that about right?

MR. HACKBARTH: Round 2 comments.

DR. HOADLEY: So I have a couple things I want to talk about. One, picking up on your comments, I think

there's some useful analytical work that you highlight, and I think part of it is this question of benefits. And Scott's right to talk about premiums by themselves are not a good indicator. But part of the problem is we don't actually have -- I have not seen recently good indications of sort of what the benefit trend has been. So whether it's as Craig says that we really haven't seen any erosion -- and some of the discussions of benefits sometimes are around just kind of trivial parts of the benefits. So it may not be easy to do that. But if there's something we can do, that would be useful. And I think networks as well, I mean, I might have more concerns about the tightening networks because I'm not as confident that a plan tightening its network is making sure to get the higher performing providers as opposed to just cheaper providers or something, fewer providers just on principle. But the starting point is do we know if there has even been a trend. We know there's anecdotes of plans reducing their networks to the extent that we could measure on general -- and, you know, raw measures aren't necessarily a good indicator either. So, you know, whatever is out there that we could do to do that, and then we can still debate whether the smaller

networks are -- have been well designed to do the kinds of things that you're hoping they do or not. I mean, we may not be able to do that empirically, but I think there's some real good analytical options to sort of look at the trends.

On this risk coding thing that we were talking about, you know, it's been an ongoing issue, and I don't know whether there's something that we should try to do. I think it's really helpful that you've done now some analysis to contribute to the discussion. Whether that leads us to a point where we might want to say something in a recommendation, it doesn't seem like we're quite there yet. But it seems like something we should look into.

The Plan Finder issue you raised on the Part B premium strikes me as also something needing attention, but there's actually a broader set of Plan Finder issues that would be useful to get into. Plan Finder, there's a lot of good things about it. It's been improved in a lot of ways over the decade or so, but there's still a lot of issues. I'm more familiar with some of the ones on the drug side. But when you try to compare fee-for-service to a plan, it's just kind of hard to figure out, you know, whether you're able to see an apples-to-apples both in the dollars and some

of the things you talked about. But in other ways, when you get into some of the drug plan issues, there are similar things.

There's a lot of people trying to come up with ideas both just displaying things, but also how do we do a better job of telling the beneficiary during that open enrollment period that this is your opportunity to shop? People are facing those same issues on the Affordable Care Act with the marketplaces right now. You know, how do we tell people, you know, we're going to renew you automatically in the kind of option you have, but there is a potential advantage to you shopping? We know that people don't do a lot of shopping. They do some. They do it from time to time.

MR. HACKBARTH: Do we know anything about how many beneficiaries use the Plan Finder and how they use the Plan Finder? I know nothing about this stuff, but I imagine that companies that are in the e-commerce business, in fact, they know a lot about how people use their websites and how they use it as a tool. Is there anything known about how beneficiaries use Plan Finder, or the Part D?

DR. HOADLEY: I mean, certainly in the early

years, when Part D was just starting in 2006, 2007, work that we did said, you know, the percentage of people who went online to do things was very tiny. More people presumably used the Plan Finder through proxies, through family members --

MR. HACKBARTH: That's true, yeah.

DR. HOADLEY: -- through counselors and other kinds of things. So it's a complicated way to try to measure. We're certain that that use has gone up, but I don't know if there has been any more current -- I mean, Kaiser did a study with some focus groups and I guess a survey to ask people some -- I don't remember if they asked the specific Plan Finder question in terms of how much people shop each year and some of those kinds of things.

DR. HARRISON: I think you're right, and the brokers also use Plan Finder.

DR. HOADLEY: Brokers as well, yeah.

MR. HACKBARTH: Yeah.

DR. HOADLEY: And then the one other one I wanted to mention was this issue on the star ratings on the duals, which is kind of intriguing. Obviously we should keep monitoring what CMS goes with, whatever comes from their

RFI, but I feel like I'm frustrated, again, whether you talk about on the Part D side, where some questions have been raised, or on the Part C side, and why those differences seem to exist. And, you know, in the stuff I've done, I haven't been able to come up with any good explanation. So, you know, maybe it's an area where obviously we're trying to think about if we can explain what's going on, if there's things that should be fixed, or if this is just a difference that is going on.

So those are issues I'd put on the table.

MR. HACKBARTH: Other Round 2 comments?

DR. SAMITT: I guess I just have a methodologic question. So as we talk about our updates, you know, I notice that we don't have any formal recommendations regarding MA. Is it not standard protocol for us to make these recommendations for any of the topics that we've discussed? And should we be?

MR. HACKBARTH: Well, because of the way MA rates are set, there is not an update factor analogous to hospitals or physicians, et cetera. So that's why we don't have such a recommendation.

DR. SAMITT: And, I mean, updates aside, are there

other recommendations regarding the programs that we can make?

DR. MILLER: Go ahead.

MR. HACKBARTH: I was just going to say, you know, I did ask Mark and Carlos and Scott to look at this Plan Finder issue as a potential area for a recommendation. Mike Chernew and some other people have written pieces suggesting using empirical data that how the information is presented actually is having a significant impact on the market and resulting in fewer plans rebating all or part of the Part B premium, and that the level of price competition could be increased.

We looked at it, and the conclusion that we reached was, well, that may well be true, but a recommendation on configuration of the Plan Finder may not be exactly what we want to do.

Now, having said that, let me just raise the other facet of this, that as I've sort of learned, you know, an inch worth about this, an equally important factor may be that the plans have skewed incentives here. If they offer additional benefits, they get to claim their administrative load on that and keep some of the money for themselves.

To the extent that they use their savings to discount the Part B premium, they can't claim a load on that and keep some of the money for themselves. And so they lose all of that. And that may be as big a factor in skewing behavior here as how the information is portrayed on the Plan Finder.

You know, I'm open to recommendations in this area. My sense is that maybe we could have more rigorous competition if we addressed how the Plan Finder and rebate dollars are the administrative load issues in that that would be good for the program. But I'm a little bit at a loss for how to formulate the recommendations.

DR. MILLER: And I'm sorry, I do just want to add, remember that the whole benchmark issue that is working its way out through 2017 was a result of recommendations that came out of here, and just last time we recommended changing how the bid for the employer plans was calculated. And we also made a recommendation to move hospice into MA. So we're not dormant on this issue. It just happens to be this time we don't have a set of recommendations.

MR. HACKBARTH: The fact that we were the ones who for years recommended reducing the benchmarks, that's why

you got the speech from me a few minutes ago.

MR. ARMSTRONG: Glenn, I don't have a real strong point of view on the website, but just one point worth making is -- and it relates to a comment you guys made about five stars, the star system. My experience is that star ratings really don't have much influence in the choices patients make, and from a policy perspective it seems to me we would want them to have more of an impact.

I wonder why the website doesn't somehow prioritize or amplify or somehow give more attention to organizations with higher stars as a way of supplementing the attention we also want them to be giving to the out-of-pocket costs and so forth.

And so to be honest, I'm not very familiar with the website itself, so how they treat stars I'm not very familiar with. But my sense has been that CMS could do much more to give much more attention to the star ranking of the plan alternatives.

MR. ZARABOZO: Well, this particular slide, the first thing that you see does contain the star information for a plan.

The other thing that you can do at Plan Finder is

to say I want this ranked not by cheapest but by highest star ratings. They also point out that the five-star plans, they have a special icon that says, "This is a five-star plan. This is a great plan." And then on the low-rated plans, they say, "You better think twice before enrolling in this plan because this is a low-rated plan." So there is some of that going on already.

DR. NAYLOR: Just following on that, I do think Scott and Carlos' recommendation for us to think about the star rating system as it exists and it's the opportunity to focus more on outcomes, and particularly to think about mental health. Certainly when you look at the disabled population and poor performance for under 65, the linkage between physical and mental health issues are profound in that population, and so not to draw attention to what might be possible ways to continually improve while the rest of the world is trying to figure out how to get more to outcomes I think is a missed opportunity. So I hope we can pursue that.

MR. HACKBARTH: Any other comments? Since we don't have any draft recommendations, we don't need a Round 3.

[No response.]

MR. HACKBARTH: Thank you, Scott and Carlos.

[Pause.]

MR. HACKBARTH: So, on we move to our final session on payment adequacy for long-term care hospitals.

[Pause.]

MS. CAMERON: Good morning. Today, we are here to discuss how payments to LTCHs should be updated for fiscal year 2016. We will discuss changes in policy that are current law. Then, using the established framework, we will evaluate the adequacy of Medicare payments in LTCHs.

First, just a little bit of background information. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for an acute care hospital and have an average Medicare length of stay of greater than 25 days. Care provided in LTCHs is expensive. The average Medicare payment in 2013 was over $40,000. Similar to short-stay acute care hospitals, Medicare pays LTCHs on a per discharge basis with an upwards adjustment for cases with extraordinarily high costs. LTCHs also have a downward payment adjustment for all cases with extremely short lengths of stay.

Congress passed legislation that establishes what it calls site neutral payments for LTCHs beginning in fiscal year 2016. The policy is similar to what the Commission recommended in 2014 and discussed yesterday with some key differences.

Under current law, beginning in 2016, an LTCH discharge must meet two criteria to receive the full LTCH payment rate. First, they must have an immediately preceding acute care hospital stay. Second, the discharge either needs to have three or more days in the referring hospital's ICU or receive an LTCH principal diagnosis that includes prolonged mechanical ventilation.

Discharges that don't meet these criteria will receive a site neutral payment equal to the lesser of an IPPS comparable rate or 100 percent of the costs. Beginning in 2020, if more than 50 percent of an LTCH's discharges are paid at the lower rate, then that LTCH will no longer qualify for the higher LTCH payment rate for any of its discharges.

The Pathway to SGR Reform Act also changes the calculation of the 25-day average length of stay requirement to exclude cases paid at that lower site-neutral rate as

well as cases paid by Medicare Advantage. The legislation also created a moratorium on new facilities and additional beds, with some exceptions, through September of 2017.

As Jeff mentioned yesterday, the Commission's 2014 hospital recommendation included criteria that defined CCI patients. This recommendation differs from the current law policy for several reasons. First, the recommendation includes spending eight or more days in an ICU during an immediately preceding acute care hospital stay. Second, there would be an exception for cases with prolonged mechanical ventilation in the referring acute care hospital. Third, the payment for these non-CCI cases would be set equal to the IPPS comparable rate. And, fourth, the savings from this policy would fund additional outlier payments for CCI cases in an acute care hospital setting.

I will now turn to the question of how payments to LTCHs should be updated for fiscal year 2016. To determine the update recommendation, we review payment adequacy using our established framework you've seen throughout the last day and a half.

We have no direct indicators of beneficiaries' access to needed LTCH services, so we focus instead 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 payments. There are no clear criteria describing the need for LTCH care, and the absence of LTCHs in many areas of the country make it particularly difficult to assess the adequacy of supply. About 40 percent of fee-for-service beneficiaries live in counties without LTCHs and receive similar services in other settings.

There is extreme variation in the number of LTCH days per fee-for-service beneficiary by county. For example, the median utilization for LTCH care is six days per 100 fee-for-service beneficiaries, where the 90th percentile equals 23 days. Of note, these ten percent of counties account for one-third of total LTCH fee-for-service days. Further, almost three-quarters of the counties in the top 90th percentile are located in three States.

Given this high concentration of LTCH use, most beneficiaries receive care in acute care hospitals. Research has shown that outcomes for the most medically complex beneficiaries who receive care in LTCHs are no better than those for similar patients that do not have an

LTCH stay.

To gauge access to services, we typically look at available capacity. This slide shows growth in the number of LTCHs nationwide in green and in the number of beds in yellow. You'll note that 2013 is not included on this slide because of inconsistencies in the cost report data. However, analyzing Medicare's Provider of Services file, we estimate that both the number of facilities and beds decreased by about one percent between 2012 and 2013.

This chart shows what's happening with LTCH cases per 10,000 fee-for-service beneficiaries. After rapid growth through 2005, volume continued to grow, but at a slower pace. Controlling for the number of beneficiaries, the number of LTCH cases declined by about one percent in 2012 and 2.2 percent in 2013. This decrease in volume has been observed across other inpatient settings, as well, including acute care hospitals, which affects the number of admissions to LTCHs.

In terms of quality, LTCHs only recently began submitting quality data on a limited number of measures to CMS using the LTCH CARE data set and CDC's National Health Safety Network. None of these data are currently available

for analysis. Instead, we continue to rely on claims data to assess gross changes in quality of care in LTCHs.

Between 2008 and 2013, mortality and readmission 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 facilities or within 30 days of discharge. Among the top 25 conditions in LTCHs, this ranges from a high of just over 50 percent for patients with septicemia and prolonged mechanical ventilation to a low of four percent for patients with diabetes with complications and comorbidities.

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 two-thirds of all LTCH cases. However, prior to the enactment of the recent LTCH legislation, the availability of capital said more about the uncertainty regarding changes to regulations and legislation governing LTCHs than it did about the payment rate.

The recent legislation provides near-term

certainty in terms of having defined patient criteria required for full LTCH payment, which initially stimulated the market. The phase-in period provides LTCHs with several years to adapt their costs and case mix to mitigate the effect of the payment reduction for cases that don't meet the new criteria. While the increased certainty of LTCH payment policy would typically increase the availability of capital, the new moratorium significantly reduces opportunity for expansion and, thus, the need for capital.

Turning now to LTCHs per case payments and cost, you can see why we have reason to believe that LTCHs will adapt to the upcoming regulatory changes. 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. After 2007, the growth in cost per case stabilized to less than three percent per year. Between 2012 and 2013, the average cost per case increased by 1.8 percent. However, for the first time since 2008, payments grew at a slower rate. The slower payment rate can be attributed to the application of a budget neutrality adjustment and from reductions in

payment from sequestration.

Margins track 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 also began to fall. However, after 2008, with cost growth well under control, LTCH margins began to increase again until this year.

As you can see in the top row of the table, the aggregate Medicare margin for 2013 was 6.6 percent, reflecting the effect of sequestration that was in place beginning on April 1 of 2013. There is a wide variation in the margins, similar to what we see in other settings, with the bottom quarter of LTCHs having an average margin of minus 12.4 percent and the top quarter having an average margin of 20.2 percent. The for-profit facilities have the highest average margin, at 8.4 percent, while the nonprofit facilities have the lowest margin, at negative 1.7 percent. There are a number of reasons why hospitals have lower costs and higher margins that we will discuss on the next slide.

We looked more closely at the characteristics of the established LTCHs with the highest and lowest margins. This slide compares LTCHs in the top quarter for 2013

margins with those in the bottom quarter. As you can see in the top line, high-margin LTCHs tend to be larger and to have higher occupancy rates, so they likely benefit from more economies of scale. Low-margin LTCHs had standardized costs per discharge that were 38 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. As you remember, these short-stay cases often have reduced payments. Lastly, high-margin LTCHs are much more likely to be for-profit.

We estimate that the aggregate LTCH margin will decline in 2015. Updates to payments in 2014 and 2015 were reduced by PPACA-mandated adjustments. CMS also made a budget neutrality adjustment in both years that further reduced the payment updates. We also anticipate an approximate two percent reduction from sequestration.

Overall, while we expect cost growth to continue to be below market basket levels, we think it will be higher

than payment growth. Thus, we have projected a margin of 4.6 percent in 2015.

In sum, growth in the volume of LTCH services per fee-for-service beneficiary declined by about two percent. We have little information about quality in LTCHs, but mortality and readmission rates appear to be stable. The combined effect of regulatory certainty with a moratorium for the next several years will likely limit growth at this time. Our projected margin for 2015 is 4.6 percent.

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 2016. CMS historically has used the market basket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2016 will produce savings relative to the expected regulatory update, even assuming the PPACA-mandated adjustments. We anticipate that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in cost with no update to the payment rates for cases in LTCHs in fiscal year 2016.

With that, I turn it over to you.

MR. HACKBARTH: Thank you, Stephanie.

Would you put up Slide 3. So, in the Pathway for SGR Reform Act, Congress did something that was similar to what we recommended, but less --

MS. CAMERON: That's right.

MR. HACKBARTH: -- allowing more cases to qualify for the higher LTCH payment. And, this may be in the paper, I'm just forgetting it. Can you characterize how much less it was than our proposed change? So, how many cases lost the LTCH higher payment under the SGR Act versus what would happen under our proposed change?

MS. CAMERON: So, I want to start with saying that under our proposed change, we would expect about six percent of the current IP beneficiaries using IPPS facilities, about six percent of the discharges from IPPS facilities to qualify.

MR. HACKBARTH: Okay.

MS. CAMERON: Under the Congressional legislation, we expect almost one-quarter of the discharges from acute care hospitals to qualify.

MR. HACKBARTH: Okay.

MS. CAMERON: What this means is that many more cases would qualify for the full LTCH rate. When -- do you want to talk about our projections?

MS. KELLEY: Yes.

MS. CAMERON: Okay.

MS. KELLEY: When we looked at current LTCH cases to see how many of them had the requisite three versus the eight days, our analysis found that about 40 percent of current LTCH cases met the eight-plus days or had prolonged mechanical ventilation. When you go to -- when you move that down to three days, I think we estimated -- we estimated that it was over 50 percent of LTCH cases, is that right?

MS. CAMERON: That is right, and I think where we're hesitating is that we do believe there will be quite a bit of behavioral change. And, so, for LTCHs to meet the criteria, while we do -- when we look at the current caseload, we are finding that about 60 percent would meet the legislation criteria. We do expect there to be changes in the mix of that caseload so that, ultimately, likely more than that will meet the criteria.

MR. HACKBARTH: So, what I'm trying to get at is a

smaller version of what we recommended is in law now. It's starting to happen. And, I'm interested in looking at that experience to try to gauge what the effect of our larger scale proposed change would be. So far, we're not seeing -- well, let me just leave it as a question there. Are we seeing any signs of anything bad happening as a result of the change that is --

MS. CAMERON: Not at this point. There is a phase-in period that's fairly lengthy --

MR. HACKBARTH: And, remind me what that is --

MS. CAMERON: Sure. So, the policy officially starts with cost reporting periods beginning in fiscal year 2016.

MR. HACKBARTH: Ahh, that's why we haven't seen --

MS. CAMERON: However, because they are -- because it is --

MR. HACKBARTH: It's even -- it was smaller than I thought it was. I was thinking it was this big and it's only this big.

MS. CAMERON: That's right, and because it's hinging on the hospital's cost reporting period, for about one-quarter of LTCHs, they will only have one month of this

policy beginning to phase in in fiscal year 2016. So, we really don't expect the full policy to be in effect for a full year until fiscal year 2019.

DR. MILLER: Do I recall that after the legislation passed, there was a Wall Street reaction?

MS. CAMERON: There was, and it was fairly positive.

MR. HACKBARTH: Fairly positive in --

MS. CAMERON: Meaning that stock prices went up.

MR. HACKBARTH: This didn't -- well, it didn't hit at all.

[Laughter.]

MR. HACKBARTH: Okay. Kathy.

MS. BUTO: Yeah, I'm just fairly ignorant about LTCHs. So can you describe the difference in the nature of the service that's provided in LTCHs for these procedures as compared to similar conditions treated in SNFs? And I guess I'm -- part of this is just wondering about site-neutral -- we just left that issue with IRFs and SNFs, and I'm wondering, are there any issues like that here?

MS. KELLEY: So I think the best look at this was done in some work that RTI did for CMS where they looked at

LTCH cases and kind of found three groups -- two distinct groups and then an amorphous middle. There was the most severe group -- which this is reaching back into my memory, but I think it was about a third of LTCH patients. The most severe group was much similar -- was very similar in the services they received to ICU or step-down patients in the acute-care hospital.

At the other end of the spectrum, there was a group of patients -- and I think it may have been about 15 to 20 percent -- that looked very much like SNF patients in terms of the services they received and the complexity of their conditions.

Then in the middle there was this very amorphous group, and that group I think probably varies greatly across LTCHs. I think there are -- you know, that's sort of at the aggregate. But within any given LTCH, I suspect there's a very different distribution, some LTCHs looking a lot more like SNFs and other LTCHs looking a lot more like acute-care hospitals.

MS. BUTO: I was just wondering whether we ever actually looked at a site-neutral kind of policy looking at those conditions for which SNFs provide, you know, 50

percent or more of the care for those kinds of patients who were also dealt with in LTCHs. Just curious.

MS. KELLEY: So we haven't done that. I think part of the notion of the PAC PRD was to look at whether or not there could be a common assessment tool and payment system across the different providers.

One of the things that historically been the big thorn in the side of researchers looking at LTCHs, whether comparing -- no matter what other facility you're comparing them to, is that we don't have an assessment tool here. So we really are limited to the extent that we can control at all for differences across patients.

DR. MILLER: I think you're tracking this, Kathy, just in case other people aren't, I mean, we did go through the exercise of the site-neutral between the hospital setting and the LTCH.

MS. BUTO: Right [off microphone].

DR. MILLER: Got it. Okay.

DR. REDBERG: I just wanted to point out, you know, clearly this is a really sick population, and you'll notice septicemia with prolonged mechanical ventilation and 51 percent mortality rate. So the other things we've

discussed in the past before you joined is, Should these patients have been directed to hospice care? Because not really SNFs -- I mean, they clearly had prognoses of less than six months. You know, we were doing a lot of very expensive things that are not comfortable and not really great for patients -- mechanical ventilation, central lines, all kinds of things -- and should more of them have been directed to hospice?

MR. HACKBARTH: Okay. Clarifying questions?

DR. HOADLEY: I assume from what you said earlier that when you're projecting the margin for 2015, there won't be any real impact of the new legislation because it really won't have gone into effect. Is that correct?

MS. CAMERON: That's right.

DR. HOADLEY: And are there any regulatory issues that CMS either has opined on relative to implementing the new legislation or is expected to? Or is it pretty straightforward?

MS. CAMERON: There will likely be some regulatory questions that we would expect to see in the proposed rule coming out this spring.

DR. HOADLEY: The one for this spring.

MS. CAMERON: That's right.

DR. COOMBS: So on Slide 13, is the standardized cost per discharge a reflection of just the large numbers in terms of combining the short-stay cases with that 74 percent occupancy rate? Does that number jibe well with you in terms of not just efficiency in terms of what they do but there's something else at work in terms of just the actual numbers? In other words, are the short-stay costs for these patients really, really much less than the other high -- the low margins?

MS. CAMERON: So there are a few things going on with the standardized cost. One, of course, yes, it very well could be the short-stay patients, but there's also, as you can see, the high-cost outlier patients, on average, there are fewer -- a lower percentage of high-cost outliers in those settings as well. And by definition, the high-cost outlier patients get paid 80 percent of cost above the threshold. So that likely has to do with the standardized cost per discharge differential.

DR. COOMBS: I'm just wondering if there's a cumulative advantage of having short stays in the low margin. Is there something else that allows them to make

even more money on the short stays?

MS. CAMERON: I don't believe so.

DR. COOMBS: Okay.

DR. MILLER: And remember -- I may be missing the underlying question. You can have more short stays, but you still have to have the 25-day length of stay overall.

MS. CAMERON: That's exactly right.

DR. MILLER: But you can, you know -- there's a distribution underneath, absolutely, and those two numbers would suggest that something goes on there.

MS. KELLEY: One of the things that we did look at in the past was trying to look at the nature of short-stay cases. And one thing we found was that there are short-stay cases which have lengths of stay that are closer to the average length of stay for the DRG, and they don't look that much different from patients that stay the average or longer.

The very short stay patients look very different. They're much more likely to die. That's the reason they have short -- one of the reasons they have very short stays. Even when they don't die, they have much more severe case mix. And one of the things that we speculated about in the

past was that some LTCHs may not be as savvy in terms of admitting patients that can really benefit from the LTCH care and may instead admit patients who perhaps shouldn't have been transferred. And so that might result in certain LTCHs having a higher proportion of short-stay cases, and that might affect their bottom line.

MR. HACKBARTH: Any further clarifying questions?

DR. CROSSON: Just for interest, as it indicates in the recommendation, this is a recommendation to the Secretary, because there's no current law in this particular case. So the savings that would be projected, do they get characterized in any way differently than if we were making a recommendation that was contrary to current law or not?

DR. MILLER: Okay --

MS. CAMERON: I was going to say no, they don't.

DR. MILLER: There is no difference [off microphone].

MS. CAMERON: There is no difference between the recommendations that speak to statute relative to those that speak to the Secretary.

MR. HACKBARTH: I would rephrase the question a little bit differently, and that is, how is the current law

baseline established when, in fact, it's year by year in the discretion of the Secretary? Usually what establishes the baseline for which savings or costs are calculated is written into statute. Here they, for a variety of reasons, elected not to do that, granting it all to the Secretary. How does CBO calculate the baseline?

DR. MILLER: Well, often I take these questions, but we're actually probably sitting with somebody who's deeper with me, so I'm going to withdraw.

MR. HACKBARTH: Okay.

MS. CAMERON: CBO makes assumptions based on what has happened in the past as well as what they expect to happen in the future, and given that the LTCH payments have been updated by a market basket by the Secretary historically, they continue to do that in the baseline for the future. So in this situation, we would assume that there is some update in the baseline, and not making an update or recommending to not update that does create savings relative to baseline.

MR. HACKBARTH: Other clarifying questions?

[No response.]

MR. HACKBARTH: Okay. Let's move to Round 2.

I've got one, and this may be for the economists in the room. Stephanie, are you an economist?

MS. CAMERON: Can I plead the Fifth?

MR. HACKBARTH: Be careful how you answer this.

[Laughter.]

MR. HACKBARTH: Okay. Here's my question --

DR. CROSSON: Stephanie plays one on TV.

MR. HACKBARTH: Yeah, right. So here's my question, and this spans a number of our conversations over the last couple days. In analyses like these, we often look at relationship between financial performance and occupancy rates and sometimes size and refer to, well, there might be economies of scale, and larger institutions and ones with higher occupancy rates perform better because of that. So that's one thing.

Now, thinking back to the analysis that Jeff presented at the last meeting where he said, contrary to conventional wisdom, in fact, fixed costs in acute-care hospitals are pretty low. The question for my economist friends is: If fixed costs are low, to me, the utter layman, that should mean that there really aren't much in the way of economies of scale. All the costs are variable.

You know, you match your cost to your patient volume. And all this stuff about occupancy rates and size should be not of zero importance, but of diminished importance in terms of explaining financial performance. Does that logic hang together, Kate?

DR. BAICKER: I think that makes lots of logical sense. There's still some room for economies of scale, I would think, if you have bigger purchasing power so your per unit cost on variable cost things is lower.

MR. HACKBARTH: Right.

DR. BAICKER: But I would think that the primary vehicle for economies of scale is being able to spread fixed costs over a bigger population. So big fixed costs should mean bigger opportunities for economies of scale. Small fixed cost doesn't eliminate them because of potential advantage in lower variable costs. But I think what you said makes sense to me.

MR. HACKBARTH: Yeah.

DR. BAICKER: One out of one economist agrees.

[Laughter.]

MR. HACKBARTH: I'll stop there. That's good enough. I just think we need to be careful in glibly

referring to scale and occupancy rates as explainers of cost performance. It may not be -- that relationship may not be as strong as we sometimes imply.

DR. MILLER: Right. I also thought that the -- and I have line of sight here, so if this is wrong, you need to fix it. I thought the other thing that you were saying in your analysis last time, Jeff, was the time that it could take a facility to respond, that that was the other point that you were making.

DR. STENSLAND: Yes, two things we looked at over one year [off microphone]. We looked at how they could change things over one year, and the other important thing is the vast majority of acute-care hospitals have 2,000 or more discharges. And I looked at my analysis of saying like 10 to 30 percent of costs are fixed for those with 2,000 or more discharges. But those with a very small number of discharges, it got up to about 50 percent were fixed. And if you look at the LTCHs, we're talking about 500 discharges. So the economy-of-scale issues might be different between acute-care and LTCHs.

MR. HACKBARTH: Good point. That's helpful, Jeff [off microphone].

We're into Round 2. Questions, comments?

[No response.]

MR. HACKBARTH: We are into Round 3 then. So why don't we start with Rita this time? Round 3, thoughts on the draft recommendation.

DR. REDBERG: I support the draft recommendation.

MR. GRADISON: I do as well [off microphone].

MS. BUTO: I support.

DR. SAMITT: I support.

DR. HALL: I support.

MR. KUHN: Support the recommendation.

DR. BAICKER: I support the recommendation.

MR. THOMAS: Support the recommendation.

DR. COOMBS: I support the recommendation.

DR. HOADLEY: I support it as well.

DR. CHRISTIANSON: I support the recommendation.

MR. ARMSTRONG: Yep, me, too.

DR. NAYLOR: Me, three. 17, 16 --

DR. CROSSON: Four.

MR. HACKBARTH: Thank you very much. Good job.

We'll now have our public comment period, and I'd like to see everybody who plans to make a comment come to

the microphone so I have a sense of how many are going to participate.

Anybody else? Okay. We've got two.

Let me just quickly repeat the ground rules. When the light comes back on, that signifies the end of your two minutes. Please begin by introducing yourself and your organization.

MS. ARCHULETA: Hello. I'm Rochelle Archuleta with American Hospital Association. The AHA appreciates the thought and attention given to site-neutral policy this morning. Site-neutral payment policy for IRFs and SNFs is very complex when all of the policy and behavioral considerations are taken into account, and we believe that more time in policy work are needed to study these variables before we can really understand the ramifications on the benes, SNFs, and IRFs.

Several key missing pieces were flagged today, and we share the Commissioner's concerns about these gaps. In particular, we are concerned about the relying on the IPPS discharge diagnosis as the sole identifier of site-neutral cases. This prevents the policy from accounting for the patient's functional status, which we know is the key to an

accurate post-acute placement, and it's also a key to identifying appropriate site-neutral cases. So we consider this a major challenge for the policy.

Today, we also heard a lot of discussion about the complex interplay between the 60 percent rule and site-neutral payment. Even though the 60 percent rule wasn't specifically on the table, a lot of very particular details were touched upon, such as changing the threshold, changing the qualifying conditions, or even which site-neutral cases should be included in the denominator, so really heading into a lot of detail, even though it's related, but a completely separate policy.

And we encourage very careful analysis, especially when you consider that an IRF can lose its payment classification if it becomes noncompliant with the 60 percent rule, so really significant potential impact on IRFs.

And finally, with regard to further regulatory relief, we would suggest that when the formal recommendation is considered in January that thought be given to adding and specifically articulating regulatory relief as a core component of the policy because we do think it's critical in

the future, should site-neutral payment policy be rolled out.

So thank you very much.

MS. KENDRICK: Good morning. My name is Martie Kendrick, and I'm here on behalf of the American Medical Rehabilitation Providers Association.

AMRPA submitted a letter to the Commissioners regarding its concerns with the site-neutral payment policy for inpatient rehabilitation hospitals and units and nursing homes, so I'm not going to take the Commissioners' time to reiterate those concerns now.

But I do want to say that AMRPA is troubled by MedPAC's process for considering the additional comments for inclusion in the site-neutral payment policy, which from our perspective has really not been transparent. Specifically, MedPAC is evaluating 17 additional conditions. There's 22 altogether for possible inclusion in the site-neutral payment, but has not made that list available for public review or evaluation. So we look forward, hopefully, to being able to see that list and being able to provide some additional insight and commentary to you.

In addition, AMRPA is very concerned about the

data, and in some cases the lack of data, that underlines some of the Commission's considerations. Any changes in Medicare policy need to be evidence-based and give consideration to long-term patient outcomes.

I appreciate especially the thoughtful discussion today which clearly a number of the considerations that were raised by various Commissioners are very much at the core of AMRPA's concerns as well.

So thank you.

MR. HACKBARTH: Okay. We are adjourned.

[Whereupon, at 11:13 a.m., the meeting was adjourned.]