MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, December 10, 2015
9:30 a.m.

COMMISSIONERS PRESENT:

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JON B. CHRISTIANSON, PhD, Vice Chair
SCOTT ARMSTRONG, MBA, FACHE
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
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AGENDA PAGE

P R O C E E D I N G S

[9:30 a.m.]

DR. CROSSON: Can we start to take our places, please.

So good morning and welcome to our attendees. For those of you who are familiar with the work of the Commission, as well as those who are not, today starts a portion of our work that is focused on making recommendations to Congress about payment updates across the Medicare spectrum of payments.

It's been customary -- and I apologize for those of you who are old hands, but some of you are not -- it's been customary to kind of explain how we do this process. We will be reviewing nine presentations between today and tomorrow on 10 different areas of Medicare payments. The discussions will have some similarities, and they will have some differences, and they will go relatively rapidly. So I think to help you understand some of the basis for how we do this, I will give a short primer.

We are required by law, of course, to do this work. It's part of the mandate of the Commission. We do this every year in December, where we introduce --

generally speaking, we introduce recommendations, and then we vote on those recommendations or amended recommendations in January. These recommendations are for the payment year 2017.

We examined each payment area in rather exquisite detail. We have staff members here at the Commission who are expert in each of these areas. We pay attention to the changing circumstances that exist in the Medicare program and within the provider community.

We have an analysis framework that many of you may be familiar with to try to determine whether or not current payments are adequate and how they should be changed, if at all.

We look at beneficiary access to services, the adequacy of access to services, quality of care, financial performance, and access to capital by the providers.

The Commission then examines the evidence that's presented and tries to reach, as much as possible, a consensus judgment on how we should understand the information and how it should lead to an update recommendation.

A little philosophy, Medicare, of course, is an

entitlement program. Entitlement, though, is for the beneficiary and not for the providers or the plans. That said, we do try to recommend payments for providers and plans that are both fair and that recognize efficiency, and we try to ensure, through that process, access for beneficiaries to high-quality care.

This is different, though, than making recommendations for payments that ensure the profitability for every individual provider, particularly irrespective of inherent efficiency. Why? Because in doing this work, we have to keep in mind the burden on our country of expenditures and its impact on the national debt and on the debt that will be borne by our children and grandchildren, and in addition, the modest income enjoyed by many Medicare beneficiaries, whether they're aged or disabled.

Therefore, we start our discussion -- analysis and our discussion with an assumption of no increase as long as access is good and projected payments are high enough to cover anticipated cost growth. But each case is different, and we make individualized recommendations to increase payments sometimes as contained in current law. We may freeze payments, however, or reduce or rebase

payments based upon the facts and the projections that we have from the staff.

A couple of additional comments. There is currently, as most of you are aware, a sequester of 2 percent. That sequester has been in place for a while, and it is still in place. You will see in the presentations that we reflect, in the margin projections, the fact of the sequester, but our final recommendations with respect to payment increases, no increases, or decreases do not have the intent or the fact of trying to make up for the sequester. That is not the intent of the Commission.

One other point, you will see, for those of you who are grizzled veterans of MedPAC attendance, that we will be discussing, to some degree, more than we have in the past, marginal profits; that is, the profit or margin that can accrue to a provider for seeing the next incremental Medicare beneficiary. We use that information to help us understand the range of financial performance that we're viewing, but we use it advisedly.

And, finally, as I mentioned a little bit earlier, we will not be voting today. I will be looking for the degree of consensus or not that exists in the

Commission. One of the reasons for that is that, as we did last year, if in fact and when we find a significant degree of consensus among the Commission in one payment area or the other, rather than have an extended discussion repeated in the January meeting, for those areas where we have already seen significant consensus, we will be having an expedited voting process at the January meeting for those areas. And the purpose of that -- if we achieve that, the purpose of that is to make room in the January meeting for a whole range of other pressing issues that the Commission is facing and that we have agreed during the year that we need to address by the time this term ends in April.

So, with that, let's move on to our first presentation, which his going to be on Medicare Advantage program. We've got Scott Harrison, Carlos Zarabozo, and Andrew Johnson. And, Carlos, you look like you're starting? No. Scott is starting.

DR. HARRISON: Good morning. I am going to present our analysis of the Medicare Advantage enrollment and bids for 2016. Carlos will briefly discuss the MA market structure, then update you on plan quality performance. Finally, Andy will discuss MA risk-adjustment

and coding intensity differences between MA and fee-for-service. Both Andy and I will present Chairman's draft recommendations for you to discuss.

Due to time constraints, this material is compact. You see more detail in your meeting materials, and we will be happy to take your questions and requests for additional information.

Diving right in. In 2015, MA enrollment grew to 16.7 million enrollees. Since 2006, enrollment has more than doubled and plans project continued growth for 2016. Overall MA growth in 2015 was about 6 percent. By plan type, enrollment in HMOs grew 6 percent and local PPO enrollment grew 9 percent. Regional PPO and private fee-for-service plan enrollment decreased. While still significantly higher than the growth in fee-for-service enrollment, I should note that the 6 percent growth figure is lower than the 9 percent annual growth we have seen over the prior few years.

In 2016, Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries. On this chart, you see trends over the last seven years, but to save time,

let's just walk down the 2016 or right-hand column.

Ninety-nine percent of Medicare beneficiaries have at least one plan available. Ninety-six percent of beneficiaries have an HMO or local PPO plan operating in their county of residence, and this is an all-time high. Seventy-three percent have a regional PPO available, up from 70 percent, as a New Jersey plan is now being offered, and 47 percent have a private fee-for-service plan available, the same as 2015.

The average number of plans available in each county remains at 9. When weighted by the number of beneficiaries in each county, the number of average plan choices available to the average beneficiary is 18. In either context, the decline from 2010 levels is due to a decrease in private fee-for-service offerings.

And the average rebate that plans have to invest in extra benefits in 2016 has increased to $81 per member per month.

Using the plan bids, we estimate that in 2016, MA benchmarks, bids, and payments, including quality bonuses, will average 107 percent, 94 percent, and 102 percent of fee-for-service spending, respectively. These numbers did

not change from 2015.

While plan bids average 94 percent of fee-for-service, that number is kept down because HMOs are bidding 90 percent of fee-for-service on average. The other plan types bid much higher, and local PPOs are bidding 105 percent of fee-for-service.

Note that the employer plans bid 103 percent of fee-for-service and recall that we had a recommendation two years ago to address high employer bids. That recommendation is reprinted in the chapter draft we have.

Although the bids are often below fee-for-service on average, Medicare is paying above fee-for-service, even for HMOs. This is due to the benchmarks averaging 107 percent of fee-for-service.

So why are the benchmarks so high, and why did they not decline from 2015, despite the continued phase-in of benchmark reductions? The answer to both parts of that question is quality.

In 2016, the quality bonuses add an average 4 percent to the benchmarks. That add-on increased from 3 percent in 2015.

The difference in the quality increases can be

explained by noting that 71 percent of MA enrollees are projected to be in quality bonus plans in 2016, and that's up from 59 percent in 2015. And Carlos will shed some light on the quality increases shortly.

Also note that all the numbers on this slide assume that risk differences are properly accounted for, and Andy will discuss risk and coding differences later.

So to sum up the current MA program status in broad terms, MA enrollment continues to grow faster than Medicare fee-for-service. Currently, at least 30 percent of Medicare beneficiaries are enrolled in MA plans.

There has been improvement in some measures of plan availability, including the rebates that provide extra benefits, and there has been progress toward financial neutrality with Medicare fee-for-service.

If there were no quality bonuses and/or risk coding differences, the benchmarks would average 103 percent of fee-for-service and plans would be paid an average of 99 percent of fee-for-service in 2016. But there are coding differences unaccounted for, and there are some intercounty benchmarks inequities that could be addressed. And let me address some of them now.

Back in October, you may remember we discussed how CMS measures county-level fee-for-service spending, which is used to set the benchmarks. CMS calculates spending for beneficiaries enrolled in either Part A or Part B, but MA enrollees must be in both Part A and Part B.

Average spending is higher for beneficiaries enrolled in both A and B. So, in counties with an above-average or below-average share of beneficiaries enrolled in both A and B, fee-for-service spending will be over- or underestimated. A solution to the fee-for-service estimation problem is complicated, and more work is needed. For now, we have asked CMS to work on the issue and to consider relief for disadvantaged counties.

Now let's address two other intercounty equity issues we discussed in the October.

Recall there is a double quality bonus that increases the benchmarks for some legislatively selected counties. The benchmarks for plans with four or more stars are normally increased by 5 percent of fee-for-service spending in the county. But in the 236 double bonus counties, the benchmarks for those same plans are increased by 10 percent of fee-for-service spending.

At the same time, the law generally caps a county's benchmarks at the its 2010 benchmark updated to the current year. In 2016, the caps reduce the benchmarks of over 1,400 counties, and most of these reductions limit the quality bonuses.

So the law includes a double quality bonus that inequitably raises quality bonuses for plans in some counties, and it includes a benchmark cap that inequitably lowers benchmarks, especially quality bonuses, for plans in other counties.

An option to address the inequities would be to eliminate both the benchmark caps and the double bonuses. We have a Chairman's draft recommendation for your consideration.

An option to address the inequities would be to eliminate both the benchmark caps and the double bonuses, and we have a Chairman's draft recommendation for your consideration.

The Chairman's draft recommendation reads, "The Congress should eliminate the Section 1853(n)(4) cap on benchmark amounts and the doubling of the quality increases in specified counties."

As far as implications, we expect that, overall, this recommendation would result in some small savings for the program, as the cost of eliminating the caps is completely offset by the elimination of the double bonuses.

Also, we expect some redistribution of planned payments. Some plans, depending on the mix of counties they serve, would see increased payments and some would see decreased payments. As a result, plans may find some markets more or less attractive than they are now. Also, plans may have a new incentive to improve quality in previously capped counties. Beneficiaries' access to plans, thus, may increase or decrease, depending on plan reactions to the new benchmarks.

I look forward to your discussion, but now let me turn it over to Carlos for market structure and quality.

MR. ZARABOZO: In this year's report, we provide some information about the market structure of the MA program, pointing out that it is relatively concentrated, and with pending mergers among the largest MA contractors, it is likely to become more concentrated. As of 2015, the top four companies have the majority of MA enrollment, at 54 percent. Overall, 69 percent of MA enrollment is in the

top ten organizations.

Compared to 2007, the year after the Medicare Advantage program began, the program now has higher concentration of enrollment. But on a per county basis, in 2015, there are more companies participating in MA through the offering of coordinated care plans, that is, HMOs or PPOs. In 2007, the average was 2.6 companies per county. In 2015, the average has increased to 3.2 companies per county.

Looking at quality in MA, one way we evaluate quality in the MA program is to determine whether quality measures improved on a year over year basis, using results for plans that have two years of reported data. This year, we found that most measures that could be compared on that basis remain stable. A few measures improved, including measures that are in the star rating system, such as medication adherence measures.

The MA star rating system, which determines plan quality bonuses, is based on a subset of the measures that we examine, along with additional measures that the CMS develops. For the recently released 2016 stars, a slightly higher number and a higher share of current beneficiaries

are in plans rated four stars of higher, which is the level of stars necessary for bonus payments. For bonus payment purposes, in 2016, plans will receive bonuses based on their 2015 ratings, which were known at the time plans submitted bids in June of this year for 2016.

Something that affects the share and number of beneficiaries in bonus plans is contract consolidation, where one contract's enrollees are folded into another contract which is then the sole surviving contract. When there are contract consolidations, the contract involved can have different star ratings. In 2016, about 900,000 enrollees are being moved from a contract that would not have been in bonus status to a contract that is in bonus status. The contracts that these beneficiaries are leaving do not have 2016 star ratings, which reduces the denominator when we make a statement about what share of current enrollees are in plans with 2016 star ratings. So, if you look only at contracts that have star ratings in both 2015 and 2016 to determine whether star levels are rising, we see that the enrollment weighted star levels change very little between the 2015 stars and the 2016 stars.

And now, Andy will talk about coding and risk assessment issues.

DR. JOHNSON: Thanks, Carlos. We are now going to discuss health risk assessments and diagnostic coding intensity.

The Commission has expressed strong support for the use of health risk assessments and home-based care for care coordination and planning. When combined with follow-up care and other resources, assessments administered in the home or in any setting play an important role in care management and we support their continued use in that capacity.

In October, we also discussed a policy option that would remove health risk assessments as a source of diagnoses for risk adjustment. Through the next slides, I will explain how this issue is distinct from the role of assessments and home visits for care coordination.

Our consideration of the policy option is motivated by concerns that reliability of assessment-based diagnoses and about the appropriateness of Medicare payments for conditions identified on an assessment that have no follow-up care.

We analyzed MA encounter data for 2012 to assess how frequently assessment-based conditions were treated with Medicare services. We found that 63 percent of assessment-based conditions were treated with the Medicare service that is included in risk adjustment. For these services, Medicare reimbursement was generated as intended. The Commission has expressed support for this use of assessment, as it is combined with related treatment. It is important to note that this set of conditions and the Medicare payment generated by them would not be affected by the policy option.

We also found that six percent of assessment-based conditions were treated with a Medicare service not included in risk adjustment. The cost of these services is addressed through non-condition factors affecting risk scores, such as demographic information.

Finally, we found that 31 percent of assessment-based conditions were not treated by any other encounter. These are the conditions that generate concern and are targeted by the policy option. Many of the conditions are serious, and if the diagnosis is accurate, some follow-up care would normally be expected. Although no follow-up

care was provided for this group of conditions, we estimated that they were associated with $2.3 billion in Medicare payments. However, we also found that the number of conditions without follow-up care and the associated Medicare payments varied significantly across MA plans.

Some Commissioners commented that certain conditions may be treated with services not covered by Medicare. These may include various forms of telehealth, medication management by a pharmacist, or certain nutritional services. MA plans are allowed to provide these services to enrollees, but the key issue here is that they must be financed through Medicare rebates paid to MA plans or by enrollee premiums. Risk adjustment only determines payment for Medicare-covered services. Therefore, the policy option removing assessment-based diagnoses from risk adjustment has no direct bearing on the financing of non-covered services.

The Commission is in support of MA service innovations that provide health care more efficiently than fee-for-service Medicare. Many such innovations use services not covered by Medicare to reduce the amount spent on Medicare-covered services. As the overall cost of

Medicare-covered services is reduced, MA plans may reduce their bid and receive a larger Medicare rebate in the following year. With additional rebate funding, MA plans can provide additional services that are designed to attract new enrollees. Therefore, we believe that removing assessment-based diagnoses from risk adjustment does not limit the payment that plans are due and is consistent with the Commission's support of MA service innovations.

We are now going to switch gears and discuss diagnostic coding intensity. Risk adjustment creates a greater financial incentive to identify and report all diagnoses in MA compared to fee-for-service. As a result, enrollees of equivalent health status may have higher risk scores and, therefore, generate higher Medicare payments when enrolled in MA.

Last year, we conducted analysis of risk score growth that compared cohorts of 2013 MA enrollees with cohorts of fee-for-service beneficiaries enrolled for equivalent periods of time. We found that cumulative MA risk score growth was about eight percent higher than fee-for-service growth. This year, we updated the analysis with 2014 cohorts and found that cumulative risk score

growth would have been nine percent higher than fee-for-service for risk scores based on the same model.

However, in 2014, CMS began phasing in a new risk score model which reduced the different in growth rates. When fully implemented in 2016, we estimate that the new model would reduce the difference in growth rates by two to three percent compared to the old model.

In addition, we and others have found that MA risk score growth rates continue to increase faster than fee-for-service by about one percent per year. Conservatively, that would mean that the coding intensity impact for 2017 would be between six and nine percent.

In each of the three prior years, CMS applied the minimum coding adjustment required by law. In 2017, the minimum required adjustment is about 5.7 percent, which is less than even the most conservative estimate of coding intensity impact.

This slide presents a draft Chairman's recommendation addressing coding intensity differences. The draft recommendation reads, "The Congress should direct the Secretary to develop a risk adjustment model that uses two years of fee-for-service and MA diagnostic data and

does not include diagnoses from health risk assessments from either fee-for-service or MA and then apply a coding adjustment that fully accounts for the remaining difference in coding between fee-for-service Medicare and Medicare Advantage plans."

This option would prescribe that CMS use two years of diagnoses both in calibrating the risk score coefficients using fee-for-service data and in calculating MA risk scores. In addition, health risk assessments would not be included as a source of diagnoses for risk adjustment, just as diagnoses from other sources, such as home health and hospice, are not included now.

The option also requires that CMS analyze the impact of coding differences after implementing these two model adjustments and then make an across-the-board adjustment for that amount.

We expect that the draft recommendation would result in savings to the Medicare program. CMS would be directed to apply a larger overall adjustment for coding intensity than the minimum adjustment currently required by law. Since the law took effect in 2014, CMS has applied the minimum required adjustment.

We do not expect the draft recommendation to have any impact on beneficiaries' access to care or quality of care they receive. To the extent that plans currently use aggressive recruitment techniques or focus on generating assessment-based conditions without follow-up care, however, beneficiaries may experience some relief.

We do not expect the aggregate impact of the draft recommendation to significantly influence plans' willingness to participate in the MA program. However, the draft recommendation will have differential impacts on plans given that there is variation across plans in coding intensity and in documenting assessment-based conditions without follow-up care.

Plans with higher coding intensity would receive a higher effective adjustment and vice-versa. However, I would like to reiterate that plans providing follow-up care for assessment-based conditions will not receive an undue effective adjustment as a result of removing assessment-based diagnoses. Only plans that document conditions without providing follow-up care would receive a higher effective coding adjustment.

This concludes our presentation. We look forward

to your discussion. Thank you.

DR. CROSSON: Okay. Do you want to make a comment?

DR. MILLER: Yeah, just one thing. I want to hit this point again, because listening to it back, I think we -- I just want to make sure that you guys have this in your head.

So, the recommendation is designed to work like this. There is a coding difference between fee-for-service and MA, and that's estimated each year, and by law, that's supposed to be adjusted, and it's done across the board. The intent of the recommendation is to say part of that could be accounted for differentially by plans who are engaged in the health risk assessment but not following up, and so that that -- if this is the amount of the coding adjustment, that part of it would be taken differentially across plans and then the remaining difference would come from the across the board. So, some of the thought process here is this would be more equitable when that coding adjustment is taken than the current approach, which takes things across the board.

And, we said that, but I just wanted to say it

again, because we are really motoring, given our time constraints.

MR. KUHN: Can I ask a question on that, Mark?

DR. CROSSON: Yeah, just a second.

MR. KUHN: Okay.

DR. CROSSON: Thank you, Scott, Carlos, and Andrew.

We are going to do a round of questions and clarifying comments, and then we are going to take the recommendations separately. So, we have to be efficient. They are both on MA, but they are significantly different enough, I think we would get confused if we try to discuss them together.

Clarifying questions. Herb -- let's just -- it's almost everybody, so let's go down that way and then come back up this way. Clarifying questions.

MS. BUTO: So, are we starting with me?

DR. CROSSON: Yes, Kathy. Sorry.

MS. BUTO: Okay. So, quickly on the second recommendation, coding intensity, a question of, realizing that the statute or the law requires CMS to make an adjustment, but is the issue of whether or not diagnoses

that are captured in an HRA not followed by an encounter, is that in the law? If not, could CMS make that change without -- our recommendation goes to changing the law or asking Congress to direct them to do things. So, my question is really about the law.

DR. JOHNSON: There is no law about assessment-based diagnoses, and I think CMS could make that change without any change in the law. They proposed to do so in the last -- for 2014 and 2015, but did not implement that change.

The reason that the law is invoked is that there is currently a minimum adjustment applied, and given that this new approach might change how the across-the-board adjustment, as Mark said, is what the minimum adjustment invoked by the law is addressing, we might have to change --

DR. MILLER: [Off microphone.] You're exactly right, that the first half probably could be --

DR. CROSSON: Herb.

MR. KUHN: So, just a quick follow-up question on Mark's clarification, which is very helpful, about differentiation across the board versus maybe some

targeting, if I understood right, on different plans. I'm just curious about the administrative feasibility of that for CMS. Is that something that they -- do they do that now with plans? Is that something they could actually implement and do effectively?

DR. MILLER: Andrew's perfectly capable of answering this, but I think the answer is, is if you said, Look, HRA only-and I'm short-handing here -- doesn't count, that automatically differentiates among the plans.

DR. JOHNSON: That's correct. And currently, diagnoses from face-to-face physician visits, outpatient visits, and inpatient visits are used as a source of diagnoses for risk adjustment. So this would move the assessments into the other categories not included for risk adjustment, which is home health, hospice, nursing facilities.

DR. CROSSON: Thanks, Scott.

MR. ARMSTRONG: Two questions actually back to Recommendation Number 1, and the first is a little general. Maybe it goes to round two. But I'm really trying to understand, on the double bonus payments, what's the strongest argument for why that was a good policy? And I

think what I've heard is, Well, at the time of implementing this program, it was a way of protecting some of those markets from what otherwise would be significant changes in their payment rates. I was hoping to just give you a shot at the strongest argument that would have been made for that policy.

DR. HARRISON: I think that's as good an argument as any, yeah.

MR. ARMSTRONG: Okay. Thank you. And then second, you do acknowledge that implementing Recommendation Number 1 would redistribute overall payment, would maybe bring it down a little bit, but basically, redistribute it between plans. Do you have a sense for, are there categories of plans that would get more or less through the kind of shake-out of that redistribution

DR. HARRISON: So generally, there's 236 counties that would see a decrease in their benchmarks and only for high-quality plans. And they are -- they tend to be -- well, they're going to be in lower cost areas and they're going to be urban because that's who gets the double bonus. Now, something like 52 of those counties are already capped anyway, so they may not actually be getting the double

bonus. So there's probably 180 counties that would see some change.

Now, plans who have beneficiaries in those counties may also have beneficiaries in outlying counties that are more likely to be capped. So I don't know that any -- you know, we didn't run things plan-by-plan, but it's not likely that there's going to be a huge hit for any particular plans.

MR. ARMSTRONG:

MR. ARMSTRONG: Thanks.

DR. MILLER: Which is kind of another way of saying it's a county phenomenon and it's kind of all over the place if you look at it. It's not like it's all here or all these kinds of brands.

DR. CROSSON: Yeah. For the Commissioners, you may remember in an earlier discussion we actually had a map that identified the counties. Bill?

DR. HALL: This is for Andy, I think. On Slide 15, if you could put that up for a minute, on Recommendation 2, the risk adjustment model uses two years of data. Is that existing policy or is there a reason we picked two years out of it?

DR. JOHNSON: That is not existing policy. Currently one year of data for both fee-for-service and MA is used.

DR. HALL: So the rationale of adding the second year was --

DR. JOHNSON: Is that there are some differences in coding across year for people who have certain chronic conditions. There was some background in the June 2012 MedPAC that we looked at.

DR. HALL: I'll come back.

DR. MILLER: And I don't know if you guys said this to each other, isn't some of the other motivation here is that we're giving a larger window for the plan to code a condition that they treated the patient, and so that they would have the ability to get the adjustment in the risk.

DR. CROSSON: Excuse me. For those of you in the audience who feel compelled to take pictures of the slides, please turn off your flashes. It's a little disturbing to watch the flashes while we're trying to talk. Thanks. Andrew?

DR. JOHNSON: So the two years of data addresses an issue where with chronic conditions somebody may be

coded one year and not the next or not one year and then the next. And so, it evens out some of the coding that is not due to other reasons but should be coded, but it's just unevenly coded across years. And so, it has a coding effect because there's more of the variation in fee-for-service than in MA.

DR. CROSSON: Mary?

DR. NAYLOR: So this has to do with consolidation, and I mentioned 900,000 moved in one year to a bonus plan. So how does that affect a given year? So if the consolidation happens in 2015, does that mean that the bonus award to those additional 900,000 who weren't in a bonus plan are now awarded or is it the subsequent year?

MR. ZARABOZO: It is. What is happening is this year, somebody's in a certain contract. Those people are being moved to a different contract with the same company and they know what the bonus status is of that contract because you have to use retrospective stars because you're admitting in advance. So for next year, they're putting these people in bonus plans, essentially, based on an old star rating. So they know in advance, here's the star rating. These people are coming from a three-and-a-half

star plan. I'm going to put them into a four-and-a-half star contract or a four-star contract. I can do that.

But then the question becomes, well, let's say you're moving the same number of people, exactly the same number of people from three-and-a-half stars to four stars, in the following year, then you have to sustain. You already have to improve to four. You might go to 3.75, which would still get you four, but you would -- so it could, in some cases, be a one-year phenomenon of yes, you're getting a bonus. In the future, you may not necessarily get a bonus for these people that you moved into bonus status.

DR. NAYLOR: So you said benchmark differential 4 percent was accounted for by the quality differences. I saw that most of the changes in quality were in process measures and I know they're weighted differently, colorectal screening and so on. Is that where most of the adjustments in quality happen?

MR. ZARABOZO: Well, a lot of it also was the improvement in the adherence measures which are heavily weighted, and as mentioned in the paper, the improvement computation, which is weighted the highest weight, five,

also pushed some plans over to bonus status.

DR. NAYLOR: Thank you.

DR. CROSSON: Warner?

MR. THOMAS: I just had a couple of questions. One, there was a reference in the chapter about this new policy being implemented, the CMS HCC policy being implemented for multi-years. Was that -- I'm not totally familiar with that, but how do you see that impacting or does that impact any of your recommendations or areas that your recommendations could affect? I mean, is there any duplication there?

DR. JOHNSON: Just to clarify, in our paper when we discuss the two years of data as a source of diagnosis? Is that what the question is about?

MR. THOMAS: No. There's a reference in there about there's a new CMS HCC model being implemented between 2014 and 2016.

DR. MILLER: You're talking about the vocabulary in B-22?

MR. THOMAS: I guess I got the wrong vocabulary.

DR. JOHNSON: No, it's --

DR. MILLER: [Off microphone.]

MR. THOMAS: That's right. I don't have the super top secret key.

DR. JOHNSON: So there was a revised model which remaps diagnoses to HCCs and uses a new statistical analysis to come up with the risk coefficients and that is being phased in from 2014 through 2016. So in discussing the coding impact, when that is fully phased in, compared to the old model, I think the growth rates would be reduced by about 2 to 3 percent.

But then considering our analysis of 2014 risk scores with three additional years of growth in that difference, which we tend to estimate is about 1 percent per year, it's where they put their file numbers, so that the new model is taken into account in the number of 69 percent.

MR. THOMAS: I guess, is there some duplication of impact of the policy being implemented and the recommendations or can we even tell?

DR. JOHNSON: If CMS -- and this is what would make the most sense to you since it will be the model in place starting in 2016, but they used that model in making the adjustments for two years of data and removing health

risk assessments. They've assessed the remaining impact using that new model in place and it would not be duplicated.

MR. THOMAS: Okay. For the two-year recommendation, what impact on risk scores would you anticipate that would have? Because one would think that if you have two years of data, you have longer to identify conditions, whatnot, that it would actually drive risk scores higher.

DR. JOHNSON: The balance is on the fee-for-service side, that more people are included as having a condition by using two years of fee-for-service data, so that that group is a larger group and would bring down the risk score coefficients.

MR. THOMAS: Okay.

DR. MILLER: And by that -- for both of those questions, if you went to the new model, we think that the difference between fee-for-service and MA gets compressed.

DR. JOHNSON: Correct.

DR. MILLER: And going to the two-year model, when you just said in your last sentence it lowers it, it lowers the difference?

DR. JOHNSON: Lowers the difference.

DR. MILLER: So both of them have the effect of compressing the difference between MA and fee-for-service.

MR. THOMAS: But intuitively, you would think that if you have multiple years in the risk scores, I mean, because you identified that some years something is captured and then it's not there the next year. So if you have multiple years, I mean, it could inflate scores.

DR. CROSSON: Correct me if I'm wrong, but I think what I'm hearing is, the two years applies to both MA and fee-for-service.

DR. JOHNSON: That's correct.

DR. CROSSON: What you're saying is, I think, that it would more affect fee-for-service; therefore, the difference would narrow. Although, Warner, it would still be, as you say, available on the MA side.

MR. THOMAS: Right. So you think that what would potentially happen is the -- and I'm just trying to understand this -- the fee-for-service may actually increase. So you would see a reduction in the difference between MA and fee-for-service?

DR. JOHNSON: That's correct.

MR. THOMAS: Okay. The last question was about the in-home assessments, you know, the 63 percent. You identified 31 percent had no other encounter. And my experience there is that the more the encounters get tied back into the medical record, the more there's a follow-up versus kind of a stand-alone type of assessment that's just done kind of separate and apart from the medical care. Did you do any -- was there any information on that? Did you have any sort of assessment there?

Because, I mean, I can understand, okay, you've just got folks go out and do assessments and there's no tie to medical record, but it also seemed like there's 63 percent that may be. So I get concerned that we're just going to, you know, tossing it all out when sometimes those home assessments are important to identify things for people that have trouble getting out of the home and they're tied back into the medical record and then followed up on. So I understand there's about 30 percent that are not, but there's also 63 percent that are.

DR. JOHNSON: Right. We didn't have any information on whether or not there was an assessment provided associated with the program, with follow-up, and

services or whether it was just a stand-alone assessment. So we simply had to look at assessments that also had an encounter for the same condition and then had -- and it would be included in the risk adjustment model that way.

MR. THOMAS: Okay.

DR. JOHNSON: I don't think that this was part of your question, but just to be clear that those diagnoses would still be included in the risk adjustment model through the other encounter and wouldn't be dismissed from an inclusion in the risk adjustment model.

MR. THOMAS: Okay. So basically, even if there's a home assessment and that's eliminated, if there's other components, I would say those are still there.

DR. JOHNSON: Right.

MR. THOMAS: I think part of my question is that I think sometimes those are identified in home assessments because people are not coming into the office.

DR. JOHNSON: True.

MR. THOMAS: And I think that's what I, you know, as I look at this, if I understand it correctly, that's one of the things I get kind of concerned about is, those things are identified. If they're tied appropriately back

to the medical situation, then there's appropriate follow-up. I understand that that's not always the situation and there's kind of a stand-alone home visit done. So it's just something to maybe think about.

DR. JOHNSON: I think that's an important point to make. It would provide an incentive for having follow-up care for the conditions that are needed rather that just going out and --

DR. CROSSON: And I think, Warner, when we reviewed the top ten diagnoses --

MR. THOMAS: Yep.

DR. CROSSON: -- at least it looked to me like all, or the vast majority of them, were conditions that should have resulted in an encounter.

MR. THOMAS: Yeah. And I think that my point is just that, you know, if we think about this, I mean, why eliminate the home visit from the scoring if there is the appropriate follow-up? I understand just going out and there's home services done to just drive scoring up. I get that. But if it's really to identify conditions that are then followed up on, I just think it's something we ought to think about and consider. That's all.

DR. MILLER: And let's be really clear on -- and I think you know this -- in your choosing to speak to the home visit. Our policy is agnostic on home visits. It's about the health risk assessment --

MR. THOMAS: With no --

DR. MILLER: -- with no follow-up, and I think our reasoning and your 63 percent from the slide is a good point.

What appears to be happening most of the time is they do a health risk assessment -- home, office --

MR. THOMAS: Nothing happens.

DR. MILLER: -- Walmart, whatever it occurs, and then they follow up on it. And our expectation would be if that's good coordination and planning, then the people who aren't doing it will move in that direction as opposed to the people who are doing it will move in the other direction. That's the expectation.

MR. THOMAS: I just wanted to make sure -- and once again, I may not be understanding it, but if there is the appropriate follow-up, then the information, the one I identified in health risk assessment, would be included in the adjustment.

DR. MILLER: Yes. Yes.

MR. THOMAS: Okay. All right.

DR. MILLER: As information that came from an encounter, though.

DR. CROSSON: Yes.

MR. THOMAS: Okay, great. Thank you. Thank you.

DR. CROSSON: Up this way. Jack and then David.

DR. HOADLEY: So I had a question on Slide 4 where you present the average rebates. Have you done anything to look at the breakdown of how those rebates are spent vis-a-vis premium reductions, Part D premium reductions, cost sharing, and whether that's changed at all over time?

DR. HARRISON: I think you will see a little bit of that on the Part D presentation next month.

DR. HOADLEY: Okay.

DR. HARRISON: But I don't think the shares have changed a lot.

DR. HOADLEY: Okay. And then my next question is probably parallel to Scott's question, but just thinking of it on the first recommendation relative to the percentages on Slide 5, I think my read of how you're characterizing

this is that the impact of the first recommendation on these kinds of percentages at this rounded level is that those should not change if the policies were recommended would have been implemented in 2016. Is that --

DR. HARRISON: Yeah, that's correct.

DR. HOADLEY: And that what you would get is some playing around in the plans that add up to make these averages.

DR. HARRISON: Correct.

DR. HOADLEY: And then on Slide 10 on the concentration question, you talked here about average number of counties -- or average number of companies per county growing, but my sense is it's also true that the degree of concentration is much greater at geographic areas than sort of the top four organizations with 54 percent of the enrollment kinds of things that you're showing in the first slide. So that in some markets, there's really one or two dominant plans, even though there may be more, a growing number of companies per county.

MR. ZARABOZO: Yes. And Kaiser just released an analysis of that, company level. That's correct.

DR. HOADLEY: And then my last question really

goes to some of the stuff that was in the reading material on the star ratings and the impact of the relative thresholds, and I guess it's something -- and maybe it's not worth taking time right here now, but trying to understand more about how that's working, because as I looked at the example you had in the paper, it seemed like the threshold was up, and there were fewer plans that were -- so I was trying to understand what CMS was doing when they make a relative threshold adjustment that it looked like. I mean, it seemed like there were some numbers that you didn't show that might show it differently, but it looked like it wasn't so much like a relative adjustment. It just raised the threshold, and maybe at some point later or offline, if that's more appropriate, I want to try to understand more of what's going on in these because I'm interested also in how it plays out in Part D where we've seen some net shifts up and down from year to year. So I don't think that needs an answer right now, but --

DR. CROSSON: Thank you, Jack.

David?

DR. NERENZ: Just a quick follow-up to Scott's question about rationale for the double bonus. In the

back-and-forth -- I forget who said it -- it was the phrase was "at the time the program was established." The Medicare Advantage program goes way back. The double bonus is an Affordable Care Act thing. So does that amend the answer in any way? What payment disruptions needed to be addressed five years ago?

DR. HARRISON: So, in the Affordable Care Act, benchmarks were changed a lot, right? We've having large decreases for some counties, and so the double bonus at that point may have helped to blunt that.

DR. NERENZ: Okay. That helps clarify. We're not talking about a bunch of payment disruptions back decades ago. We're talking --

DR. CROSSON: But the Urban Floor counties were --

DR. HARRISON: 2004.

DR. CROSSON: 2004.

DR. HARRISON: Yeah.

DR. MILLER: Let's be clear how much policy we're talking about here, okay? Yeah. And so you can kind of construct these arguments, but when he asked his question, it's -- you said, What's the strongest argument you can

make?

DR. CROSSON: Okay. Good. Our fine questions are over.

Let's turn to Slide No. 9, and we're going to take on the first draft recommendation. Congress should eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties as a combination recommendation. Just to be clear, this is not to disparage MA in general or MA plans. It's to create greater payment equity across plans and across counties, and by extension, then the beneficiaries as well.

So I'd like to start with Kathy. Support recommendation? Don't support?

MS. BUTO: Support.

MR. KUHN: I support the recommendation.

MR. ARMSTRONG: Yeah. I strongly support lifting the cap. That really disrupts the quality payment incentive that we've -- it's very hard to push. And I wouldn't argue against getting rid of these double bonus payments, but I wish I had a better sense for who is really going to be affected by that.

I'm a little concerned that the plans that we use

as models for advancing the agenda for Medicare program and MA in particular will be disproportionately hurt by that. I think in the end, I would support it, though.

DR. CROSSON: Thank you.

Sue?

MS. THOMPSON: I support the recommendation.

DR. CROSSON: Bill?

DR. HALL: Support on the basis of equity.

DR. CROSSON: Okay.

MR. GRADISON: I do as well.

DR. NAYLOR: As do I.

DR. CROSSON: Mary. Warner?

MR. THOMPSON: I support it.

MS. UCCELLO: I support the recommendation because I think it's removing rules that are causing distortions in decisions when plans are deciding where and whether to participate.

DR. CROSSON: Thank you.

Jack?

DR. HOADLEY: I support it, and I like Cori's statement on that and I think also the fact that the net change we're talking about here is quite small. And we

also think that the net change at the plan level -- and this sort of goes to Scott's point -- is likely to be small, but anything we could learn more to make sure that that's reinforced would certainly be helpful.

DR. REDBERG: I support the recommendation. I think it will help improve equity.

DR. CROSSON: Thank you, Rita.

David?

DR. NERENZ: I support. Let me just echo Scott's comment, though. Here and elsewhere, it would be great if we could have illustrations in as much detail as possible of who gains and who loses, because a lot of our recommendations have average effects, but they don't have differential plans and counties and regions are affecting in a different way. So the more we can know about that, I think the better it would be.

DR. CROSSON: Yeah. I'd turn to Mark on this. I mean, we've got -- what is it? -- 236 counties and then a thousand in the -- 1,400 or something, and it would seem to me that if we were -- we did have a map of which counties we're talking about.

DR. MILLER: We did.

DR. CROSSON: To do an analysis county by county of who's up, who's down, by plan, by county, for each of these two things, this would be pretty complicated.

I mean, we could pick out individual counties or individual plans, but whether those would be truly representative or not or even the best examples, I think would be hard to do. Am I right?

DR. MILLER: I mean, in particular, the way you described it, plan by plan, county by county, it would be hard to digest. We can certainly bring back -- and honestly, I can't remember. Are the maps in this version of the -- I think we presented them last meeting or the meeting before. We can bring that back, so you can at least see around the country where these counties are.

DR. NERENZ: And just to clarify, clearly there's a staff time and feasibility issue underlying that, and I fully appreciate that. And if it could be even a couple selected examples or something, I'm just observing that we appropriately make recommendations across whole policy issues. I mean, we say MA Plans in general, but then what we find down the road is that certain regions or counties or entities or something are really hit hard, and some are

not hit so hard, and some benefit. And the more we could know about it in advance, the better, but I understand some things you just can't tell, and it takes too long to sort out.

DR. CROSSON: Jack, on this?

DR. HOADLEY: Yeah. I mean, it seemed like part of the answer that was given was that when a plan looks at it, it's got to make one bid across a set of counties, and anything that would spell that point out more, it seems like goes to that point, so that it's not that we necessarily care as much about what happens in every plan in every county, although internally a plan has obviously got to think about that. But it's the extent to which there is "Okay. It's only 3 of my 40 counties that are going to be affected by this," so that kind of gets lost in the -- and to the extent you can sharpen that point anymore, that seems like what would be helpful to me.

DR. CROSSON: Okay. Thank you.

Kate?

DR. BAICKER: I support the recommendation both to improve equity and to reduce the distortions Cori mentioned.

DR. COOMBS: I support.

DR. CROSSON: Jon?

DR. CHRISTIANSON: Yeah. I support and also acknowledge that we can bring back the map, but I think Scott's point was more about the plan than the counties, so --

DR. CROSSON: And I support the recommendation as well.

Okay. Seeing no further comments, let's turn to Slide 15, and here we have the recommendation with respect to health risk assessments and coding adjustments that would follow.

The purpose here, of course, is to eliminate extra payments that are due solely to coding behaviors and not the inherent characteristics of the beneficiary.

To do this at the individual plan level is the point, and what we are trying to do, as the discussion that Warner led pointed out, is to eliminate from the scoring, diagnoses made only during health risk assessments, wherever they occur, but not apparently, subsequently carried through into encounters.

To reiterate a point that Mark made, this is

again about health risk assessments. It has nothing to do with the inherent value of home health visits, and in fact, there was recently or just this week an article, Andrew, I believe, in Health Affairs that appeared to show that it was advantageous both in terms of quality and also financial performance for plans to do home health visits and then use those to improve care coordination.

So, again, there's nothing here meant to disparage to discourage home health visits. In fact, just based on some evidence, it appears that that should be in the interest of plans, anyway.

So here we have Recommendation No. 2. It has two parts, A and B, and this time, we'll start with Jon.

DR. CHRISTIANSON: I support this recommendation. I just think it makes a lot of common sense in terms of how to manage the MA program.

DR. CROSSON: Alice?

DR. COOMBS: I support the recommendation.

DR. CROSSON: Kate?

DR. BAICKER: Yeah, I support them, and I don't even think that it undermines the HRA in the sense that anything that's found in the HRA and followed up on will be

accounted for in the risk adjustment. So it maintains the good while pruning the less sensible.

DR. CROSSON: Good. Good point. Thank you.

David?

DR. NERENZ: I support. Just one wording clarification. I note that on October 28th, CMS announced a proposed change that they were considering in the HCC model to include dual status, and I just want to clarify that the absence of mention of that here doesn't mean that we somehow are recommending against that. That this is silent and agnostic about the issue of the duals, right?

DR. MILLER: In fact, their implementation of that is based on things that we as a Commission said before that. Parsing the dual -- partial dual and full duals in the model came directly out of work that those guys did and that we said that's something that should happen.

DR. NERENZ: I understand. I just want to make sure that the absence of mention, it is --

DR. MILLER: No. It assumes that that's going into effect --

DR. NERENZ: Perfect.

DR. MILLER: -- and that we support it.

DR. NERENZ: Perfect. that's all.

DR. CROSSON: Rita?

DR. REDBERG: I support the recommendation. I agree with what Kate said, that it will improve equity, and I certainly support home visits, but identifying conditions that are then never included in encounter data doesn't smell right, so continuing home visits with this is great.

DR. CROSSON: Thank you.

Jack?

DR. HOADLEY: And the fact that the data we saw showed that the extent to which these behaviors occurred was very skewed by plans sort of reinforces that point that it isn't something that's fundamental to how the health risk assessments are used, and so I very much support the recommendations and compliment the staff work on both of these.

MS. UCCELLO: Yeah. I agree that this is fantastic work, and I strongly support this recommendation for the reasons others have stated.

If and when something like this is implemented, I would just want to kind of make sure there's some kind of monitoring going on, to make sure that those conditions

that don't appear to be followed up on, that seem like they might not be completely valid, that there aren't ways to game things a different way to make them valid, so not all of a sudden getting additional encounters just so that can be checked off in terms of, okay, we found somebody with this condition, that we took them to the doctor, and now had that doctor find this condition as well. And so, I mean, I think that's a minor concern, but I think it's something just to kind of think about unintended consequences down the road.

DR. CROSSON: Okay.

MR. THOMAS: I have a concern about the proposal, not the HRAs, and the clarification on that was extremely helpful. I think the other modifications to the risk adjustor, I'm concerned about how that -- how the current policy being implemented with this change, you know, with the changes and the continuing step-down of MA payment rates, what that kind of equates to at the end of the day from a payment perspective, and I just have trouble understanding, you know, with all those changes kind of going on simultaneously, what will be the end result on MA premiums.

So, I totally understand the HRA and the fact that if there's items identified that are not in the encounter data, that's a problem. So, I agree with that. I'm just concerned about the other components. When you've got two or three pretty significant changes going on at the same time, what is the ultimate financial impact on premium and how would that impact the viability of plans in some of these counties or some of these states? So --

DR. CROSSON: So, when we bring this back in January, I think on both these points, perhaps we can provide a little bit more clarification on that.

MR. THOMAS: That would be great. Thank you.

DR. CROSSON: Yeah, because I think -- just not to do that right now, but with respect -- in between plans, between plans this recommendation, as I understand it, would reduce payments to plans who are receiving payments based on codes that come from the health risk assessments and are not backed up by encounters. Having said that, if that is, in fact, what happens, then the net required reduction would be less of a reduction for the other plans. Now, how much that would be, I think perhaps we could lend some information to.

But, I think it's important to understand that the sense of this here is that if this recommendation is, in fact, enacted, or taken up by -- yeah, enacted -- that the plans that appear to be doing this, that is, using these assessments to increase their codes, would not be able to do it anymore. The recommendation, then, is to net that against the required minimum reduction. The net effect of that on the other plans who are not doing this would be that they would receive less of a reduction than they would otherwise.

MR. THOMAS: Once again, I -- philosophically, I don't disagree with the recommendation at all. I think what I'm concerned about is just with the CMS policy that's being implemented with this change, with the continued tracking down on premiums, just what -- as you look at that in aggregate, what do we see the impact? I just would like to have a little bit better understanding of that. But philosophically, what's being done, I don't have a philosophical issue with. It's more just transparency on those impacts.

DR. CROSSON: You're correct. There are a lot of moving pieces.

MR. THOMAS: A lot of moving pieces.

DR. CROSSON: We'll see if we can help with that, yeah.

Okay. Mary.

DR. NAYLOR: So, first, I want to compliment you. This was an outstanding chapter. I really also appreciate how much attention was paid to trying to clarify the value of health risk assessment for the right purposes in assuring great care coordination for Medicare beneficiaries. I strongly support this recommendation.

I actually want to build a little on Cori's -- when you look at the diagnoses of major depression and arrhythmias and COPD and heart failure which are being diagnosed and not followed up, I think this is a quality issue. It's almost an ethical issue, that there isn't follow-up if these are really actual diagnosed problems.

And, so, as we look forward, we might not only think about is there the continued follow-up for diagnostic purposes, but evidence of treatment. And, so -- but, anyway, I strongly support this to benefit the beneficiary.

DR. CROSSON: Bill.

MR. GRADISON: I support it.

DR. CROSSON: Bill.

DR. HALL: I also strongly support it, and I'd just like to add a clinical footnote here for maybe discussion next month, is that in the high-expenditure Medicare recipient, a year can make a huge amount of difference. An example would be someone who has a stroke one year, someone who has Alzheimer's disease. It's about a five-year disease once it becomes high expenditure. There's no reason to think that expenditures, and by implication the quality needs that they have, will be pretty much the same over two years. They will vary quite a bit.

So, I think suggesting that health risk assessment as a process that should be rewarded probably does not make any sense, but again, I hope that we don't throw the baby out with the bath water. This is often a way of reducing expenditures in year two, because some things you won't find out unless you look for it. But, I think we're very much on the right track here.

DR. CROSSON: Thank you. Sue.

MS. THOMPSON: I support this recommendation and also want to compliment the staff. Great work.

DR. CROSSON: Thank you. Scott.

MR. ARMSTRONG: I'd like to take just a minute and make a couple of general comments, and then I'll get to the question.

First, no one's really said this, but when you just kind of step back and look at the status report and the general conclusions that you drew, I think, overall, it's worth acknowledging the Medicare Advantage program is working incredibly well and that in so many respects, this is headed in the direction we would like to see it heading in, that for, what is it, a $170, $175 billion program, we are demonstrating improved quality. We're kind of seeing the gaps between overall cost per beneficiary compared with fee-for-service close, and, anyway, in many respects, part of our conclusion is to decide is it going in the right direction or not, and I would just say, next month when we get to that, that from my view, it really is.

Second, now, you know, we get into health risk assessment and I go running for my nearest actuary and I say, please, Cori, help me out here. This is not my area of expertise. But, I just generally want to acknowledge that my hope is, maybe it's building on what Warner was

talking about earlier, but that we could spend a little time, or sometime the Commission should spend more time, or maybe I just need some remedial help on this, but our whole approach to evaluating the health risk assessment methodology and so forth is to address the fact that in MA, coding and documentation is leading to higher reimbursement than in fee-for-service. And our conclusion is that that's bad and that that gap needs to be closed.

I live in a world where, most of the time, really rigorous documentation and coding is actually good, because it improves how much we know about the patient. It improves the likelihood that other people in our system are going to have good knowledge about the patient. And, yes, it improves our reimbursement, but it's not just about reimbursement.

And, in fact, I would argue that the real problem is less over coding in Medicare Advantage and under-documentation and under-coding in fee-for-service, which results in horrible problems in our health care system.

And, so, I just feel like we're too quick to just kind of walk into, geez, how do we deal with this problem of over-coding and over-documentation in MA and kind of

squeeze the gap a little bit. Like I said, I'm sure there's really strong responses to that, but it seems to me as a Commission we ought to just put that back on the table every once in a while and remind ourselves what is it that we are trying to do.

Specific here to the recommendation, I can support where we're going. I have had a little trouble separating the HRA itself from the risk assessment, because the solution seems to be largely a risk assessment kind of adjustment. And while I would agree completely that if there are patients who are being seen in the home who really clinically should be seen by others in other places and they're not, we should confront that.

I'm not convinced, however, that patients being seen in the home necessarily -- with these diagnostic codes -- need to be seen other places. More and more, we are moving doctors and nurses and pharmacists and diagnostic tools and all sorts of care capabilities into patients' homes. And, I just want to make sure that some of our policy around home health care, which is a vitally important part of a care delivery system that's going to achieve the outcomes we want, aren't dated by changes and

advancements in the way care is being organized and provided.

And, so, that may be kind of off point from the specific recommendation here, but I just feel like I need to throw that in there.

And, I think that given all those comments, and particularly given that this is one of two recommendations that, frankly, are relatively small tweaks within a $170 billion system, I suspect that I'm going to be supporting this recommendation. Thank you.

DR. CROSSON: And, I'd just like to emphasize again that even though a significant proportion of the health risk assessments occur in the home and that there is apparently a growing industry to do that, you know, our recommendation here is not about home health visits, and I think our backgrounds are similar. You know as well as I do that that's valuable.

As I said also earlier, though, when we looked here at the Commission at the ten most common diagnoses which were part of health risk assessment diagnoses that were not then followed up by an encounter, it was hard for

me as a clinician to look at those diagnoses and believe that they could be properly managed only at home, which led me to this point.

MR. ARMSTRONG: I think one other point I would make here, too, is that -- others have made this -- this may also be the case. We should just make sure -- just check as we go through the next month, there are a small number of providers who, it appears, are using the home health visit and the documentation and so forth inappropriately and that we just should be very careful that our policy conclusion is not a blanket conclusion that deals -- is solving -- is not necessarily solving the specific problem with a very general kind of policy change.

DR. CROSSON: Thanks.

DR. MILLER: And I just want to make one narrow follow-up to the last point that you're exchanging. So, if somebody enters the home, does a health risk assessment, and there may be a condition that, clinically, you two were saying, yeah, you would have to see that person beyond the home, but just to make sure the public and the audience understands, if the encounter occurs in the home, that counts, right. So, just to make sure that nobody's missing

that. So, if I do a physician visit in the home and I put the diagnosis on that to treat the diabetes, that counts. And, so, it doesn't have to be, if they're a homebound patient, that they have to leave the home to get the care. In case anybody was missing that, I just wanted to --

DR. CROSSON: Yeah. No, thank you for that. That's an important clarification.

Yes, Herb.

MR. KUHN: I support the recommendation. Also, if I may for just a moment, can I ask a question about the draft chapter, or can we do that later?

DR. CROSSON: About the what?

MR. KUHN: About the draft chapter. I have a question about the draft chapter. Are we still going to have conversation about this issue after this round?

DR. CROSSON: You want to go back to round one?

MR. KUHN: No, no, no --

[Laughter.]

MR. KUHN: I just have a question about --

DR. CROSSON: Go ahead, Herb.

MR. KUHN: I guess just one question I had, because I didn't think this was a round one question and

I've been waiting for round two --

DR. CROSSON: Well, one-and-a-half, you can go either direction. Go ahead.

MR. KUHN: Okay. So, I guess in the March 2015 report, there was a section in there where we looked at margins for MA plans, and unless I missed it, this was omitted from this particular draft one. Is there a reason for that?

DR. MILLER: It was omitted and we're kind of still messing around. We were trying to think this through from a C and D perspective, to bring a more holistic view to it, and there are some technical difficulty, and so we don't have the margin that you saw last year in that and we're still kind of trashing through both the C and D.

MS. BUTO: [Off microphone.] Do you think you will have it in January?

DR. MILLER: Well, that was the part I was hoping I was going to get away with not saying --

[Laughter.]

DR. MILLER: -- because I'm still not sure. The intent is to have this information. Exactly where we are and how well we're going to be able to do it is what we're

kind of messing with right at the moment.

DR. CROSSON: The razor-sharp eyes of a former CMS person.

[Laughter.]

DR. CROSSON: Kathy.

MS. BUTO: So, I strongly support the policy, but I have reservations about the recommendation, and my reservations go to asking Congress to direct the Secretary when Congress doesn't need to direct the Secretary. I'm generally concerned about asking Congress to give this level of specific direction, particularly on the private plan side of Medicare, where when legislation is developed, it often turns out different --

DR. CROSSON: Really?

[Laughter.]

MS. BUTO: -- than was originally intended. And I actually picked up a third point -- so, I have three concerns about asking Congress.

One is just that, the mischief that can be made.

The second is -- and the level of specificity that I just don't think it's appropriate for Congress to get into telling the Secretary how to do risk adjustment.

The second issue is the time it takes to get legislation. This is a problem that the agency could take on much more quickly, although albeit not as quickly as we all would like.

And the third one is something of what Scott was touching on, which is the technology could change, and if you embed the risk adjustment approach in legislation, it really requires you to go back and change the legislation every time you want to make adjustments to risk adjustment, and I just think that's a path we don't want to go down.

So, I support the policy. I just don't like going through legislation unless there is no other option. That's just my --

DR. CROSSON: Very thoughtful. Mark, do you want to weigh in on how we chose this particular route?

DR. MILLER: Yeah, and I think the main reason -- I'm looking at the crew to make sure I get this right -- the main reason is for the second half of the recommendation. So, what the second half of the recommendation says -- you know, there's some implied arithmetic here. There's some coding difference that exists. And if you did this HRA adjustment -- and this is

some of what Warner was asking about -- that coding difference would be this, whatever that math is. And then the Secretary -- or then you say, okay, now take the rest with an across-the-board.

And the reason that we felt that we needed to go through legislation is, right now, this is -- I mean, the other, and I don't mean this in an argumentative way -- practically, the Congress has directed the Secretary to take an across-the-board and given her a minimum number. If this adjustment and the V22, which Warner is really deep on --

[Laughter.]

DR. MILLER: -- you know, were to, you know, the change in the risk system and the change in how the HRA is counted were to drop this below the minimum, the Secretary would be required to take the minimum.

DR. CROSSON: To take the minimum, yeah.

DR. MILLER: And, so, we feel that in order for that second half to work operationally the way we expect it to work, or would want it to work, you have to change the law, at least for that portion.

But, I do want to acknowledge up front, A could

be done by the Secretary. The Secretary controls the risk system. But to get them to work together, we felt in the arithmetic in the second one, that the Congress had to enter.

MS. BUTO: Well, that strikes me as a little weird, because there are other things going on that I think you mentioned earlier that are going to narrow the difference between fee-for-service and MA risk adjustment --

DR. MILLER: The V22, for example.

MS. BUTO: Yeah, the V22. So --

MR. THOMAS: [Off microphone.] I told you.

[Laughter.]

MS. BUTO: -- there are other things that are happening that CMS is going right ahead with that might also affect that minimum threshold. It just strikes me that -- you know, again, my basic concern is that once you go down the road of asking Congress to make all these risk adjustment changes down to the level of whether an HRA encounter or non-encounter counts or doesn't count, you go -- and then it strikes me if they made that methodological change, then -- as they are with this V-whatever-it-is

change, then, somehow, that has to be addressed anyway.

I don't know the answer. I'm just saying that I think this is not that different from what they're doing administratively to narrow those differences anyway. This is just another --

DR. CROSSON: I think -- do you want to -- my sense is we'll come back in January. We're going to look more broadly, as we said earlier. That feeds into this question, as well, and my sense is we can come back in January perhaps with an amended recommendation or perhaps with the same recommendation but a better -- more information explaining why. Is that what you were going to say?

DR. MILLER: The only -- I can do all that. The only thing I would say is that, in some ways, if CMS were to take a bunch of administrative action and, let's say, narrowed things to the point that you were below the minimum just separately, Congress would have to reenter. Otherwise, the Secretary would be compelled to take more --

MS. BUTO: And I think that's fine and Congress would do that, but here, we're asking them to direct the Secretary to make a methodological change, a specific one.

DR. CROSSON: Right. So, we have to weigh that against the risk that we could end up with a reduction significantly higher than what we had intended.

Okay. Thank you. This has been a very good discussion, a very good discussion. Thank you, Carlos, Scott, Andrew.

We'll move on to the discussion of hospital payment.

[Pause.]

DR. CROSSON: Okay. We are going to move on to the hospital update. We've got Jeff, Craig, and Zach, and Dan in the bullpen.

Okay. Complex stuff. Who wants to start out?

Okay, Zach.

MR. GAUMER: Well, good morning. This session will address issues related to Medicare payments to hospitals. We will cover both hospital inpatient and outpatient payments, and we'll discuss whether payments are currently adequate.

In addition, we will provide you with a summary of the 340B program and then also the Chairman's draft recommendations for updating payment rates for 2017.

To evaluate the adequacy of Medicare payments, we use a common framework across all sectors. When data are available, we examine provider capacity, service volume, access to capital, quality of care, as well as providers' costs and payments for Medicare services. When we discuss costs and margins, we will present Medicare margins for the average hospital. New this year, we'll offer a financial indicator we refer to as "marginal profits." We also discuss the margins for relatively efficient hospitals and projected margins for 2016.

As you can see on the bottom row of the table above, in 2014 Medicare hospital spending amounted to approximately $173 billion in fee-for-service hospital services and a 4 percent increase in spending per beneficiary from 2013 to 2014. These figures are the sum of three components: inpatient spending, which declined 7 percent per beneficiary from 2013 to 2014; outpatient spending, which increased 11 percent per beneficiary; and new uncompensated care payments that are the result of revisions to DSH policy.

The decline in inpatient spending was largely offset by the $9 billion in uncompensated care payments,

and some of the inpatient decline was also due to a shift of cases to the outpatient setting. The relatively large growth in outpatient spending was the result of a general shift of services to the outpatient setting, but it was also in part due to a policy change which began packaging lab-related payments into outpatient payments. This is how we arrive at a net 4 percent increase in hospital spending.

Access to hospital care is good, and although the hospital industry appears to be changing, we do not see any issues that would affect beneficiaries' access to care. The use of inpatient discharges declined 4 percent per beneficiary in 2014, but the use of outpatient services increased 4 percent per beneficiary. This shift to outpatient is in part explained by hospitals purchasing physician practices and the growth in the use of observation services.

The hospital industry maintains excess inpatient capacity. The aggregate hospital occupancy rate was 61 percent in 2014, down from 2006. Excess inpatient capacity was more pronounced at rural hospitals, where more rapid declines in inpatient volume have led to even lower

occupancy.

Access to capital is good for most hospitals. Interest rates remain relatively low, and this has led to a high level of hospital bond offerings in 2014.

We observed several positive financial indicators across the industry. Uncompensated care costs and the share of self-pay patients declined. All-payer volumes and overall revenues have increased in 2015, so far. In addition, we are seeing private payer prices increase faster than costs.

Similar to prior years, we continue to see hospitals that might lack access to capital engage in mergers with larger facilities or systems. We observed an increase in hospital construction spending in 2014, and more than in prior years, this construction is focused on developing outpatient capacity.

Finally, in fiscal year 2015, we observed a 3.5 percent increase in hospital employment. This is the fastest single-year growth in over a decade, and it was faster than the rest of the health care sector.

And Craig will now take you through our findings on hospital quality.

MR. LISK: The quality of hospital care has been improving as a growing portion of hospital inpatient payments are affected by hospitals performance under three different quality programs: the hospital readmission reduction program, the hospital value based purchasing program, and the hospital-acquired condition reduction program.

We find that readmission rates are declining, mortality rates are improving, and the number of hospital-acquired infections and other hospital-acquired conditions are falling.

Hospital cost growth remains relatively low. In 2014, inpatient cost per case grew by just 2.2 percent, compared with 5.7 percent in the 2001-to-2008 period. This low cost growth occurred despite a sizable increase in case mix of 2 percent, most of which we believe is due to hospitals treating more complex mix of patients rather than coding changes.

If we adjust for this increase in case mix, case mix-adjusted cost growth was only .2 percent in 2014, which was 1.5 percentage points less than underlying input price inflation, of 1.7 percent.

This compares with 2001-to-2008 period when costs were increasing faster than input price inflation and input price inflation was also much higher.

So let's move on and discuss margins. We assess the adequacy of Medicare payments for the hospitals as a whole. Medicare margins reflect the relationship between Medicare payments for all services, including uncompensated care relative to Medicare-allowable costs.

Since 2009, the overall margin has held relatively steady, ranging from -4.9 percent to -5.8 percent. In 2014, it stood at -5.8 percent but differed across hospital groups, as you can see here.

I am going to now introduce to you a new measure that is the product of discussion we had with you to help refine our update framework last year. As you may recall, we had a robust conversation last year about marginal cost and marginal profits, and whether these should be included as one of your data points in the framework.

With marginal profit, we basically ask the question of whether providers have an incentive to take another Medicare patient. If payments are more than marginal cost, a provider has a financial incentive to take

the patient, but if marginal payments do not cover the marginal cost, the provider may have a disincentive to take the patient.

To operationalize this concept, we compare Medicare fee-for-service payment rates to the marginal cost of providing those services, marginal cost exclude expenses for building and fixed equipment.

In 2014, we find that the marginal profit for Medicare services in hospitals was 10 percent, meaning that hospital have an incentive to take additional Medicare patients. You will be seeing this marginal profit measure in most of the other update discussions later today and tomorrow.

While Medicare margins continue to be low, all-payer margins are at a record high, as you can see here with the red line, where they rose to 7.3 percent in 2014. These high all-payer margins are supported by private insurers paying about 50 percent above the cost of care on average and declining uncompensated care costs.

Other total hospital financial indicators stayed strong in 2014, as shown by the operating margins and the EBITA, which is a cash-flow measure

Next, we discuss our projection of the overall Medicare margin for 2016, the current policy year. We project margin for 2016 based on margins in 2014 and policy changes that take place in 2015 and 2016.

We estimate that the overall Medicare margin will decline from -5.8 percent in 2014 to around -9 percent in 2016. Although payment rate updates and case mix growth will increase payments, cost growth is expected to be larger than the payment updates.

We expect the margin to decline primarily due to a $1.8 billion decline in EHR incentive payments and a $3 billion decrease in uncompensated care payments coming from the Medicare trust fund, but keep in mind that these payments are falling because there has been a decrease in the number of people who uninsured. Margins will also decrease by about three-tenths of 1 percent due to increased readmission and hospital-acquired condition penalties. There is a tension that some may see that we should not factor in these penalties when computing margins.

First, the practical effect is that the projected overall margin would still be around to -9 percent, even if

we ignore the effect of these penalties. The numbers on this slide would not change.

Second, we do have an additional analysis that looks at some margins for hospitals that do relatively well on quality metrics. We can ask what would margins look like for hospitals without penalties. Specifically, we examine what margins would look like for hospitals that have good quality scores and good cost metrics. This is our efficient provider analysis, which we turn to next.

So turning to our relatively efficient hospitals, we identify a set of hospitals that perform relatively well on quality of care measures while also doing relatively well on cost measures.

In this year's analysis, we identified about 15 percent of hospitals that we had usable data on as having been relatively efficient for three straight years, from 2011 through 2013.

If we look at the first column of numbers, we see that that historically efficient hospitals in 2014 had 12 percent lower mortality and 5 percent lower 30-day readmission rates, while keeping costs 9 percent lower than the national median. Lower costs allow more than half of

these hospitals to generate positive Medicare margins in 2014, with a median margin of 1 percent.

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

So to summarize our payment adequacy findings, access to care is good. Access to capital remains strong. Quality is improving. Medicare margins are low for the average provider, but payments cover the marginal cost of treating Medicare patients.

Relatively efficient providers were able to break even serving Medicare beneficiaries in 2014; however, as we just discussed, there are payment policy changes in 2015 and 2016 that reduce payments to hospitals. If current law holds, we would expect some negative margins in 2016, even for relatively efficient hospitals.

Margins are expected to be negative, but hospitals will still have a financial incentive to see

Medicare patients due to revenues exceeding marginal cost of providing care.

Now Jeff will continue on with our discussion.

DR. STENSLAND: Over the last year and most recently in November, the Commission discussed how hospitals receive significant discounts on Part B drugs through the 340B program. We had initially estimated that 340B hospitals receive discounts equal to about 23 percent of their Medicare Part B drugs costs.

In November, the Commission discussed having the program and the beneficiary share in these savings. Specifically, we discussed having Medicare payments reduced by about 10 percent of average sale price. This means that about half of the savings would stay with the hospital and about half would go to the program and the beneficiary. However, some Commissioners raised questions regarding whether hospitals needed all these funds to fund uncompensated care.

Since our last meeting, the Office of Inspector General estimated that hospitals actually save 34 percent on Part B drugs in 2013. They had some access to some ceiling price data we did not. Because the OIG had this

additional data, this is a better estimate than our initial lower bound of 23 percent. The 34 percent savings is equivalent to hospitals saving about $1.3 billion on drugs provided to Medicare beneficiaries.

In addition, we examined the uncompensated care costs of the 1,200 PPS hospitals in the 340B program to address this question about uncompensated care. We find that the 340B hospitals on average only provide slightly more uncompensated care than non-340B hospitals. In fact, 40 percent of 340B hospitals provided less than the median level of uncompensated care.

Today the Chairman has proposed revision of the policy option we discussed last month. The new option is to reduce the price of 340B drugs by 10 percent, as we discussed before, but in a shift from last month, the program's $300 million in savings would be redistributed to hospitals based on each eligible hospital's share of uncompensated care costs.

Now, I put the 10 percent in this slide in brackets because that could be a point of discussion for the Commission.

And I would also want to say that this policy

only affects PPS hospitals. Critical access hospitals are paid based on cost, and so this would not affect their 340B drug payments.

Now, a key question is how the uncompensated care pool of dollars should be distributed. In 2016, the uncompensated care pool had $6.4 billion in it and the policy change I just talked about, the 340B policy, would add about $300 million to that pool. However, CMS currently distributes the fund based primarily on Medicaid days, and this has the effect of Medicare paying hospitals $160 for each Medicaid day.

We did some analysis and we found that Medicaid is really a poor predictor of uncompensated care. A better alternative that is available is the Schedule S-10 in the Medicare cost reports, which has hospitals directly report their cost of charity care and bad debts.

We compared this S-10 data to an alternative source of audited charity care data from a sample of 1,400 hospitals that have their charity care for the uninsured audited in order to receive Medicaid DSH payments. What we found is the S-10 data matches the audited uncompensated care charity data better than using a Medicaid proxy that's

currently in use by CMS.

The effect of using the S-10 would be to materially increase payments to some large public hospitals because they provide lots of charity care to the uninsured, and it would increase payments a bit to rural hospitals for reason I'll discuss later. And this leads me to the Chairman's draft recommendation.

The draft recommendation reads, The Congress should address the Secretary of Health and Human Services to update inpatient/outpatient payments rates by the amount specified in current law, reduce payment rates for 340B hospitals Part B drugs by 10 percent of the average sales price, direct the program savings from reducing Part B drug payments into the Medicare uncompensated care pool, and distribute uncompensated care payments using data from the Medicare cost report Schedule S-10. The use of the S-10 uncompensated care data should be phased in over three years.

And the rationale behind the recommendation goes as follows: First, balancing beneficiaries' good access to care, the potential for declining Medicare margins that Craig talked about, and the lack of fiscal pressure applied

by private insurers, and update equal to current law is warranted. Redirecting the 340B savings to hospitals providing uncompensated care is a more direct way to help hospitals that are serving the uninsured.

And finally, phasing in the use of the S-10 over three years will improve targeting of uncompensated care dollars, will create incentives for better S-10 reporting, and will prevent large swings in payments to a hospital in a single year.

Now, this table shows the policy impact on different types of hospitals. And I only show the policy impact here for the 80 percent of hospitals that receive DSH dollars. The proposal would not affect non-DSH hospitals and would not affect critical access hospitals. So let's start looking at that first column. This shows the average change in payment across the categories of hospitals, and the average hospital would lost $32,000, and this is just because as we reduce the price for these Part B drugs, the beneficiary saves a little bit in cost-sharing, and that $32,000 the hospital is losing is just what the beneficiary saves in the reduced cost-sharing.

Next, look at 340B hospitals in the second row.

On average, they receive a slight increase, and the reason this is, is that because the benefit of using the S-10 to distribute dollars actually helps these hospitals more than the cost to them of having their loss of these 340B dollars and having those redistributed into the uncompensated care pool.

Now, you also see that rural hospitals tend to benefit a bit, and this may be because they provide a lot of their uncompensated care in the outpatient setting, like care in their emergency room, and CMS is currently distributed uncompensated care dollars based on Medicaid days, which is an inpatient-only measure. And the S-10 factors both inpatient and outpatient uncompensated care and that will help rural providers a little bit.

Third, government hospitals would see the largest increase in payments, and this is because these hospitals often provide an unusually large amount of care to the uninsured. In particular, there is some large county hospitals and charity hospitals that provide lots of uncompensated care, and the amount of uncompensated care is bigger than we would expect just by looking at their Medicaid days.

In the second column, we see that in every different category, meaning each row in this table, there are some hospitals that gain and some hospitals that face reductions. Payments are increased more than 50 percent of government hospitals and rural hospitals, but they're increased only for 29 percent of the for-profit hospitals.

And the last three columns shows you that using the S-10 dollars to redistribute the uncompensated care pool will result in material declines in payments for at least 10 percent of hospitals in many of these categories. And for this reason, the Chairman recommends phasing in the policy over three years. So the reductions you see in that 10 percent column and the increases you see in the 90 percent column would be phased in over three years.

The package of recommendations has a combination of impacts. First, for the Medicare program, there is no change in spending from current law. Second, for the beneficiary, there's a slight reduction in their cost-sharing on Part B drugs. And finally, for providers, there would be a redistribution of payments basically to those that tend to provide more uncompensated care to the uninsured.

I'll turn it over to your questions and discussion.

DR. CROSSON: Thank you, Jeff, Craig, and Zach, and I think we'll start with clarifying questions. I can't remember where we started the last time. Maybe we'll start with Alice.

DR. COOMBS: So in the paper, you do a great job of talking about the penalties, the combination of all the other factors that are going to influence the outcome. Now, I didn't see where you combined the DSH -- because the DSH is an exception for the readmission penalty. Is that the case? Do you have an exceptions to any of the penalties for the DSH hospitals?

MR. LISK: No, no. The only issue is for the readmission penalty and the hospital value-based purchasing-I mean, the VBP. Those are based off of base payments; whereas, the HAC, the hospital prior condition penalty, 1 percent for those at the bottom quarter, that's off of their total payment. So that's also off of their DSH payment. The DSH payment is partly, you know, the amount of DSH payment gets part of the reduction there in terms of how the HAC program is structured.

DR. COOMBS: So the Table 1 where you have a combination of the various impacts -- I'm sorry. There's a chart that you have in the handout. I think you put it up there as well. It's a combination of the penalty.

MR. LISK: There.

DR. COOMBS: So the DSH proportionate share hospitals are not going to be unfairly disadvantaged, in other words, of layering of the HAC and the removal of the EHR? I was just kind of trying to understand the cumulative effect of all of the pluses and minuses.

MR. LISK: Yeah, and I hope to have something in the paper that will kind of -- that might summarize that for next time. The finalized HAC program -- the HAC program for 2016, the penalty has actually not been finalized, or actually, it's supposed to be released, from looking at something I got yesterday, today in terms of who actually is going to receive the penalty for 2016, because there were some issues with -- they added in surgical, post-surgical infections and there were some problems in the reporting of that, and the data went back to the hospitals.

And so the new information on who's going to get

penalties will be reported, supposedly released today, from my understanding. So we're going to take a look at that.

DR. NERENZ: This is going to sound like a semantic question, it is that, but I think it's got some substance underneath, and this is going to relate to Slides 14, 15, 16, and also a couple pages. The terminology here slips bullet by bullet from charity care to uncompensated care, and then we talk about uncompensated care and then we talk charity care. I think everyone understands they're not interchangeable terms. They don't have the same meaning, and I think generally one is a subset of the other. Charity care is a subset of uncompensated care.

So the question I have is, when we talk about this, and ultimately get to this recommendation about what's the best reflection of a concept, I want to know, when is Medicaid under-payment in and when is it out? So now let's move to the chapter we got, bottom of 26. This is where we talk about what's a better predictor or what's a better indicator.

On the bottom of 26, it says, The thing being predicted is a measure of care for the uninsured, which I take to be synonymous with charity care, but it's not

synonymous with uncompensated care. And then we say, Is it the S-10 number, is it some other number, and we conclude the S-10 number is a better predictor or marker of charity care.

But then when we come to the policy recommendation side, we say we want to use it as the indicator of uncompensated care. But the concept of that, as I understand it, includes Medicaid under-payment with the uncompensated care, does it not?

DR. STENSLAND: When we've talked about uncompensated care in the Medicare context in the past, we have always said uncompensated care in terms of bad debt and charity care.

DR. NERENZ: Okay. Now, is that the universally understood meaning of that term?

DR. MILLER: We may be slipping back and forth n the terminology in the paper and on the slides and we can clean that up. But uncompensated care in the definitions, both the policy and what we're trying to say are charity care and bad debt.

DR. NERENZ: Not Medicaid under-payment. Thank you. Okay. That's clarification

DR. REDBERG: Thanks. It was an excellent chapter. On Slide 7, in the case mix change for 2014, you noted that you thought this really reflected complexity and not coding, and I was wondering on what data you based that.

MR. LISK: We took a look at what happened in terms of mix of changes in surgical cases and medical cases and also, we also had this big shift into the outpatient side, and from looking at past patterns of when we see coding change, this appeared to be due to shifts in the mix of the patients. The less severe patients, the less complex patients going -- we were starting to get a lot of shift into the outpatient observation here, too, so the easier cases with lower case mix scores -- we're also going to add the inpatient into the outpatient setting and stuff.

DR. HOADLEY: I just have a couple of questions and I really do appreciate all the work in this chapter. It's been great. It's great stuff. On Slide 3, you cited $9 billion in uncompensated care payments in 2014, and then when you were talking about the options going forward, you talked about, I think it was, $6.4 billion in 2016. Does that simply reflect the lowering of the number of uninsured

over that period of time?

DR. STENSLAND: Yes. So when the exchanges started up and the Medicaid expansion started up, the number of uninsured went down quite a bit, and so that's why we have this drop from 2014 of $9 billion to 2016 of $6.4 billion. But going forward, we don't expect any really big drops because now it's getting more difficult to reduce the number of uninsured and all the projections are for it to not decline quite so fast anymore. So that $6.4 billion isn't going down to zero. It's going to be more closer to that $6 billion range in the coming year.

DR. HOADLEY: Only to the extent that some states move forward on Medicaid expansion may move it a little bit, but we've had the big change. Yeah, that makes sense. And then you talked in broad terms about the $9 billion in 2014 offsetting the drop in inpatient payments, particularly the DSH payments, in the aggregate. How true is that sort of down at lower levels? Given that it's measured by Medicaid days and we've got Medicaid expansion states and non-expansion states, is that relatively uneven down at the hospital level or at a regional level, or does that kind of wash out or have you looked at that?

DR. STENSLAND: I don't think it would be huge, but we haven't looked at it.

DR. HOADLEY: Okay. It seems like that could be interesting, particularly as we go on to talking about the impact of this. On Slide 15 where you report on the reduction in beneficiary cost-sharing under the policy proposal, I assume that's to directly parallel beneficiary cost-sharing reduction to the 10 percent reduction in the payments. We had talked at the last meeting about at least one of the options being doing more with beneficiary cost-sharing beyond what was done or as a separate option. But here you're just talking about directly parallel to the 10 percent.

DR. STENSLAND: Yes.

DR. HOADLEY: Okay. And I guess the last question I have is on this S-10. So what exactly is -- when hospitals are asked that, what are they directly being asked? Are they asked specifically about uncompensated care? I mean, what sort of definition? Given that we were just talking about what these terms mean, I just was trying to get a sense of what hospitals are told to report.

DR. STENSLAND: And this is a very good point

that Dave made, and we should really expand this in the paper for the next round, is when the Medicaid people talk about uncompensated care, they also add in losses on Medicaid patients. But, in general, we don't want to set up a situation where we tell a state, the bigger your loss on Medicaid, the more the federal government is going to pay you.

DR. HOADLEY: Right.

DR. STENSLAND: That would just be far too tempting to the state treasurer. So, when we talk about uncompensated care, in general, we talked about two things, the charity care and bad debts, and so what the S-10 does is it makes you say, well, what is the charity care you provided for your uninsured and for your insured, because sometimes even if they're insured, they'll offer charity care if they have no money to pay their coinsurance. And they break down those two, and almost all of it is on the uninsured side in terms of what the charity care is. And they say, what is your charges? What is your cost-to-charge ratio? And then what is your estimated cost of that charity care?

Then you also do something similar on the bad

debt side, of you're saying, okay, what was your bad debts, and they try to break down the bad debt expense by multiplying it by cost-to-charge ratio to get some estimate of what the cost of those bad debts are to the hospital. That's a little more complicated. We can get into the details.

The push-back that you'll hear from a lot of people is, well, the S-10 data isn't always accurate, and as I say, there are some winners and some losers. Some people will gain, some people will see reductions, and some people who will see reductions might kind of troll through the data and say, aha, look at this hospital. They didn't fully fill out this field. If you look on line 22, they left it blank. This data is not accurate. And I think one of the important things to say is, right now, this data really isn't being used for payment, and so we don't have all of the hospitals in here, because there were a few that had some squirrelly data. But once you tell hospitals that you get to share in the $6.4 billion if you fill out this form, we think the filling out of the form is going to be better.

DR. CROSSON: You think?

[Laughter.]

DR. HOADLEY: Yes. I mean, it seems like it might at some point be worth an appendix or something, just kind of either literally showing what the line items that -- it would just help us understand, because, I mean, we're clearly getting a lot of questions about sort of what these different terms mean and what exactly would be reported and how it relates. Thank you.

DR. MILLER: And even though there is a time issue, I just want to say a couple things here. So, you kind of asked a lot of these questions, I can't remember if it was in the last meeting or the meeting before. We put a section in the report to try and lay out this DSH uncompensated care, how the picture works thing, but it's a bit hard to keep your eye on the ball. So, we put that in. We were going to try and present it, but we're way up against time, and so we pulled that out. And, so, I'm going to do the junior varsity version.

So, there was something like $11 billion in DSH payments. What PPACA did is come along and say, I'm going to take part of those payments and I'm going to continue to pay them on the basis of DSH, and I'm going to call that $3

billion, and I'm going to take the rest of it and I'm going to pay it for uncompensated care, and the sense was -- and we had big arguments about it -- it was about uncompensated care as we're defining here. And then that would float down as the number of insured went up. That was the configuration in PPACA. So, trust fund dollars become -- go for uncompensated care.

That number was nine -- nine plus three, eleven -- or, right --

[Laughter.]

DR. MILLER: Around nine. Sorry. Around nine. And that has floated down to $6 billion based on the uninsured -- or the number of insured going up, and that's the exchange that Jack and Jeff just had. That should stay relatively constant based on current projections, and that's why you have about six in uncompensated care, three in DSH. That's the nine I was looking for, and that's the current state of play, because there's been a lot of exchanges and you said, would somebody explain what happened. We tried do that in the paper and we just didn't have time to do it and so I just took it to do it.

You know, you do hear a lot in the fields, like,

well, the DSH is gone. The DSH is gone. But three of it is there and six has become uncompensated care, and then what Jeff and the others have explained is that that currently is still being distributed on Medicaid days, which is very much a DSH concept, even though it was constructed -- we think -- to be an uncompensated care concept.

So, I just wanted to do the box for you.

DR. HOADLEY: Yeah, and I appreciated the material in the chapter, as well. I just -- I hear what you're hearing in the field, is you hear, oh, we've had the DSH cuts, then they'll talk about the sequester cuts and all that, and obviously legitimate, but you don't hear, oh, but we're -- and I sometimes ask, well, are you getting payments from the uncompensated care pool, and you kind of get quiet then, so --

DR. MILLER: Right.

DR. HOADLEY: I thought it was useful to get that into the discussion.

DR. MILLER: Exactly.

DR. CROSSON: Cori, Warner.

MR. THOMAS: So, I had a couple of questions on

the -- so, on the efficient hospital, because it seems like that's how we're really trying to determine the effectiveness of payments, so now the overall Medicare margin is one percent for efficient hospitals, or relatively efficient hospitals. Are there relatively efficient hospitals with losses? Is it significant? Is it a few? Do we know?

MR. LISK: Well, it's less than half, because we're getting down to one percent efficient hospital margin, but it varies in terms of what their margins are. But, on average, they are better than other hospitals.

MR. THOMAS: Okay. And, what is the -- going back to the recommendation of the reallocation of 340B, what is the ultimate goal? Is it -- just what's the ultimate goal with that change, that recommendation?

DR. MILLER: I think some of the thinking, when Jay and I were talking about it after the last meeting, because remember the entrance in the last meeting, and this was done in the presentation, was should the beneficiary and should the program benefit from the discount, and you guys had that conversation and there were some mixed views about that.

One of the issues with 340B can be, well, the dollar hits the hospital and exactly what is done with the dollar is not particularly hard-wired. It could go to a lot of different things, and if you talk to hospitals, they'll tell you they're doing a lot of different things with that dollar. So, I think some of the thinking here is that if you take that dollar, instead of taking it as savings -- and remember, the $300 million now doesn't leave the hospital world, it just goes differently -- and put it in an uncompensated care pool, the thought process is, at least you're looking -- that dollar will go to the hospital that shows a greater percentage of uncompensated care.

And while it's not accountability in the sense of that dollar travels to uncompensated care, at least you're allocating it to hospitals on the basis of some indication that they're providing more uncompensated care than their next-door neighbor. I think that's the thought process.

MR. THOMAS: Was it considered that -- so, I mean, getting back to the Medicaid program, I mean, my understanding, to basically qualify for 340B, it's a mix of uncompensated care and/or Medicaid services that are provided and you have to qualify to get into the program,

is that right?

DR. STENSLAND: So, to get into 340B, it all depends on your DSH adjustment, and that's purely depending on your Medicaid days primarily. That's 85 percent of it. And about 15 percent of it is how many of your Medicare patients are on SSI. So, you really don't get any credit for serving the uninsured in terms of getting in the 340B program. The only thing they could say is it is true that the hospitals that serve a lot of these Medicaid patients also tend to have a little bit more uninsured, but uninsured doesn't directly help you with getting in the 340B program.

MR. THOMAS: And is the concern that, essentially, 340B dollars are underwriting the Medicaid program? Is that the concern?

DR. MILLER: I mean, what I would say, and, you know, again, this is based on conversations, at least for the Commission, the conversation on 340B was enjoined by why aren't the taxpayer and the beneficiary getting the benefit of the discount, and Kathy and others -- I'm forgetting specific actors -- were pretty strong on this point. We brought that to you. There was some back and

forth. And, so, in a sense, it's saying rather than take the -- those savings and devote them to the deficit, you devote them to an uncompensated care objective.

DR. CROSSON: Yeah. I mean, my memory of our conversation was that, in general, in the discussion, people were -- felt positively towards making the beneficiary whole for at least a portion of this savings.

MR. THOMAS: Absolutely.

DR. CROSSON: Then the question was, well, okay, but what about the, now what appears to be 30-plus percent drug margin on the hospital side? Should that money -- any portion of that money be returned to the Medicare program, and I think the concern on the Commission was, well, right, but this money was intended for a good purpose, right?

MR. THOMAS: Mm-mm.

DR. CROSSON: So, what we've done here is to say, okay, but let's sharpen the focus of that good purpose by, A, putting that money into the uncompensated care pool and not returning it to Medicare, and in addition, requiring that the whole uncompensated care pool that exists, which is $6 billion, be focused on uncompensated care and not Medicaid.

MR. THOMAS: Okay. And then in the S-10, how is bad debt associated with insured patients handled? Because, I mean, as we see more and more high-deductible health plans, I mean, we just see people that cannot afford $1,000, $3,000, $5,000 out-of-pocket, so that's just uncompensated.

DR. STENSLAND: So, the way it's done is they take whatever the bad debts are, whatever this person owes that isn't collected, and they multiply it by the cost-to-charge ratio to get some estimate of what the bad debt cost is, and then you can add that bad debt to your charity care cost and get your total uncompensated care cost.

And from a practical standpoint, in some cases, you're probably underestimating the cost, because if you take a patient that didn't pay anything --

MR. THOMAS: Right.

DR. STENSLAND: -- and bad debt on that patient, when you multiply it by the cost-to-charge ratio, you're going to come up with something that's probably lower than your actual full cost of treating that patient. On the other side, if you have somebody that's actually insured and that came in, let's say they had an admission to the

hospital and the total cost was $15,000 and their deductible was $2,000 and you got the $13,000 from the insurer and you got zero from the patient, so, that $2,000 that you had in bad debts, you would still get some credit by moving that down into -- by multiplying the cost-to-charge ratio. In that sense, you're probably being overestimated on how much you lost on the patient. On the other one, you're being underestimated.

I mean, this is too -- I'll try to write this up, but --

[Laughter.]

MR. THOMAS: You're now way over my head, so anyway --

DR. STENSLAND: But, in general --

DR. MILLER: Well, let's not lose the concept. The concept is an insured person's bad debt is counted --

DR. STENSLAND: Right.

DR. MILLER: -- given what the tools of the S-10, how --

MR. THOMAS: Yeah.

DR. STENSLAND: So, basically, the general concept is losses on bad debt is treated equally as losses

on charity care.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: Okay. We're going to have to pick up the pace on this portion of the discussion. Moving around the table, Mary.

DR. NAYLOR: So, I'll go fast. I want to build a little on Jack's question about the beneficiary and the reduction in beneficiary cost sharing that would be the direct result of the ten percent. Were other opportunities in terms of redirecting, reallocating, in addition to this to the beneficiary, some of the savings to the program, considered? I thought they were, but if -- and if so, what's the rationale for not selecting that?

DR. MILLER: I actually didn't follow your question --

DR. NAYLOR: So, as I understand, the ten percent reduction in Medicare payment for the hospitals will result in a $70 million cost sharing reduction for the Medicare beneficiaries. And now, the reallocation of the savings is going to the uncompensated programs. My question was, were any other options considered to further reduce the beneficiaries' cost sharing by reallocating some of these

savings? I thought we had discussed them, but maybe --

DR. CROSSON: Mary, do you mean more than the ten percent --

DR. NAYLOR: That's right. Exactly.

DR. CROSSON: -- take more than ten percent --

DR. NAYLOR: Right, and so --

DR. CROSSON: -- for the beneficiaries? Okay.

DR. NAYLOR: -- here, you're talking about the program savings being allocated to uncompensated care. The beneficiary just isn't paying as a result of having a further ten percent reduction for that cost sharing. So, I just wondered what --

DR. CROSSON: Right. Right. My sense of this was that, you know -- because that money is lost to the hospitals, right. So, what we've come up -- I mean, you can argue this, but what we've come up with is a balance here which creates the figures you saw in terms of how much the hospitals lose overall. To the extent that we increase the percentage of that take-back and provide it to the beneficiaries beyond the ten percent, then we're increasing the -- we're reducing the overall payments to the hospitals.

DR. NAYLOR: I understand that. But, my -- in earlier work, we had talked about ten percent was a choice we made in terms of where to start in reducing payments for 340B drugs. But we also had talked about the tremendous cost sharing burden on beneficiaries beyond the ten percent.

DR. CROSSON: Right. So, anyway, that's how we arrived at it, but that's certainly -- I mean, you can certainly argue for a change in the recommendation.

MR. GRADISON: I just want to say I think this practice is a very artful balance, balancing of a lot of divergent interests.

DR. HALL: I agree with what Bill just said.

I have just one question: Who actually decides on the reallocation, and what legislative level does that take place? It wouldn't pay to reduce the national debt or build bridges or something.

DR. STENSLAND: It would be a legislative recommendation.

DR. HALL: Okay.

DR. CROSSON: Sue.

I'm sorry. Kathy, did you have a point on this?

MS. BUTO: I'll wait for my turn.

DR. CROSSON: Okay. Scott.

MR. ARMSTRONG: Just a brief question. Somewhere we in our annual cycle, at least in the last few years, we've taken a deep dive into potentially preventable emergency room admissions and hospital admissions, and for some reasons, I was expecting it to be in this chapter. And I'm just curious. Is it really somewhere else, or did we choose not to bring that forward in this chapter?

MR. LISK: We are actually doing some analysis on that that is not ready at this time. So we are looking at that area.

MR. ARMSTRONG: Yeah. Because it's great to see how some of the policy levers we've pulled have shown real changes in readmission rates and some of the other things. It just seems a frontier going forward is going to be keeping those avoidable patients from getting into the hospitals to begin with.

DR. CROSSON: Thank you.

Herb.

MR. KUHN: Yeah. Just a couple quick questions. One is the Health Resources and Services Administration,

which actually oversees the 340B program, since it is a public health service program, I understand they're moving some new regulations on management of that program. Have we looked at how those new regulations might impact the recommendation we're making here today or this proposal that we're making here today?

MR. WINTER: So, yeah, they've released what they call "draft guidance." The lingo is the "Mega Guidance" in the industry because it covers a lot of issues, including things like patient eligibility for the program, contract pharmacy arrangements, that sort of thing. It does not address provider eligibility for the program. It doesn't -- they are constrained by statute in terms of how hospitals become eligible through the DSH percentage adjustment on -- they can't change that. So I don't see a direct connection between their proposed guidance and the draft -- the Chairman's draft recommendation, which as Jeff said would require a statutory change.

MR. KUHN: Great. Thank you.

And maybe don't want to -- need to answer this one, but just an observation. So, on the current uncompensated care pool of the 75 percent of the old DSH

dollars that are being redistributed that is using SSI and Medicaid days, there is a school of thought out there that it was a conscious decision to do that to try to bring pressure on the 20 states that have not expanded Medicaid, and therefore, if you are the 30 states that have, you get more of this money coming your way to put pressure on -- financial pressure on those other states to come a long way, so just a comment on that. At least that's what some of the trade press will lead you to believe.

The final thing is the projection for 2016 of the negative 9 percent for hospitals. So page 30 in the materials that we received ahead has a graph that shows us from 2001 to 2014 that shows in 2001, it was a 5.4 percent positive. Now we're negative 5.8, soon to drop to maybe negative .9. In the history of the PPS system, in the 30 years of the PPS system, have we ever seen a negative 9 percent or anything of this order of magnitude?

MR. LISK: No. The lowest was in 2008 when we had -7.3, when the recession hit and a bunch of things happened, and we also were at the end of a very high cost-growth period, so that's when we had -- that's the lowest we saw.

DR. CROSSON: Kathy?

MS. BUTO: So I was wondering whether in the next round, you could look at what would happen if we increased the 10 percent to between 20 and 30 percent. In other words, take the whole amount, which would sort of address Mary's point. It would reduce the beneficiary cost sharing, but then also redirect all of that money to the uncompensated care fund and redistribute it, because as I look at this, some of the big beneficiaries are the 340B hospitals. So, you know, again, what does that look like? Do they end up being net gainers or what? Because one of the original concerns we had when we looked at reduction in Medicare payments to 340B hospitals for -- or entities was that it would -- that that money was intended to subsidize their operations, the operations of safety net providers.

So if they're going to get even more money from a redistribution, why wouldn't we lower the beneficiary cost sharing even more? is my question, but maybe there is a really big dislocation that happens elsewhere that we don't want to see happen.

DR. CROSSON: So, Kathy, just to be clear on what you're saying, what I heard Mary saying, I think, was, if

I'm right, a 10 percent reduction that would be returned to the uncompensated care pool, but a higher 20 to 30 percent reduction for the beneficiary. Is that right?

MS. BUTO: Yes.

DR. CROSSON: That would be returned to the beneficiary.

MS. BUTO: Right.

DR. CROSSON: Were you saying the same thing --

MS. BUTO: No.

DR. CROSSON: -- or a 20 to 30 percent reduction overall?

MS. BUTO: Right.

DR. CROSSON: Okay.

MS. BUTO: I just want to see what the impacts are. The chart on page 19 of the slides, Slide 19, with that higher percentage, you could take 20 or 30. Thirty is, I guess, the IG number. Maybe that's too drastic, but something more than 10 that would both lower beneficiary cost sharing more and would also return more money to the uncompensated care fund to be distributed according to the S-10.

DR. CROSSON: Okay. So I think that is noble.

DR. MILLER: Yeah, it is.

DR. STENSLAND: It is noble, but I don't want you to think that just because the 340B hospitals are gaining here that they would gain even more if we took 20 or 30 because they're gaining because of the redistribution of the 6.4 billion, and then they lose a little because we're redistributing the 300 million away from them and to more people.

So right now, the gain on the 6.4 billion is outweighing the redistribution of the 300 million, but if that became a $600 million redistribution or a $900 million distribution, it could flip the sign in terms of whether they're gaining or losing.

MS. BUTO: And that's exactly what -- if we could do that, it would be good to see that.

DR. CROSSON: Okay. Thank you.

Okay. So here's what I think here. I'm going to do something slightly different than what I said I was going to do.

[Laughter.]

DR. MILLER: Do you need to get to Jon?

DR. CROSSON: Oh, I'm sorry. Did you have your

hand up?

DR. CHRISTIANSON: No.

DR. CROSSON: Yeah. Because where did we start? We started with -- okay, I'm sorry.

There have been enough suggestions here, I think -- and good ones -- to suggest that we're going to at least look at some alterations to these set of recommendations on Slide 17.

Could I have Slide 17?

So let me go over for a minute the rationale here. So what we're saying here is that we are concerned about the fact that the margins are falling, and therefore, we are -- in this particular case, for hospitals, we're making a recommendation for a positive update, and we're making that recommendation based on current law.

And I think we've had a good discussion here, but we are doing what I said a few minutes ago with respect to the rationale for the 340B program.

Having said that, there's a number of suggestions here, I think, for more information and for more -- particularly on the 340B side, looking at a wider range of options.

So, if I poll now, one by one, and I say do you support the recommendation or not support the recommendation, I think we'll find a lot of people saying, "Well, I kind of support it, but don't you remember I said I wanted this other information?" So I don't want to do that, but I do want to get a sense because this is clearly coming back in January. This is not in the category of an expedited kind of recommendation.

But I do want to get a sense in here, and you can either raise your hands all the way up or halfway up. I do want to get a sense that if we resolve the kinds of questions here, roughly to everybody's satisfaction, is this direction that is providing a positive update to hospitals based on current law and moving somewhere in the direction of redirecting an aliquot of 340B -- is that something that you could generally support, pending details and further discussion in January?

So everyone who thinks that that's something that they could support in general, without the details, let me see hands.

[Hands raised.]

DR. CROSSON: So those who kind of feel that they

would be opposed, irrespective of further clarifications?

[Hands raised.]

DR. NERENZ: I just have to -- the word "opposed," I have serious reservations and questions, but I wouldn't use the word "opposed."

DR. CROSSON: Okay. Not at this point.

DR. NERENZ: And part of it is because we just saw details for a proposal about a half hour ago. It's got implications up, down. It raises some real philosophical questions to me about whether issues of Medicaid underpayment should or should not be in the way the money is flowed, and I understand that discussion plays out differently strictly in Medicare than elsewhere, but this just goes beyond a little minor tweak, a little tweak.

DR. CROSSON: Yeah.

DR. NERENZ: I have serious concerns.

DR. CROSSON: And some of those are resolvable, frankly, and some are philosophical and not resolvable, but I understand your position.

Warner?

MR. THOMAS: Yeah, just briefly. I think we're mixing three different issues, and I think that's what I'm

concerned about. So we're looking at the hospital update factor, and then we're mixing the issue of how we look at the 340B program, and then we have the issue of out-of-pocket cost for drugs for beneficiaries. And to me, I mean, they are -- they're not necessarily -- I mean, they obviously interrelate because of the program, but I think they're just three very different issues, and I just think putting them all together is not necessarily the right approach to handle it.

I'm not necessarily opposed to any of them. I mean, I think we should be looking at beneficiary out-of-pocket cost for drugs. I'm just not sure doing it through the 340B program is the right way to do that.

DR. CROSSON: Okay. So just let me be clear on this one point because this is a big of a change. We did discuss -- first of all, we did discuss these two things together briefly at one of our previous meetings, and that was if we're going to move on 340B, then what implication would that have or not have for the hospital update?

The way we left that was, well, let's do the hospital update first and then we'll talk in the spring about the 340B issue.

When Mark and I and John and Jim got together about this, we thought that it would be better for the purposes of clarity and a more comprehensive understanding of the impact of these on various types of -- all of these changes on various types of hospitals to do it all together. So that was a conscious decision to do it that way, and I can certainly understand why you might not like it, but that's why we decided to do it.

MR. THOMAS: And just one more quick comment on that. I think the other thing I'm concerned about with the approach just generally is that it essentially mitigates or lessens the impact of hospitals taking care of Medicaid patients, which I don't necessarily -- I mean, I think when the initial program was put in place, my understanding -- and I'm not an expert in 340B -- is that it was intended to assist in both of those areas, and it seems like we are redirecting significant funds in one area versus another, so that's just an observation.

DR. CROSSON: And it's a good one, and again, it touches on a set of philosophical issues with respect to the uses of Medicare money, and I realize that's a valid issue.

However, not to argue it out incompletely, but we are -- we're not starting this idea. We're dealing with a program already that transfers money in this way.

So I'm sorry. On this point, we've got a bunch of stuff, so yeah.

DR. NERENZ: No, this will be real quick.

DR. CROSSON: And, Herb, I know you want to weigh in as well.

DR. NERENZ: That's important.

I just want to also ask a question about the word "beneficiary" because I know I am hearing that a lot, and that seems to be a concept that's driving a lot of people's thinking in this direction.

A question, though. In the Medicare patients in 340B hospitals, how many are dual eligible? Because in that case, they are not paying the copays. Medicaid is paying the copays. And how many of them had Medigap coverage? Because they're not paying the copays either. And I guess when we feel that we're giving some money back to the beneficiaries, I'd really like to know how often is that an individual beneficiary, and how often is that either the Medicaid program or a Medigap coverage?

DR. CROSSON: We can try to answer that. Again, some of the money is going to go directly to the beneficiary. Some of the money is going to go to the beneficiary's Medigap plan and hopefully over time reduce the cost of the plan to the beneficiary, and then some of it is going to go, as you say, back to the state, which then brings us back to the issue of cross-subsidy.

Okay. So I have Rita, Cori on this point or just a general point, and then Kathy on this point. So, okay, Rita, Cori.

DR. REDBERG: I just wanted to comment that, maybe this is outside of our purview, but it seems like on Slide 14, the problem with 340B is that a lot of the hospitals are not sort of in the intent of the program, right. They're getting this great discount, but not providing high levels of charity care or uncompensated care and not kind of addressing that --

DR. CROSSON: Yeah, I think that's right. I mean, to go back to our initial discussion of this, we entered this because we felt that the use of 340B discounts was accelerating and that there was reason to believe that not all of that usage comported with the purposes of the

340B program, and this recommendation is an effort to try to get it back to where it ought to be.

Cori.

MS. UCCELLO: So, I am on board with this idea of trying to better target this money, but building off of what Dave said, when we're talking about the beneficiaries getting a reduction in their out-of-pocket cost sharing, are we talking about it just going to just those who get their drugs from these particular hospitals, and is that fair? We're causing -- are we causing some inequities, then, between beneficiaries who are getting their care at particular hospitals versus those at others?

DR. MILLER: It is true that the way this executes is that, you know, we're not mailing checks to people. We're talking about a beneficiary walks into a 340B hospital. The ASP price in that hospital would be ten percent, or whatever you ultimately decide on, less, and, therefore, the beneficiary's copayment, whether it's gap or state or personally that they pay, would be lower by that amount. And, so, yes, it's a patient that's walking into that particular hospital or pharmacy that's under contract.

DR. CROSSON: And the belief, I think, that's

been expressed by some Commissioners, is that that's okay because the likelihood of those particular individuals being more vulnerable financially is much greater. Is that right? Okay.

Kathy.

MS. BUTO: I just wanted to clarify something, back to something that Warner was saying about 340B being intended to -- I can't remember the exact words, but to sort of address or recognize or acknowledge the role of Medicaid, and I know it does in sort of the formula for qualifying, but 340B was always intended to be a discounted drug program for safety net hospitals and those rates are actually based on Medicaid rates. So, Medicaid rates are the rates that are being paid for drugs in Medicaid and this allows that price to be extended to more hospitals that are serving more low-income individuals.

So, I don't think it was ever directly intended to help Medicaid, or I'm not sure exactly what your words were, but I just wanted to clarify. It's a drug discount program intended to help safety net hospitals.

DR. CROSSON: Okay. Herb.

MR. KUHN: So, I was one of the ones that did not

raise my hand when you were looking for comments.

DR. CROSSON: Yeah.

MR. KUHN: So, you know, I guess -- and I appreciate all the conversation and I appreciate the creativity going to the S-10, thinking this thing through, how to keep the money in the system and target it better. But I guess for me, the fundamental issue comes back to the fact that this is a Public Health Service program and we're the Medicare and Medicaid Payment -- or Medicare Payment Advisory Commission, and while this does impact Medicare, I'm just worried about kind of mission creep here a little bit. Are we getting into the Public Health Service area where we might not want to go, and that was a conversation we had in the spring. There were some concerns raised at that time.

And, so, that's kind of my fundamental concern there that I've got to sort through in my own head. I'm willing to be open to listen to the continued refinements out there, but that's a fundamental issue that I've got going forward.

DR. CROSSON: Yeah. So, I think you're exactly right, and I think, at least as I remember that

conversation, and we had a serious conversation about not moving into HRSA turf, if you will, but what we felt was that the one portion of this 340B issue was to the extent to which it impacted the Medicare program and its beneficiaries. And, so, that's -- in lining up a solution for that piece, that's how we arrived at this.

So, okay. I think we're going to be -- guess what. We're coming back in January --

[Laughter.]

DR. CROSSON: -- and we will be trying to address the very good concerns, I think, that have been brought up by folks. I have to say, I'm sure that those that are technically feasible will be professionally addressed.

Some of the issues that have been brought up are, I would say, more in the philosophical arena and we're not going to be able to resolve those, and so we're going to have to make a decision in January based on the best information that we can put together at the time, recognizing that not every concern or question can be answered.

Okay. With that, it comes time for the public session. If there are any members of the audience who

would wish to make a comment at this point, please come to the microphone. Let me see how many people we have.

It's hard to tell who's leaving and who is lining up, so let it shake out for a second here, okay?

We have reasonably good representation at the microphone. So we're going to start and hear from you. Let me just make a point that I believe some of you may know. This is not necessarily the only way or even the best way that you can provide information to the Commission and staff. There are avenues both on the MedPAC website as well as direct connection with the MedPAC staff. They make themselves available during the interim between meetings, and so just to let you know that we are going to listen to you, but there are other ways to bring your points forward.

In one second, I am going to turn this light off and ask you -- and first in line -- to begin. I'd ask you to identify yourself and any organization that you belong to or represent here, and we will have two minutes for your comments. When the light comes back on, it means the two minutes is over, and we'd ask you to stop. Thanks.

MS. HIATT KIM: Hi. I'm Joanna Hiatt Kim with the American Hospital Association, and I wanted to mostly

comment on the 340B program. To emphasize, this is a public health program. It's not a Medicare program, and the Congress specifically designed it to help hospitals stretch scarce federal resources to expand an improved access for our nation's most vulnerable patients.

To be clear, Medicare does not subsidize 340B programs or pay them different rates. Rather, it pays 340B hospitals the exact same rates that it pays to all other hospitals through their predetermined rates. Some hospitals, certainly, through one mechanism or another, obtain better prices for their items and services, including drugs, but also including labor and cotton balls. Penalizing a hospital for its ability to obtain better prices on one specific item is contrary to the point of a PPS, and it's patently unfair.

It's also troubling when considering congressional intent. Specifically, this recommendation entails MedPAC calling into question the wisdom of Congress in designing the 340B program because it essentially says that the Commission thinks Congress has targeted the wrong hospitals through that program, and that MedPAC needs to step in and fix the intent of a public health program.

We are very concerned about the Commission going down these slippery slopes, especially based on an estimated 340B drug discount that seems to change wildly from one meeting to another.

In reality, 340B hospitals represent about a third of all hospitals, but provide 62 percent of the uncompensated care, and 340B drugs represent 2 percent of the almost $400 billion annual prescription drug market. In contrast, Part D accounts for about 20 percent or $70 billion.

We're unclear as to exactly the problem that is trying to be solved here, but if it is that Medicare wants access to discounts on drugs, then we urge it to do so and access those directly.

Thank you for your time.

DR. CROSSON: Thank you very much.

MR. DAVIS: Hello. My name is Jeff Davis. I am counsel with 340B Health. We represent hospitals in the 340B program. It's been a great continued conversation about 340B today, and I just want to pick up on this point about the uncompensated care that 340B hospitals provide.

There's been conversation about different

definitions of uncompensated care, but it's absolutely correct that the program was intended by Congress to target hospitals that treat high levels of low-income patients, and that is primarily driven by the low-income Medicaid population. So I think it would be incorrect to not take a look at the unreimbursed cost of treating Medicaid patients if you're looking at whether the correct hospitals are in the 340B program, and in fact, when you do look at uncompensated care, including unreimbursed Medicaid cost, you find that 340B hospitals provide 60 percent of the overall hospital uncompensated care.

So the program is correctly targeting the safety net providers who are deserving of this benefit, and I would just urge the Commissioners to keep this in mind as they're thinking about the concerns they have and how to address them.

Thank you.

DR. CROSSON: Thank you.

MR. SHAPIRO: Hi. I'm Howard Shapiro from the Alliance of Community Health Plans, and I'd like to comment on the recommendation on the double bonus counties.

You may argue that there is no strong policy

rationale on this, but mitigating the impact of the largest benchmark reductions from the ACA on plans and their beneficiaries is not an insubstantial rationale. So I'd underscore that this change would substantially cut funding for benefits for MA enrollees, and in the way it plays out, it would have a severely disproportionate impact on non-profits, smaller, regional plans.

ACHP members who are many of those smaller plans represent about 13 percent of enrollment and would see about 42 percent of the net impact of the two recommendations combined.

And yes, you can do an analysis at the plan level, at the country level, and I have some examples for you. And these are all in low fee-for-service, low benchmark counties, and these are all 4.5 star plans. For example, Capital District Physicians Health Plan would lose $3.3 million in Albany County alone. Geisinger Health Plan, well known to all of you, would lose $2.3 million in Lackawanna County; independent Health in Buffalo, New York, $19 million in Erie County alone. Priority Health, another 4-1/2 star plan in Grand Rapids, Michigan, would lose $10 million in Kent County. And I could provide many, many

other examples.

So I would summarize by -- or I would close by saying that if this change were to become law, it would be one more threat to the viability of not-for-profit, independent health plans, and so we would urge you to reconsider the recommendation when you reconvene in January.

Thanks very much.

DR. CROSSON: Thank you.

Okay. We are adjourned, and we'll reconvene at 1:30.

[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.]

DR. CROSSON: Okay. Welcome back from lunch, everybody, and welcome to the afternoon session, those of you who have come in.

We are going to start. We have four areas to discuss this afternoon -- five, actually, two in the first one, and we're going to take on payment adequacy for physician and other health professionals, and in addition to that, although we will have a separate round, I think, on ambulatory care center services.

So, we've got Kate, Ariel, and Dan this time out of the bullpen. Zach is back in the bullpen.

[Laughter.]

DR. CROSSON: So, take it away.

MS. BLONIARZ: This afternoon, Ariel, Dan, and I are going to present the payment adequacy assessment for two sectors, physician and other health professional services and ambulatory surgical centers, or ASCs. We'd also like to thank Kevin Hayes for his invaluable assistance.

So, we start with physician and other health

professional services. These services are paid under Medicare Part B and occur in all settings. In 2014, Medicare paid $69 billion, or 16 percent of fee-for-service spending, which covered over a billion services provided by nearly 900,000 clinicians.

The Medicare Access and CHIP Reauthorization Act of 2015 repealed the sustainable growth rate formula and established a set of updates in law. In 2017, the update is 0.5 percent. And starting in 2019, there will be an incentive payment available for clinicians who participate in an alternative payment model and a separate payment adjustment for non-APM clinicians.

Our approach to assessing payment adequacy starts with access. We have two main original sources of data, a yearly telephone survey of beneficiaries and privately insured individuals, and focus groups and site visits of beneficiaries and providers. We also look at other surveys of both beneficiaries and providers.

This year, like prior years, beneficiary access to services is similar to privately insured individuals. Most beneficiaries do not have trouble obtaining physician services, but some groups experience more trouble. This

year, our survey reported a higher share of minority Medicare beneficiaries facing trouble accessing routine care than white beneficiaries. This is of concern to us. Our survey is small and the numbers can bounce around, but we are keeping a close eye on that.

From our survey, we generally find similar to or better than access reported for Medicare beneficiaries as compared with the privately insured. Eighty-eight percent of Medicare beneficiaries reported that they were very or somewhat satisfied with their care as compared with 80 percent of individuals between age 50 and 64 with private insurance, and these figures are generally comparable to last year.

When looking for a new physician, beneficiaries overall do not face significant problems. First, most beneficiaries aren't looking for a new doctor during the year. Seven percent seek a new primary care provider and 16 percent look for a new specialist. Among that group looking, beneficiaries seeking a primary care provider face more trouble than those seeking a specialist, and these results are also consistent with prior years as well as other data sources.

Alice, you've asked us to look at wait times, so we've continued to track them. In 2013, a little less than half the beneficiaries reported getting an appointment in three days or less. This share has declined slightly since 2010.

Moving to other indicators of access, the share of providers who participate in Medicare remain high, and over 99 percent of claims were paid based on assignment. The ratio of providers to beneficiaries is similar to prior years. The ratio of primary care physicians remains stable. Specialists fell slightly, and advanced-practice nurses and physician assistants increased. Medicare's payments to physicians and other health professionals averaged 78 percent of private PPO rates, similar to prior years.

With respect to quality, over the past few years, we have been pivoting from process measures to a few key population-based measures, but difficulties with measuring clinician quality at the individual level still remain. In the mailing materials, we discussed two sets of measures, one of low-value care and one of rates of potentially avoidable hospitalizations, which have declined for a few

key conditions since 2010.

I'll turn it to Ariel now to talk about volume changes.

MR. WINTER: Great. So, the next indicator of payment adequacy is volume growth. We measure the change in volume for each billing code as the change in the number of services multiplied by the relative value units for each code from the fee schedule. Volume growth accounts for both changes in the number of services and changes in the intensity or complexity of services. For example, the substitution of a CT scan for an X-ray represents an increase in intensity. Across all fee schedule services, volume per fee-for-service beneficiary grew by 0.4 percent in 2014.

This chart breaks down volume growth by type of service. In 2014, there were small increases for evaluation and management services, major procedures, and other procedures. The other two categories, imaging and tests, experienced small declines.

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

For imaging, cumulative growth was 85 percent, and for tests, it was 86 percent. By comparison, the cumulative volume decreases since 2009 have been relatively small, negative-nine percent for imaging and negative-one percent for tests.

The growth of imaging and tests has led to concerns about the appropriate use of these services in the medical literature. In response to such concerns, more than 70 specialty societies are participating in the Choosing Wisely initiative, which identifies tests and procedures that are often overused.

Another factor affecting volume decreases for imaging and tests is the ongoing shift of services from freestanding offices to hospitals. As the Commission has previously discussed, this change in site of care increases overall program spending and cost sharing. In the context of our volume analysis, volume growth is sensitive to shifts in setting, and this is because practice expense RVUs, which are part of the volume calculation, are often lower when services are provided in a facility setting, such as an outpatient department, than in a freestanding office. Even if the total number of services are the same,

volume will appear to be lower when services are delivered in a setting with lower RVUs.

To illustrate this point, we'll look at the shifts in setting for cardiac imaging. From 2013 to 2014, the number of echocardiograms per beneficiary in hospital outpatient departments rose by seven percent, but the number provided in freestanding offices declined by almost six percent. During the same period, the number of nuclear cardiology studies per beneficiary provided in OPDs increased by 1.1 percent, while the number in freestanding offices declined by 9.6 percent.

This chart shows that volume growth has contributed significantly to an increase in spending for fee schedule services. From 2000 to 2014, payment updates, as shown by the yellow line, have increased cumulatively by ten percent. This is less than the 29 percent cumulative increase in the Medicare Economic Index, which measures changes in input prices and is shown by the white line. However, spending per beneficiary grew at a cumulative rate of 70 percent, the red line.

Volume growth accounts for most of the difference between the payment updates and spending growth. The red

line shows that there was a small increase in spending per beneficiary in 2014, 1.8 percent. Several factors influenced this change: The small increase in volume in 2014, the small increase in the conversion factor, the sequester, and payment updates outside of the fee schedule -- outside of the update process, excuse me.

The Commission has expressed concern that mispricing in the fee schedule contributes to an income disparity between primary care and specialty physicians. This chart is based on physician compensation data from 2014. As in prior years, average compensation was much higher for some specialties than others. The specialty groups with the highest compensation were the non-surgical procedural group and radiology. The average for each group was over $500,000. By contrast, average compensation for primary care was about $250,000. Previous Commission work has shown that such disparities also existed when compensation was analyzed on an hourly basis.

So, to summarize, payment adequacy has not changed. Access indicators are stable, as measured by surveys, focus groups, and provider participation rates in Medicare. There was a small increase in volume. The ratio

of Medicare's payment rates to private PPO rates is stable. And rates of potentially avoidable hospitalizations declined.

So, the Chairman's draft recommendation is, "The Congress should increase payment rates for physicians and other health professional services by the amount specified in current law for calendar year 2017." And just to remind you that the current law calls for a 0.5 percent update.

In terms of implications, there would be no change in spending, and we believe that this would maintain beneficiaries' access to care and providers' willingness and ability to furnish care.

This draft recommendation does not address broader issues in this sector and we are planning future work in the following areas. To address disparities in compensation related to the fee schedule, we will continue to discuss options to replace the primary care incentive payment program with a payment policy that better supports primary care.

And as Jay mentioned at the November meeting, we will begin looking at alternatives to the current structure of the fee schedule.

Finally, we plan to come back to you in January with further work on alternative payment models and the merit-based incentive payment system which will take effect in 2019.

And now, I'll turn things over to Dan.

MR. ZABINSKI: All right. This is ambulatory surgical centers. Important facts about ASCs in 2014 include that Medicare payments to ASCs were more than $3.8 billion. The number of fee-for-service beneficiaries served in ASCs was 3.4 million. And the number of Medicare -- let me start again. The number of fee-for-service beneficiaries served in ASCs was 3.4 million and the number of Medicare-certified ASCs was 5,446. Also, the ASC payment rates will receive an update of 0.3 percent in 2016 and most ASCs have some degree of physician ownership.

It is important to compare ASCs with hospital outpatient departments because OPDs are the setting most similar to ASCs and the ASC payment system is based on the hospital outpatient prospective 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. In addition, ASCs have

lower Medicare payment rates than OPDs, which can result in lower payments for Medicare and less cost sharing for patients.

A concern is that most ASCs have some degree of physician ownership, and this ownership status may give the physicians an incentive to furnish more surgical services.

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 these differences include that ASC patients have better average health status than OPD patients, minorities may be less likely to receive care in ASCs because they are more likely to be dual-eligible, and ASCs may tend to be in higher-income areas.

In our assessment of payment adequacy for ASCs, we used the following measures: Access to care, which we measure by capacity and supply of providers and the volume of services; access to capital and aggregate Medicare payments. We cannot assess quality of care because there is not yet sufficient information. In addition, we're unable to use margins or other cost dependent measures because ASCs do not submit cost data to CMS.

On this table, the value for the measures of payment adequacy in the second column indicate a stable situation in 2014. First, the number of fee-for-service beneficiaries served and the volume of services per fee-for-service beneficiary had small decreases, while the number of Medicare-certified ASCs and Medicare payments per fee-for-service beneficiary both increased.

Factors that may have contributed to the slow-down in volume in 2014 include increasingly higher Medicare payments when a service is provided in an OPD than in an ASC, and more physicians becoming hospital employees, so they may be more inclined to provide surgical services in hospitals instead of ASCs. And then, finally, ASCs appear to be shifting their resources from lower-intensity services, such as colonoscopies, to higher-intensity services, such as implanting neurostimulators.

To evaluate ASCs' access to capital, we examined the growth in the number of ASCs, as capital is needed to establish new facilities. A positive growth of 1.9 percent in the number of ASCs in 2014 indicates that access to capital has been adequate. In addition, there have been two acquisitions by companies that own ASCs where they have

borrowed at least $1 billion.

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

Now, ASCs began submitting data on quality measures in October 2012, and this fall, data on two of those measures became publicly available. Also, CMS plans to make data on five other measures publicly available in April 2016. And we're very appreciative of the effort that CMS has made to collect these data and we believe CMS is moving in the right direction.

However, the data on the two measures that are now available are of limited value in terms of assessing ASCs' quality of care. Moreover, CMS has decided that ASCs will be allowed to suppress the data on the five measures that will become available in April 2016 if the ASCs choose to do so.

Finally, the quality data affect ASCs' payments on the basis of whether they successfully submit the data, but we believe CMS should eventually change to a system that adjusts payments on the basis of performance, and the

Commission has recommended a value-based purchasing program for ASCs.

So, in summary, indicators of payment adequacy suggest a stable situation. There was an increase in the number of ASCs, which indicates that access to capital has been at least adequate. And at the same time, there was a small decrease in the number of fee-for-service beneficiaries and the volume per fee-for-service beneficiaries, but this may be partially explained by a shift to more complex services. Moreover, revenue per fee-for-service beneficiary increased at a fairly strong rate.

We also point out data shortcomings limit our assessment of payment adequacy because there is not yet sufficient data to assess ASCs' quality, and there is no program for submitting cost data, even though the Commission has recommended that ASCs be required to submit those data. These cost data could be used to develop an input price index and assess payment adequacy.

So, for the Commission's consideration today, the Chairman has the following draft recommendation. "The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2017.

The Congress should also require ASCs to submit cost data."

Given our findings of payment adequacy and our stated goals, eliminating the update is warranted, and this is consistent with our general position of recommending updates only when needed. Moreover, we want to provide motivation for submitting cost data.

Spending implications are that ASCs are poised to receive an update in 2017 equal to the projected CPI-U of 1.9 percent minus a multifactor productivity of 0.5 percent, for a net update of 1.4 percent. Therefore, this recommendation would produce small budget savings.

For beneficiaries and providers, we found growth in the number of ASCs, but a decrease in the number of beneficiaries treated in ASCs. At the same time, though, providers do seem willing and able to furnish services under the ASC payment system. Therefore, we anticipate this recommendation having no impact on beneficiaries' access to services or providers' willingness or ability to furnish them.

So, that concludes our presentation, and for today's discussion, we are especially looking for guidance on the Chairman's draft recommendations on the physician

update and the ASC update.

DR. CROSSON: Thank you, Dan, Ariel, Kate.

So, I think what we'll do here is we'll take questions and clarifying comments for both, and then we'll go around and look at support for the recommendations separately.

Bill.

MR. GRADISON: With regard to the first of these two, documents, I want to thank you, first of all, for having a text box on behavioral health. There's a lot of interest around the table in that area, and it's one of the first specific ones I can remember recently on that subject.

On page 4, Table 1, in which you have some very brief and helpful summaries of the new alternative payment mechanisms and the MIPS, you indicate the potential additional half a percent for the APMs.

But with regard to the MIPS, my understanding is that there is a theoretical, if everything went wrong, potential downside of -9 percent, and I think it might be useful in that table to have something that reflects both the potential gain and the potential loss, depending on how

that all works out.

I also would like to mention in connection with this first document that the table on page 39 in the paper you sent us in advance, I'm easily confused. This really confused me because I had a sense that it included different time periods, and maybe that is all clear enough, but as I read it through, it sounded like some of it contained annual basis. Some of it was other periods of time, and I wish you'd take a look at that or maybe clarify it. At first, I thought I was looking at at least the same period, and then I think I wasn't.

Finally, with regard to the second document, with regard to ambulatory surgical centers, on Slide 24, you mentioned that the ASCs are permitted to suppress data. That's also mentioned three times in the document you sent us earlier, pages 2, 7, and 22. I would be very interested in knowing what the rationale, if any, if any was publicly stated, was for giving that permission to suppress the data and, second, whether there was any precedent for doing that in any other part of the Medicare program, where a provider required to provide data could suppress its being made available to the public.

DR. ZABINSKI: I'll answer the second part first. I'm not aware of any other situation whether anybody has been allowed to suppress data in that way.

Is that --

MR. WINTER: That's correct.

DR. ZABINSKI: Okay.

DR. MILLER: Wait a second. I don't know if the precedent works, but since I have Ariel right at the table, what about the open payments data? If somebody disputes it, doesn't CMS not report it?

MR. GRADISON: Well, I mean, that's not a quality program.

DR. MILLER: Well, yeah, it's not quality.

MR. GRADISON: So the way it works, if the --

DR. MILLER: I didn't know how narrowly you were asking your question.

MR. GRADISON: Quality data, and because I think a general approach is that's for the public as well as for regulatory purposes.

DR. REDBERG: I think they still do report it, and they just note that it has been disputed.

DR. MILLER: I think I distracted it.

MR. GRADISON: That's okay.

DR. ZABINSKI: Okay. And then the first part of the question, there may be some sense that in trying to allow ASC's time to get their voting on the submission of these data and that sort of thing.

MR. GRADISON: Is it for just one year?

MR. WINTER: It can express for two years.

DR. ZABINSKI: For two years? Okay.

MR. GRADISON: Well, we might want to say something about that. That's a Round 2 or whatever, but thank you.

DR. CROSSON: Other questions, clarifying? Yes. Herb.

MR. KUHN: So just a question about the low-value care issue, nice write-up in the paper, a lot of good information about the Choosing Wisely campaign.

But what I'm real curious about is I'm hearing more and more, and I'm just wondering if there's any evidence of this, but I'm hearing more and more physicians and other clinicians talk about the challenge of trying to adhere to not engaging so much on the low-value care and how that conflicts with HCAHPS or other patient

satisfaction scores, whether it's an emergency room physician who wants to resist prescribing opioids, but yet the patient could give them a terrible score and that creates problems or imaging services and things like that. Is that just a lot of conversation, or is there some science and some research that's going on in that area in terms of low-value use and whether the patient satisfaction score is creating challenges there?

MR. WINTER: Rita looks like she wants to jump in.

[Laughter.]

MR. WINTER: I'll give you the first crack at this.

DR. REDBERG: I'm happy to say something.

DR. CROSSON: It just so happens. Go ahead.

DR. REDBERG: Well, we did -- JAMA Internal Medicine published a paper a few years ago looking at patient satisfaction scores, and I don't know if there's a lot of science to it. And I will say also that the response rates are incredibly low on all of the patient satisfaction, and as you know, you tend to get mostly people that have gripes and maybe people that are very

happy, but not a representative sample, I would say.

But having said that, the paper we published, they looked at patient satisfaction and found that it did correlate somewhat with getting more tests, and it also correlated with higher mortality. So they weren't -- so the outcomes were actually worse. Perhaps they were getting tests that were leading to complications and not improvements.

But just speaking from my own clinical experience, patient satisfaction I think is a lot more correlated to communication with your patient than really to how many tests you order. So I think people tend to -- in a doctor-patient relationship, I think the doctors have those sort of dominant roles, and if you reassure a patient and don't order a test, they feel pretty good. I think they really appreciate communication, and certainly, there have been other studies that have looked at tests that have been ordered just to reassure patients, and they have little to no value in reassurance. In fact, because of false positives and incidental findings, they often lead to a lot of anxiety and repeat testing. So I wouldn't want to say that patient satisfaction would be a reason to order

more tests.

DR. CROSSON: And I hate to start out like a physician saying "In my personal experience" here --

[Laughter.]

DR. CROSSON: -- because that's often something less than scientific.

But I think having spent a lot of time both as a clinician and an executive in a capitated medical group environment, some of the same dynamic you're discussing is present.

And I think in general, the sense we had is that there can be a negative correlation unless the physician takes the time and has the time to be able to explain to the patient why this particular prescription that they might have seen on television the night before is not the appropriate thing for them for why perhaps there needs to be a detailed discussion about the pros and cons of various approaches to a surgical problem all their life.

So I think maybe Rita is saying the same thing. I think it depends a lot on how the physician handles it, and as a corollary to that, the environment in which the physician is practicing and whether that environment,

whether it's self-imposed or it's part of a large organization, is wise enough to foster that sort of engagement.

MR. WINTER: The only thing I would add is, the Choosing Wisely initiative, the purpose is to encourage conversations between clinicians and patients about whether a particular test or procedure is appropriate in their case, and there are materials for physicians and other clinicians. There are also materials aimed at consumers to help them understand why a particular test or imaging study may not be appropriate for them.

DR. CROSSON: Kathy.

MS. BUTO: Just a question on ASCs. Since Medicare is not the majority payer for, I guess, ASC services, whether you have a sense of what commercial payers are paying for services in ASCs compared to Medicare and, secondly, whether it's the same kinds of services--GI procedures, ophthalmology, et cetera -- or whether it's a different set.

DR. ZABINSKI: Specifically, on the payment rates from private sector relative to Medicare, I'm really not certain. The data indicate that, as a general matter, to

the extent the data exists -- there's not a lot out there, but the operating margins are pretty good for ASCs.

And then the second part -- would you repeat that? Sorry. What's the second part of the question?

MS. BUTO: Just the procedures, are they the same, ophthalmology, GI?

DR. ZABINSKI: Oh, that I'm not -- do you got any idea? I am not certain of that.

MR. WINTER: Yeah. I don't think we have empirical data to answer that, but just looking at the large chains of ASCs, they tend to do things that are not -- that are often aimed at a younger population, like a lot of pediatric kinds of surgeries, and less heavy on the cataract surgery, which is going to be for the older populations. I think because of the age distribution, you're going to see a different procedure mix, and they're also procedures which Medicare will not pay for but are being covered by private payers, procedures that are more intensive or riskier.

DR. CROSSON: Clarifying questions? Over here, Jon and Alice.

DR. CHRISTIANSON: This is not on the slides but

on the paper, on page 20 and 21. You have a series of paragraphs where you present evidence on access to care or indicators of access to care, and then you kind of drop in a paragraph here on physician affiliation with hospitals and health systems. And then you don't relate that back to access. Did you have some implications there that you were going to make about how that would affect access or whether it would affect access or why was it there or if not -- I just was sort of struck by it was like there was a next sentence or two explaining why that would affect access, as it wasn't there.

MS. BLONIARZ: No. The only hook was that in our physician focus groups, a lot of physicians said, "Oh, yeah. I was totally approached by a hospital or a health system," and a lot of them said that they had some kind of arrangement. And so we wanted to report that out. That has been -- more and more physicians in our focus groups are saying that.

DR. CHRISTIANSON: Oh, no question about that, yeah. So the data that you have is 2012. So I guess I would encourage you to keep looking for more recent data because I think a lot of the action there has probably

happened in the last three years, so -- but I'm not sure that's an access indicator or not.

MS. BLONIARZ: No.

DR. CHRISTIANSON: Maybe it's something to track in the future, what happens with access, but not at this point, I think.

MS. BLONIARZ: Yeah, point taken.

DR. CROSSON: Alice.

DR. COOMBS: So I had a question, and it goes back to the whole discussion we had on MACRA and MIPS.

On the chart, on page 39, at the bottom where it's the CMMI, and you list the number of providers. Are those the providers that would qualify for APMs if they had the percentages right?

MS. BLONIARZ: On the bottom of page 39?

DR. COOMBS: Mm-hmm.

MS. BLONIARZ: These are not related to MACRA at all. These are CMMI's current projects that they're running, and the pool of eligible APMs will be drawn from CMMI projects, but, yeah, I wouldn't make a link there.

DR. COOMBS: Okay. The only reason why is because before I thought that it was a teeny group of

providers, and if this -- this is a much larger number than I had anticipated would qualify.

MS. BLONIARZ: This should not be connected to MACRA, MACRA's definition of eligible APMs. So the very large number here is kind of a public awareness campaign, and there's money going out to organizations to kind of facilitate physician practice, redesign, and things like that, but they're not -- it's not a model in the way that you would think of, the eligible APMs are going to --

DR. COOMBS: Just that transforming clinical practices initiative.

MS. BLONIARZ: That's right.

DR. COOMBS: And that 685 number that you have, is that mostly for infrastructure development?

MS. BLONIARZ: So I can put more detail into what that is, but my understanding is there's a list of kind of organizations that are carrying out a bunch of different projects. So let me go back and look at it and find out what it's for.

DR. COOMBS: Okay. And then on Table 6, page 15, you have a nice chart there dealing with the racial breakdown between dual eligibles and Medicare Advantage,

and I was wondering if there was any piece of the survey instrument that focuses solely on the -- and I know you have a line there for dual eligibles, but were you able to tease out anything with the dual eligibles in terms of their satisfaction with access to care?

MS. BLONIARZ: So not from the survey, but from the MCBS in prior years, we've reported on access by type of coverage. Beneficiaries with Medicaid report much poorer satisfaction, much worse access, and Medicare Advantage is actually not that dissimilar. There are a few differences, but the presence of Medicaid actually is associated with worse access to physician services.

DR. CROSSON: Clarifying questions?

[No response.]

DR. CROSSON: Okay. Can we put up Slide 17?

So the draft recommendation here is to increase payment rates for physician and other health profession services by the amount specified in current law, and I believe, Dan, you said that was .5 percent -- or you, Kate -- sorry -- for 2017. The reason is there is very little evidence of an access problem, with the exception of an increase in minority access. And as you noted in the

presentation, this is something that we're going to be keeping an eye on.

And then the only other thing I would note is after the recommendation, we come back to the fact that there are issues related to payment of physicians and other health professionals that are still on the table, and they're going to be on the table this year. And one of those is to try again to see if we can deal with the issue of primary care inequity across specialties, particularly for primary care individuals, and then also MACRA and see what information we can provide to CMS as it begins the process of preparing regulations for APMs and MIPS, and then as a corollary to both of these, whether or not there is sufficient reason, particularly related to primary care, to take a hard look at RBRVS again and question whether or not the goals that were originally set in place when that particular payment system was designed and implemented are in fact being met, particularly with respect to distribution of payment across specialties.

Well, that's the work. The recommendation here is simply to replicate the recommendation we've had in the past and to support the update as it is based in MACRA.

So, Mary.

DR. NAYLOR: So great report. I support this recommendation, and I have a couple of recommendations related to thinking about future work in similar chapters going forward. There is a dramatic change in the primary care workforce with much greater use of other health professionals, advanced practice nurses, nurse practitioners, PAs, and others. And given this change in context, I think it would be really important that we capture this, as we do our updates -- as you do your updates going forward, especially related to access and quality.

So specific recommendations are that the survey that you distribute each year explicitly focus on the primary care clinician and enables the beneficiary to talk about access to physicians, nurse practitioners, physician assistance, that your focus groups include -- go beyond physicians to include the primary care team, the workforce team that is now essentially in delivering primary care to Medicare beneficiaries, and that we really work as a Commission to think about strategies to remove barriers to knowing who is actually performing primary care services.

So one barrier, for example, is where nurse practitioners bill incident-to physicians and were, therefore, not able to capture exactly who is performing these services. There have been recommendations related to modifiers and others, but I think that these are exceedingly important.

We learned in the last week that 21 states now have full scope of practice for NPs, advanced practice nurses, and I think that only means growing opportunity for this workforce to be delivering to Medicare beneficiaries, and your own data suggests on Table 8 that this is a really major growth area in the workforce.

Thank you.

DR. CROSSON: Okay. Alice?

DR. COOMBS: Yes, thank you. Thanks so much for your excellent work in this area.

I just wanted to speak to something that we've actually talked about recently, and that is how to do right by the primary care physicians.

And so, as I look at the workforce, there's some areas where probably there's some critical access that are outside of primary care. How to fix that, I'm not sure,

but one of the areas that I think, that we cannot ignore psychiatry. And we're going forward. I know that Emily has asked many of us questions about what we think is important to mental health and behavioral health, but this whole notion of psychiatry and how we deal with the workforce, we talked about a calculation of the 560 versus the 262, or whatever the number we came up with, but that draws from the psychiatry because they're thrown in with the highly compensated professions as well, and they're not quite the same. And if you were to plot them out, they might be right at internal medicine.

As a matter of fact, in Medscape recently, they actually documented that the search for a psychiatrist is almost equivalent for a search for an internist, so that there's a definite higher demand for psychiatry. And, in many situations, the landscape is such that many psychiatrists are practicing without taking any form of insurance, so that draws the workforce down even farther.

So I think the disparity is there, and how we address that -- Mass Medical Society did a study on workforce and environmental work index, and they actually looked at areas that they thought were critical access

areas. And, interesting enough, one was neurology, and there were several others that were a mask, and one included urology. Neurology and urology, there's only 185 some-odd urologists back in 2011 or so, and so that I asked about wait times.

And thank you so much for doing that, giving us that information, but I think when you just look at primary care wait lists, there's this whole thing that's confounded because you got to get to the primary care doctor for them to say that, "Oh, you need a rheumatologist," and so that you might not unmask in a regular survey what specialists' services are needed because there might be a cognitive gap between what a patient understands "You need to actually see a rheumatologist or something along those lines." So there's a confounding variable.

When you try to compare this whole thing of "I had to wait extra long" and then there's this time frame where you get to the primary care doctor, and the primary care doctor says, "I'm going to triage you, or I'm going to refer you to this," so there's that lag time. And I don't know how well we capture that with a routine survey.

DR. CROSSON: Alice, thank you for making that

point. I mean, it is a very important point, that the issue of disparity among specialties by income is a little bit more nuanced than we talk about it sometimes. Primary care versus everybody else. And I don't want to get into parsing it myself, but there are other ways of looking at it and it has to do with whether or not a physician or other health care provider is supplying services just simply with their hands and mind as opposed to with sophisticated diagnostic or therapeutic tools that can sort of magnify utilization, to put it one way.

And I think that's one reason why, you know, in addition to considering replacing the now-expiring bonus for primary care physicians, as defined, which is more narrow, we need to consider potentially a broader look at the basis for payment. Scott?

MR. ARMSTRONG: Just one brief point. I think that the work is headed in the right direction. I feel like I want us to give more attention to the choosing wisely and the 21 to 30-something percent of work that's being done that really isn't, you know, unnecessary or -- I forget the specific term. I also realize this is one of those places where our view of fee-for-service payment

rates sort of blends in with kind of some broader issues.

But we refer to alternative payment models and there may be -- I've kind of lost track. Other than going all the way to bundling or going all the way to some other big shift in how we pay for these services, what some of the other tools are for trying to improve the quality of the care provided through these fee-for-service practices. My hope would be next month when we act on this, that we could at least spend a minute on what's the inventory of tools that the program is using to try to advance that agenda.

DR. CROSSON: Thank you, Scott. And, in fact, it's another good point because the term alternative payment mechanisms is kind of generic at the moment. In law, it's not generic. It is specific to certain so-called qualifying APMs, which are limited in some ways that Alice described and then other ways. And I think -- I suspect we're going to spend a lot of our time on qualifying APMs in our discussion since that's where CMS needs help. But it would be an incomplete discussion if we didn't add some others as well.

So here's what I think based on the questions

that we've gotten, virtually none of which have anything to do with the recommendation.

DR. MILLER: I was waiting for you to --

DR. CROSSON: But I think I'm seeing broad support for the recommendation, or perhaps the opposite, but I'm going to take this as broad support, and pending objection, we'll move this forward through an expedited voting process in January. Does that sound fine? Good. Okay. So thank you for that.

Let's turn to the second recommendation on Page 26, which is a repeat of previous recommendation from the Commission, Congress eliminate the update for the payment rates for ambulatory surgery centers for calendar year 2017, in this case. Congress should also require ambulatory surgical centers to submit cost data. I would add an editorial comment, that all things being equal, I think it may be difficult for the Commission in the future to recommend positive updates in the absence of cost data.

So we have discussion points on this, or are we in the same position with respect to general agreement with this recommendation? Kathy?

MS. BUTO: I just have a question. Is the

requiring of submitting cost data something that the agency has been reluctant to seek Congressional authority for? I'm just trying to understand what the problem there is. Is it Congress or is it the agency or is it -- well, we know that the ASCs probably don't want to do it.

DR. CROSSON: Oh, yeah.

MS. BUTO: Who's kind of not --

DR. CROSSON: But the answer to your question with respect to CMS I don't know.

DR. ZABINSKI: Well, CMS has, you know, had authority to collect the data and they've been seemingly a little reluctant to do it in the past. So it may take an act of Congress to order it.

MS. BUTO: Yeah, right, assuming Congress would be more aggressive than the agency. But I guess what I'm thinking is, maybe we ought to, as we go to January, think about something like not only are we not going to recommend a positive payment update, maybe we should recommend that some consideration be given to a penalty until, you know, that would accompany, or maybe another way to put it would be, you'll get the full update of whatever we recommend or whatever Congress decides if you submit cost data.

Otherwise, there will be some reduction in your payment update. I mean, there has to be something more than every year we come back and say, they really ought to recommend the collection of data, and then nothing happens, is what I'm thinking. I don't know. Maybe that's not too practical.

DR. MILLER: Just a couple things to think about, and I understand the frustration of, you know, saying the same thing over again and not necessarily seeing action. One thing I would just -- not necessarily about this particular recommendation, but many of the recommendations sit for many years until there is the right moment and the right collision of politics and people start to reach for changes and then they get packaged up.

So sometimes you can end up saying, for years and years, the same thing and nothing happens. And then suddenly it happens, which is not to in any way promise you that this one is going up. I don't want to distract you from that and I know you're sharper than to be distracted by that. But there's a lot of this where we'd say the same thing and nothing happens, and then it happens. That's one thing.

This has kind of a funny history to it because the industry also was really pounding away at CMS and at us and other people in the policy environment saying they wanted their own measures. Right? I can get a nod out of somebody up there? These guys acting like they haven't met me before, which is okay. And so, where this came out of is we actually did -- and by we, I mean those two guys right there did a lot of work where we said, looking at -- was this the market basket or the wage index that we were working on?

MR. WINTER: Yeah, the --

DR. MILLER: Yeah.

MR. WINTER: Looking at whether ASCs had a similar cost structure to hospitals or physician offices using the MEI for physician offices or the hospital market basket for hospitals.

DR. MILLER: And what was frustrating about the debate is they were pounding away at, you know, you're not using the right adjuster for us, and we said, great, give us the data, we'll build one for you, and they said no. So I think there's some history here that kind of brought it along that way.

And so, you're right, there's a lot of stonewalling around, and I also don't know that Congress sees this as its highest priority. Now, this was all leading up to this point. You could take an approach where you said, for any individual provider, they have to ante up their cost data. Otherwise they get -- and there have been discussions, at least internally over the years, not necessarily recently, but imagine what you'd get there.

So you get ten ASCs sending their cost data in, they get an update, which perhaps no harm no foul, but you don't have any information to build an update or their costs or these indexes that they want. So I don't have any hostility to the idea, but you get one-off cost reports, I'm not sure how much you can do with it.

MS. BUTO: I wouldn't go for one-off cost reports. I'd go for -- if anything, if we really thought this was important, and maybe we just don't in terms of our priorities, then build a more robust thing that says maybe you want your own market basket index? That would be coupled with the following, you know. Bare minimum cost report data from all ASCs or there won't be any market basket index specific data.

So it just strikes me that maybe we could think a little bit more about what would move this along, if we think it's important.

DR. CROSSON: You know, I think what you're talking about is an attractive idea. My sense is that it probably requires more thought than we can do between now and January. And perhaps this is an issue we could take up in July. So you went through two or three ways of doing a bonus or split up dates, or something. I can think of a couple of others.

My sense is, rather than try to do that and then have a vote in January, what we should do is put it on our -- even though ASCs is a small portion of Medicare payment, it's still a lot of money. And maybe what we can do between now and the next time we come up to this issue is have gone through some options and then do that.

MS. BUTO: And we might want to go beyond ASCs. In other words, there might be other areas where we think if we come up with a combination package to move something beyond where it is now we might be able to see some progress.

DR. CROSSON: Right.

MS. BUTO: So it doesn't have to just be ASCs.

DR. CROSSON: Okay. Thanks. So now I'm seeing a little stupefaction. It may have something to do with low blood glucose. I can say that quickly.

DR. COOMBS: More likely high.

DR. CROSSON: So what I'm getting the sense here, given the conversation that there's a general consensus with this recommendation given Kathy's suggestion that maybe in the next year we look at it a little bit more deeply on the cost reporting side, and we'll move this forward to expedite and vote in January. Without objection? Good.

Thank you, Kate, Ariel, Dan, appreciate it.

[Pause.]

DR. CROSSON: Kim, welcome.

MS. NEUMAN: Thanks. So, we're going to talk about hospice next. In 2014, more than 1.3 million Medicare beneficiaries used hospice, including nearly 48 percent of beneficiaries who died that year. Medicare paid about $15 billion to over 4,000 hospice providers in 2014.

As you know, 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 meet the life expectancy criteria.

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

Before we go through our hospice payment adequacy analysis, I'll review issues with the hospice payment system that the Commission identified in 2009 and update you on some upcoming payment changes and other initiatives.

Back in 2009, the Commission found that 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 compared to nonprofits across all diagnoses. This pattern suggested that there were new actors entering the hospice field with revenue generation strategies.

So, we looked at the payment system and found

that it was misaligned with hospices' provision of care. Medicare generally pays a flat payment per day, which hospices typically provide more services at the beginning and end of an episode. This makes long hospice stays more profitable than short stays.

So in March 2009, the Commission recommended that the payment system be changed to have a higher per diem rate at the beginning and end of the episode and lower in the middle. In response to the Commission's recommendation, the Congress in PPACA gave CMS the authority to change the hospice payment system as the Secretary determines appropriate.

Starting January 2016, CMS will implement changes to the hospice payment system that are consistent with the spirit of the Commission's recommendation. Instead of a flat per diem payment rate, there will be two payment rates, a higher rate for the first 60 days of the episode and a lower rate for days 61 and beyond. In the last seven days of life, hospices will receive additional payments for registered nurse and social worker visits. These visits will be paid at an hourly rate and will be paid on top of the regular per diem payment.

The new payment rates are set by CMS to be budget neutral in the aggregate, assuming no utilization changes. But the new rates will redistribute revenues across providers. CMS projects increased revenues for provider-based nonprofit and rural hospices and decreased revenues for other hospices. This would shift revenues from providers with higher margins to providers with lower margins.

Commissioners have expressed interest in broader efforts to improve end-of-life care, so I want to highlight two new developments occurring in 2016. First, CMS's Innovation Center will launch a demonstration testing concurrent palliative and curative care for certain hospice-eligible beneficiaries who are not enrolled in hospice. The idea here is that this might lead beneficiaries to receive palliative care earlier in their disease trajectory. More details are in your mailing materials on this and I would be happy to discuss on question.

Second, beginning in 2016, Medicare will cover advance care planning conversations between interested beneficiaries and their physicians or nurse practitioners.

These services will be payable under the fee-for-service.

So, this brings us to our payment adequacy analysis. We will use our standard framework like the other sectors.

First, we have data showing growth in the number of hospice providers. From the green line in the chart, we see that the total number of hospice providers serving Medicare beneficiaries has been increasing for more than a decade. In 2014, the number of providers grew about four percent. Growth in provider supply is accounted for almost entirely by growth in for-profit providers, as you can see in the yellow line.

The next chart shows the growth in hospice use among Medicare decedents. Between 2013 and 2014, the share of Medicare decedents who used hospice increased from 47.3 percent to 47.8 percent. Hospice use has grown most rapidly for beneficiaries age 85 and older. In 2014, 56 percent of decedents in this age group 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.

Here, we have some more data on utilization. The number of hospice users grew about 0.7 percent in 2014 to more than 1,320,000 beneficiaries. This is slower growth than in past years and this, in part, reflects a decrease in the number of beneficiaries admitted to hospice and discharged alive. Average length of stay among decedents held steady at about 88 days in 2014, about the same as the last two years. This follows a period of substantial growth in average length of stay between 2000 and 2012.

Underlying these data is a wide distribution of length of stay. About one-quarter of hospice decedents have stays of five days or less, and about ten percent of decedents have hospice stays exceeding 247 days.

On this next slide, we can see how length of stay varies by observable patient characteristic, like diagnosis and patient location. So, this means providers have had opportunities to focus on more profitable patients if they wish to do so. Consistent with that, we see that for-profit providers have substantially longer lengths of stay than nonprofits in 2014, 107 days versus 67 days, on average. And the higher lengths of stay among for-profits is observed for all diagnoses. When we look at margin

figures later, embedded in those margins will be the effects of length of stay differences on providers' financial performance.

Next is quality. We currently lack publicly reported data on hospice quality. Per PPACA, hospices began reporting quality measures in 2013. Providers that fail to report data face a two percentage point reduction in their update. Since July 2014, hospices have been required to submit quality data for seven process measures, for example, measures related to screening and assessment of pain and assessment and treatment of shortness of breath. In 2015, hospices are also required to participate in a CAHPS Experience of Care Survey. The survey is sent to the informal caregiver, typically a family member, of deceased hospice patients. Publicly reported data from these initiatives is not expected before 2017.

CMS, MedPAC, and others have talked about the idea of using claims data for quality measures. We intend to do future work to explore options for several different kinds of measures. Today, I have data for you on live discharge rates.

In 2014, about 17.2 percent of hospice discharges

were live discharges, down from 18.4 percent in 2013. Some live discharges from hospice are expected because a patient may improve and no longer meet the eligibility criteria, or because a patient may change their mind and decide to return to conventional care.

But if a provider has a live discharge rate that is substantially higher than other hospices, it raises questions about that provider. For example, it might be a signal that the provider is not meeting patients' needs or that the hospice is admitting patients that do not meet the eligibility criteria.

So, here we have some data on hospices that appear to have outlier live discharge rates. Among hospices with at least 50 discharges, about 12 percent had live discharge rates that were more than double the national average. These providers tended to be for-profit, they tended to be more likely to exceed the aggregate cap, and they tended to be relatively new providers. This was also more common in some states than others.

Next is access to capital. Hospice is less capital intensive than some other Medicare sectors. Overall access to capital, though, appears adequate. We

continue to see growth in the number of for-profit providers, which increased seven percent in 2014. Reports from publicly traded companies and private equity analysts also suggest the hospice sector is viewed favorably by the investment community.

We have less information on access to capital for nonprofit freestanding hospices, which may be more limited. Provider-based hospices have access to capital through their parent providers, hospitals and home health agencies, which also appear to have adequate access to capital.

So, this brings us to Medicare margins. Different from other sectors, we have historical margin data through 2013 because 2014 margins are incomplete. So, for 2013, the aggregate Medicare margin for hospices was 8.6 percent, down from ten percent in 2012. The margin decline in 2013 partly reflects the effect of the sequester. The sequester reduced Medicare payments to hospices by 1.3 percent during the 2013 cost report year.

One other thing to note. As you'll recall, we exclude from our margin calculations non-reimbursable costs, which includes bereavement costs and the non-reimbursable portion of volunteer costs. If those costs

were included, it would reduce our margin estimates by at most 1.7 percentage points.

Next, we have margins by category of hospice provider. Freestanding hospices continue to have strong margins, 12 percent in 2013. Provider-based hospices have lower margins than freestanding hospices. This is partly due to the higher indirect costs of hospital-based and home health-based hospices, which is likely due to the allocation of overhead from the parent provider.

The chart also shows margins by type of ownership. For-profit hospices have very strong margins, 14.7 percent. The overall margin for nonprofits is lower, 1.2 percent. But when we look just at freestanding providers, the nonprofit margin is 5.2 percent.

One other point to note here. Like other sectors, we have also calculated the marginal profit, which is the amount that the Medicare payments exceeds the marginal cost of treating an additional patient. For hospice, the marginal profit was about 12 percent in 2013.

The next slide shows what's underlying some of the margin differences across providers that you just saw. On the left, we have confirmation of the relationship

between length of stay and hospice margins. Providers with longer stays have higher margins.

In the right chart, we see how margins increase with the percentage of patients in nursing facilities. There may be a number of advantages to the nursing home setting, including access to patients that have conditions associated with longer stays, economies of scale from treating patients in a centralized location, and overlap in services provided by the hospice and the nursing facility.

So, next, we have a margin projection for 2016. To make this projection, we start with the 2013 margin and we take into account the marketbasket updates, the productivity adjustments, and additional legislated adjustments. In addition, we take into account the effect of the sequester. We also take into account the phase-out of the wage index budget neutrality adjustment and other wage index changes. And, finally, we make assumptions about cost growth. We assume a higher than historical rate of cost growth due to potential additional administrative costs related to new requirements for more detailed claims data reporting, new quality initiatives, and revised cost

reports. Putting all that together, we project a margin in 2016 of 7.7 percent.

To summarize, indicators of access to care are favorable. The supply of providers continues to grow due to entry of for-profit providers. The number of hospice users increased, and average length of stay was stable. Quality data are unavailable, although, as I mentioned, there is interest in exploring claims-based quality measures. Access to capital appears adequate. The 2013 aggregate margin is 8.6 percent. The 2013 marginal profit is 12 percent. And the 2016 projected aggregate margin is 7.7 percent.

So, this brings us to the Chairman's draft recommendation. It reads, "The Congress should eliminate the update to the hospice payment rates for fiscal year 2017."

Given the margin in the industry and our other payment adequacy indicators, we anticipate that providers can cover cost increases in 2017 without any increase in their payment rates, so this draft recommendation would be expected to have no adverse impact on beneficiaries nor providers in terms of their ability or willingness to care

for Medicare beneficiaries.

So, that concludes the presentation.

DR. CROSSON: Thank you, Kim.

We are open for questions, comments. Bill.

MR. GRADISON: Page ten, you have some very useful breakdowns of the participation in the hospice -- the beneficiaries of hospice services. I would suggest that you include two other data points, if you have them available. The first is what percentage of hospice revenues nationwide come from Medicare versus non-Medicare. And the second would be a breakdown of the Medicare beneficiaries between over and under age 65, if those numbers are available.

More substantively, on page 26, there's something that popped out at me, and maybe this is just a semantic problem or I don't understand it, but on page 26, the language in the text says, "CMS's contractor, Apt Associates, has shown that some beneficiaries do not receive skilled visits at the end of life." Now, the footnote says that Apt defines skilled visits as visits by a nurse, therapist, or social worker. Their measures do not include visits by a hospital aide, physician, spiritual

counselor, or volunteer.

On the face of it, that doesn't make any sense to me, that a physician would not be considered to be the provider of skilled care at the end of life. So, something in here, I don't quite understand.

MS. NEUMAN: So, two comments on that. When the skilled visit measure was first done, they used the hospice professionals, so the nurses, the therapists, and the social workers. They have recently done an analysis where they've included hospice physicians, the physicians that are employed by the physician, and so that footnote should be updated.

MR. GRADISON: Thank you.

MS. NEUMAN: Yes.

DR. CROSSON: Good pick-up. Other clarifying questions? Jack, and then Rita.

DR. HOADLEY: So, on Slide 6 on the demonstration, is this at a point where it's just been, like, announced, or are they starting to enroll hospices and beneficiaries into this, or what stage are we at here?

MS. NEUMAN: So, they've chosen the hospices and it begins in January 2016. So, I'm not sure at what exact

point they are in sort of implementing the enrollment, but --

DR. HOADLEY: But beneficiaries would start getting these services the first of the year, basically --

MS. NEUMAN: Yeah.

DR. HOADLEY: -- so whenever thereafter.

MS. NEUMAN: Yeah.

DR. HOADLEY: And, you said -- I think you say it here -- oh, yes, it's a five-year demonstration. Will there be any kind of interim reports or data available, or are we stuck waiting five years to know what happened?

MS. NEUMAN: I'm not sure. Let me see what I can find out for you.

DR. HOADLEY: And my other question relates to the figures on Slide 16, and you talked about the new payment system changes that go into effect and that they will narrow some of these differences. Do you have any sense, or has CMS estimated the potential magnitude of the narrowing that they're anticipating?

MS. NEUMAN: So, in the final rule that CMS released, there was an impact table that shows sort of the shifts in revenues that would occur. Probably the category

where you'd see the most shifting would be between for-profits and nonprofits, and I think the nonprofits went up about one percent and the nonprofit -- the nonprofits' revenues went up about one percent and the for-profits' revenues, in aggregate, of course, went down by a little less than one percent. So, roughly a two percentage point shift.

DR. HOADLEY: So, there will still be pretty big differences, but at a little bit narrower. Thank you.

DR. CROSSON: Rita, and then John.

DR. REDBERG: Very nice chapter, thank you. And it's nice to see that more Medicare beneficiaries are using the hospice benefit.

My question is on -- it was on page 21 in the mailing materials and also on the Slide 11. It's just striking that there are such different lengths of stays for the different facilities, and you comment that even for the same diagnoses, there are different length of stays. And I'm just wondering if we have any other information about, like, do patients decide whether they're going to a home or nursing facility or assisted living, or does it depend on

what's available? Are there any other differences, like in certain diagnoses tend to go to certain places? I'm just wondering why there are such differences. It sounds like you are already thinking about it.

MS. NEUMAN: So, there's a lot of factors at work in terms of where a patient will wind up. It can depend on what kind of informal supports they have at home, where they initially resided before. You know, maybe they had a hospitalization and it's been determined that the prognosis is different and so they're considering hospice, and if they came from the home before, maybe they'll go back, or if they were already in assisted living or nursing home, maybe they go back there. Or if the level of care that's needed is more than the family can handle along with hospice, a patient might go to a nursing facility.

We do know that patients with certain diagnoses tend to be in one setting more than another. So, patients with dementia are more often -- or there's a higher proportion of them in nursing facilities than patients with certain other diagnoses. So, it's kind of a mix.

DR. CROSSON: Jon.

DR. CHRISTIANSON: Kim, this refers to some

language on page 38 in the paper, and you have a paragraph talking about the differences in hospice provided in nursing facilities, and then a sentence that says, Analyses in our June 2013 report suggest a 3 to 5 percent reduction in hospice routine home care payment for patients in nursing facilities may be warranted. Remind me, did that ever become a recommendation that we made?

MS. NEUMAN: No, just analysis.

DR. CHRISTIANSON: So it was just a comment in the analysis and so you're raising that again here, but it's never been in the form of a recommendation that you know? Okay.

DR. MILLER: We never have brought it forward to a recommendation. It's something that we can think about if you'd like to do it. I don't know how much of it bears in this conversation. There's some puts and takes in kind of how you think about that number being arrived at and how you implement the policy, but we could go through those puts and takes and kind of bring it back to you.

DR. CHRISTIANSON: Just curious.

DR. CROSSON: Mary.

DR. MILLER: And actually, I'm sorry to

interrupt. There was no legislative activity around this.

MS. NEUMAN: There's been no legislative action.

DR. MILLER: Okay.

DR. CROSSON: Mary.

DR. NAYLOR: So I'm struck by the 17-day median that has not changed for many years. I'm wondering, just from your perspective, if the two, the demonstration and the payment for advanced care planning, those two choices, do they, from your perspective, the best opportunities we have to setting aside the longer lengths of stay, but you get people into and able to access a benefit for a much longer period of time?

MS. NEUMAN: So I think it's hard to predict how it will play out. I think that they present an opportunity for that medium length of stay to potentially shift out a bit and people to perhaps consider hospice earlier. We'll have to see what happens. There's a lot of factors that go into why people elect hospice and at the time that they do. Some of the patients, it's a very sudden change in their condition. There's other patients who may not have the information and so these kinds of steps might help with that group of patients. So I think we just have to wait

and see.

DR. CROSSON: Other clarifying questions? Okay. Seeing none, let's put up Slide 20, draft recommendation is to eliminate the update to the hospice payment rates for fiscal year 2017. The sense here is that existing margins are adequate, and as was mentioned in the presentation, we have new legislation and new regulations related to hospice payment that were part of, or close to, our recommendation previously to kind of deal with that U-shaped payment curve that we've discussed previously.

They are going to be implemented next year. Our thought is to hold to our previous recommendation pending an observation of how the payment changes that are underway go forward and not change two things at once. So that's how we came up with this. I didn't hear a lot of objection in the question period or comment period, so I'm going to assume once again here -- don't worry, we'll get to some more controversy if you're getting bored. I'm going to assume that we have a consensus here to move this forward to expedited vote in January. Okay? Sounds good? Yes, Cori.

MS. UCCELLO: I'm not gone yet. I support this

direction. I just wanted to piggy-back off of Jon. He talked about kind of efficiencies between the nursing home and hospice. If and when we do move forward on that, I would like to see not just thinking about the efficiencies on the hospice side, but the efficiencies on the nursing home side. Some of this is going to be outside of Medicare, to the extent that it's nursing home and not SNF, but I think the efficiencies kind of go on both sides.

DR. MILLER: Right, and just to be clear, what I was saying, maybe it was clear to everyone else and Jay reminded me, in case it's not clear to the public, when I say we can come back with Jon's thoughts and your thoughts on this, overlap between hospice and nursing and assisted living and all of that, I wasn't saying we'd be back in January with it.

MS. UCCELLO: I wasn't even expecting it to be during my tenure.

DR. MILLER: Well, given Cori asking, I assume she expected it this weekend, and so I just felt to clarify it. So anyway, we can come back and give a more developed discussion of what's going on there. And Kim actually has thought through those efficiencies that you've -- and how

this plays out, so I know this can be done. But rolling back in in January with a whole new idea, I think, is too much.

DR. CROSSON: David.

DR. NERENZ: I do support the recommendation, but just for longer term, if there's any way that we could get a deeper dive exploration of some of these different types of hospices and why we do see these markedly different margins in the two places, because it clearly hinges on length of stay, it hinges on case mix, and as we looked at the hospital, I know that the assertion is that it's an overhead allocation issue.

But I just wondered if somehow hidden in here is essentially either a clinical case mix issue, a mission issue, something, and again, it doesn't fall in the window between now and January, but sometime later on down the line. I'm still curious about that. I think there's something else going on here still that we're not quite seeing.

DR. MILLER: Let's maybe do a few sentences of history --

DR. CROSSON: Yeah, yeah, we have time.

DR. MILLER: -- here because I believe all this happened before he got here when we did the real basic work that you and Jim did. And again, I'm getting this look like you and I have never met each other again. I don't think I'm going to say anything that surprises you, Kim, but keep a close eye on things.

So way back in 2006-2007, and this goes to your conversation, too, we started talking about that U-shaped curve in 2007, and here it is finally showing up. We actually started to get approached by people from the hospice industry saying, there's a lot of things happening in the marketplace, things are changing, the complexion of this benefit is changing significantly and you guys should, you know, pay attention.

And as a Commission, we hadn't spent time on hospice in a long time. The dollars were going up rapidly and the composition of the industry was changing from not-for-profit to for-profit. There were many years of very aggressive growth and it was strictly or virtually all for-profit.

An argument that some of the people who had been in the field for years were saying is, there's a new

provider showing up. They figured out that on this daily rate, it's very profitable and it's very profitable to get the person in early. Okay? And so, when we originally did this analysis, you'd find variation by lengths of stay. If you take more dementia people, you have longer lengths of stay. But even given that, if you're for-profit, you have longer lengths of stay on any of them.

And so, we don't think it's so much a case mix issue as much as you're paying a daily rate and there's a business model approach to things. And that led to a lot of examination and recommendations. And on the nursing home angle, which you'll hear the more advanced version when we come back and do this, is you could go into a nursing home and sort of hit a number of patients at one shot and say, would you like a hospice benefit? And, of course, that allows the nursing home to step back on the Medicaid side of things. And so, you see some length of stay issues there.

So my own take, and Kim looks very pained with this rendition, I feel like it's generally consistent with what we've been saying, Kim, is that there was sort of this new approach and this business model orientation less than,

you know, there's certain diagnoses that we're paying correctly for or incorrectly for, that type of thing. And that led to this U-shaped curve, to try and take the incentive out of like just keep them in there as long as you possibly can. There was a ton of this work around 2007-2008, 2009, somewhere in there.

MS. NEUMAN: And just to add onto your point you made about diagnosis, we were looking at resource use by length of stay and diagnosis, and what we found is that when we put similarly -- patients with similar lengths of stay together, they had similar visit resource use regardless of their diagnosis. And so, you could put all the diagnoses next to each other and then you see this length of stay had this visit intensity, this length of stay had this. It was remarkable.

DR. NERENZ: And it does seem that within a more recent time period, we've had some discussion, perhaps recommendation about stepped per diem rates depending on length of stay. So that makes sense. The only thing that I still am curious about is if that dynamic linking length of stay to profitability is clear and so easy for profit-free standings to implement, why aren't the hospitals doing

it as well? Maybe there's a simple answer to that, but that's-

DR. MILLER: Well, I think it's just -- well, Kim may be better equipped. I don't know that they aren't. I think if they're not-for-profit, there seems to be some less gravitating to this model, so that might be part of it. And then we think the cost structure in the hospital is very different. Is that what you were going to say? Because I couldn't tell.

DR. NERENZ: Right, but the length of stay parameters are also different, which I think then goes directly to what we were just saying about the profitability. So it's not in this month or next month time period, but I just think there are two or three elements to this story yet that I'm curious about.

DR. CROSSON: Okay. Thank you, Kim.

[Pause.]

DR. CROSSON: Okay. Wait a minute. Where are we?

DR. CARTER: Are we ready?

DR. CROSSON: No. I can't find mine.

DR. CARTER: No? Okay.

DR. MILLER: What do you want, the schedule or the --

DR. CROSSON: No. I'm looking for the SNF handout here. Give me one second. I've got it here somewhere. I'll find it.

I'm sorry. We're going to talk about SNFs. Carol?

DR. CARTER: Great. Before I get started, I wanted to thank Anna Harty for her help with this chapter.

Today I'll be presenting an overview of the SNF industry and then present some information related to the update and end with a summary of the Medicaid trends that we are required to report.

To start with a sketch of the industry, there are just under 15,000 providers that participate in the Medicare program. About 1.7 million, or about 4.5 percent of beneficiaries, use SNF services. Program spending was just under $29 billion in 2014, and Medicare makes up 12 percent of days but 21 percent of revenues.

I will be using our update framework, which we're all now very familiar with. I'll go through the material

quickly, but there's more detail in the chapter.

Access to SNF services is adequate and stable. Supply was steady between 2013 and 2014. About 90 percent of beneficiaries live in counties with at least three SNFs, and the majority live in counties with 10 or more. Occupancy rates were unchanged in 2014 but remained relatively high at 86 percent. However, about one-quarter of facilities have occupancy rates below 76 percent.

Between 2013 and 2014, covered admissions and days declined, consistent with the decline in inpatient hospital stays, which is a prerequisite for SNF coverage by Medicare. However, the decline in SNF volume was smaller because, as the complexity of cases in hospitals increased, a larger share of hospital stays were discharged to SNFs.

The mix of days reflects the biases of the PPS design. Since the SNF PPS was implemented, there has been a steady increase in the share of days classified into the intensive rehab therapy case-mix groups. In 2014, 81 percent of the days were assigned to these groups.

Even though the number case-mix groups for medically complex patients was expanded, their share of days remains low.

The high growth in the amount of therapy furnished is not related to patient characteristics. Rather, the growth reflects three design features of the payment system. First, the amount of therapy drives payments. Second, that as more therapy is furnished, providers' costs increase, but payments increase even more. Furnishing more therapy is more profitable than furnishing less therapy. And last, payments for non-therapy ancillary services, such as drugs, do not track these services' costs, and as a result, the payments for these services are poorly targeted.

Turning to quality measures, the performance was mixed. We tracked three groups of risk-adjusted measures: discharge to the community, potentially avoidable readmissions both during and after the stay, and changes in function.

The average facility rates of discharge back to the community and potentially avoidable readmissions during the SNF stay show small improvements between 2013 and 2014, although the community discharge rate was -- the increase was not statistically significant -- no, I got that wrong. The one that during the SNF stay was not statistically

significant.

So we have improvements in two measures, but the increase in readmissions after the stay show a worsening of that quality measure, and the two function measures show no change and were essentially unchanged between the two years.

In terms of access to capital, industry analysts report that capital is generally available and expected to continue during 2016. Some lenders are reluctant to lend to nursing homes, but this reflects uncertainties about the federal budget, lower volume in the sector, and future Medicare policies, not the level of Medicare payments. Medicare continues to be a payer of choice.

In 2014, the average margin for freestanding facilities was 12.5 percent. This was the 15th year in a row that the average was above 10 percent, and these margins reflect the impact of the sequester.

Across facilities, margins vary eight-fold. One-quarter of SNFs had margins of 2.4 percent or lower, and one quarter had margins of at least 21.2 percent. There continued to be large differences between non-profit and for-profit facilities in part due to the mix of their

patients and therapy practices, but also because on average they are smaller, they have higher costs per day, and recently have had higher cost growth compared with for-profit facilities. The marginal profit in this sector was 20 percent, indicating that facilities with free beds would have an incentive to admit Medicare patients.

We also compared margins in the top and bottom quartiles of the distribution of Medicare margins. Compared to lower-margin SNFs, high-margin SNFs had considerably lower cost per day after adjusting for differences in case-mix and wages in part because they have higher average daily census and they have longer stays over which that yield more economies of scale. They have lower routine and ancillary costs per day.

And on the revenue side, high-margin SNFs have higher revenues per day in part because they provide more intensive therapy and have fewer medically complex days.

In assessing the level of payments, we also look at the rates that some MA and managed care plans pay for SNF care. In the four publicly traded firms, fee-for-service rates average 23 percent higher than MA/managed care rates, yet our analysis of patient assessment data

indicate that the characteristics of the users enrolled in MA and fee-for-service are not that different and would not explain the differences in payments. The publicly traded firms also report seeking managed care business, suggesting that the rates are attractive.

Each year we look at efficient providers, using three years of performance to identify SNFs with relatively low cost and high quality. In 2014, there were almost 900 SNFs, and that was 8 percent of the SNFs included in the analysis that were relatively efficient.

Compared to other SNFs, they had standardized costs that were 8 percent lower, community discharge rates that were 27 percent higher, and readmission rates that were 16 percent lower. They were also larger, allowing them to achieve greater economies of scale. The combination of their low cost and high revenues per day results in an average Medicare margin for this group of 20 percent.

To estimate the average 2016 margin, we assumed that costs would grow at the market basket between 2014 and 2016.

To estimate payments, we updated the payments by the market

basket updates, net of productivity and the sequester. For 2015, we also reduced payments to account for the last year of changes to the bad debt policies, and in 2016, there is a forecast error correction. The estimated average Medicare margin in 2016 is 10.7 percent, and this also includes the impact of the sequester.

In considering how Medicare payments should change for 2017, the broad circumstances of the this industry have not changed. The PPS continues to favor therapy over medically complex care. The level of Medicare's payments remains too high. The wide variation of Medicare margins reflects differences in patient selection, the mix and amount of services furnished, and cost control. The Commission has recommended that the SNF PPS be revised and the level of payments be rebased, and we'd like to review the evidence for each of those.

The Commission first recommended revising the PPS in 2008, and since then, we have continued to evaluate the accuracy of this payment system. Our work with the researchers at the Urban Institute has found that over time, payments for therapy and non-therapy services has gotten worse, despite the many changes made to the payment

system.

The overpayments for therapy services are larger, and there is increased evidence that unnecessary therapy services are furnished and payments for NTA services are poorly targeted.

Although there are not widespread access problems, we continue to hear that certain types of patients can be difficult to place at discharge from the hospital. The large difference in Medicare margins partly reflects the systematic biases of the PPS that at this point are well known and need to be corrected.

Without increasing total spending, the design we proposed would shift payments within the industry. We estimated that payments would decrease for SNFs that furnish 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 therapy practices, payments would shift from freestanding SNFs to hospital-based facilities and from for-profit to non-profit SNFs -- and you can see the numbers on the slide -- basically from the highest margin providers to lower margin providers. Payments would also increase for rural

facilities.

Now let's consider why to rebase the payments. The average Medicare margin has been above 10 percent since 2000. In 2014, the Medicare margin was 12.5 percent, and the marginal profit was 20 percent. We project the Medicare margin in 2016 to remain above 10 percent.

Our analysis of efficient providers shows that it is possible to furnish relatively low-cost, high-quality care and remain highly profitable. And, finally, fee-for-service payments are considerably higher than some MA/managed payment rates.

The evidence for the need to revise and to rebase the PPS is compelling, yet there has been little movement from CMS and the Congress on reforming the payment system. Last year, the Commission expressed growing impatience with the lack of progress. The structure of our recommendation may contribute to the delay because we call for the PPS to be first revised and then for rebasing to occur.

We did this to protect low-margin, typically non-profit SNFs. The large disparities in margins -- that's kind of in the neighborhood of 10-percentage-point spread between for-profit and not-for-profit facilities -- made us

reluctant to take large reductions in payments without first revising the PPS to redirect payments to the low-margin SNFs. An alternative strategy would be to set much smaller rebasing steps in motion while the PPS is revised.

This leads us to the Chairman's draft recommendation, and it reads: The Congress should eliminate the market basket for 2017 and 2018 and direct the Secretary to revise the prospective payment system for skilled nursing facilities. In 2019, the Secretary should report to the Congress on the impacts of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with cost.

The propose rebasing would be done in two small steps, with no update in 2017 and 2018, and a final adjustment, perhaps, in 2019 after the Secretary has evaluated the need for further adjustments.

In terms of implications relative to current law, program spending would decrease. For beneficiaries, access for medically complex patients will increase, and for providers, the recommendation will reduce the disparities in Medicare margins across providers. The impact on individual providers will vary based on their mix of cases

and their current practice patterns.

Finally, as required by PPACA, we examine Medicaid trends in spending and financial performance for nursing homes. About 15,000 facilities participated in Medicaid, and that was a small decrease from 2014. Medicaid spending is estimated to be $52 billion in 2014, and that's a small increase -- I mean, that was from '15 -- and that's a small increase form '14, and spending is projected again to increase in 2016.

The non-Medicare margin for 2014 was a negative 1.5 percent, and that was a slight improvement from last year. And the total margin remained at 1.9 percent.

And with that, I look forward to your discussion.

DR. CHRISTIANSON: So we'll start with questions, clarifications. Bill?

MR. GRADISON: On page 20, we're told that hospitals are increasingly establishing preferred provider networks with higher quality SNFs, hoping to lower their own readmission rates --

DR. CARTER: Yes.

MR. GRADISON: -- in exchange and so forth. I thought they weren't permitted to steer. What's going on

there?

DR. CARTER: I think they're explicitly not, but I think that -- what we've heard is there is some soft steering that goes on; that is, hospitals have to provide a list of post-acute care providers to a patient, but they can recommend providers to a patient, either because of their experience with a patient or kind of the practice patterns that they know that they're comfortable with.

So I think -- I mean, I use the term "soft steering," but I think that that does go on.

MR. GRADISON: Thank you.

DR. CARTER: Mm-hmm.

MR. KUHN: So, Carol, a quick question on your identification of the efficient skilled nursing facilities. Are they pretty much random across the country, or are they clustered in any particular areas? And I guess my point is -- I'm curious -- areas that are more mature in terms of care coordination, per diem payments, or at-risk payments. Are they more efficient and clustered in certain areas, or is that pretty much all over the country?

DR. CARTER: They are all over the country, and we even had two in Frontier areas, but I haven't looked

kind of by market type. But I have seen them. They are across the country.

MR. ARMSTRONG: I'm looking at Slide 17, and I understand the case for advancing this kind of rebasing, but I'm wondering why 7 percent?

DR. MILLER: So here, if I understand your question, maybe I'll start off.

MR. ARMSTRONG: Okay.

DR. MILLER: This is not a proposed number or policy number. What Carol did with the Urban Institute folks is said if you re-torqued the PPS system to pay on a patient characteristic base for therapy services -- and there's more to it than that, but that's the big driver -- this is what happens.

MR. ARMSTRONG: Oh, this is the outcome of it.

DR. MILLER: Right.

MR. ARMSTRONG: Okay.

DR. MILLER: And then just to round it out, the rebase or the payments that are policy steps and we're proposing instead of what we've said previously take a 4 percent reduction, we're saying take a softer two-year freeze while this is happening, and it's because of the

concerns raised by the Commissioners the lost time of, like, how do we build a fire here.

MR. ARMSTRONG: So I get the two to three year process you just described, and you used the word "re-torquing." I'm not sure if that's exactly the right word, but I'll use it.

[Laughter.]

MR. ARMSTRONG: So let's assume re-torquing the payment structure ends up with these kinds of shifts. Do we think that that's the right place to get to, these shifts? Because looking at some other data, it was quite dramatic, the amount of intensive therapy compared with the other kinds of services, and this is, frankly, a more subtle shift.

DR. CARTER: Right. And, actually, if you look at sort of more patient categories as opposed to -- these are sort of provider groups. But, for example, providers that have furnished low amounts of therapy, their payments would increase 16 percent, or if you concentrate in low intensive, so you don't have a lot of the high, ultra-high payments to those guys would go up 32 percent. So these are provider-level characteristics, and maybe I'll include

some of these other impacts.

It was in our report with Urban Institute last year, but there is more movement of money around, and as Mark said, these are budget-neutral. So this is agnostic about what's the level. If we kept the level the same, how does money move around?

DR. CHRISTIANSON: Sue? Bill, anything? Bill Hall? No? Mary.

DR. NAYLOR: Briefly, on Slide 8, in equality work -- first of all, great report. Can you give us a sense of -- this is the performance of skilled nursing for -- and then you had all the common diagnoses -- hip, joint, heart failure, shock. But can you give us a sense of how -- what the performance of skilled nursing is relative to alternative sectors, home care, so if someone goes home with the same diagnosis? Do we have that kind of -- I mean, this is a shift year to year in this sector, but do we have a sense of how overall quality measures relate from one sector to another?

DR. CARTER: Well, interesting you ask that because we're working -- because we are working on a consistently defined readmission measure across the post-

acute care settings.

Right now, the SNF sector, the IRF sector, the home health sector all use readmission rates in measuring quality, and we all define it just a little bit differently. And you can't really compare the rates. I could say the home health rates are higher, but they actually -- they are defined differently.

So I'm reluctant to kind of characterize that, but we are hoping to bring forward -- not for next month, but in the future because we are actively working on a common readmission measure across the settings.

DR. CROSSON: Warner. Pass. Cori.

MS. UCCELLO: Can I just get clarification on kind of what it is we're saying here. So, in the past, we've said we wanted to shift the way the payments are made, and then the thought that, well, maybe the way we're saying this isn't getting us anywhere, so maybe we should kind of figure out a different way to do this. So, now -- so, what is this saying? So, we're just keeping payments flat, but at the same time saying, but move ahead with this redoing the way the payment system works.

DR. CROSSON: Both with reforming the structure

of the payment system and examining whether or not there should be further reductions, as well. Two things. Simultaneous.

MS. UCCELLO: At the same time?

DR. CROSSON: At the same time.

DR. MILLER: So, the way I would characterize it is there was always great concern to going to a rebasing, and in that instance, and maybe we do -- speaking of terminology, maybe we need some other terminology here. We were saying, given that these margins are so high, we should actually take the rate down, and we were saying at the time as much as four percent in the first step and then figure out from there. And that's a healthy step.

But we said, given that that's so healthy and we're concerned about the disparities, first, reform the PPS, which is a -- and Kathy drives on this point a lot -- that's a Secretarial activity.

And, so, here we are. You know, we've been saying this for a few years, and I think, among others, but Kathy, I think, raised this last time, is there anything we can do to get to more forward motion. And, so, now what we're saying is, you should do this now. You should reform

the PPS, and by the way, your rates are frozen now for two years.

And just to make sure you understand the math here, this is not taking the rate down four points immediately, obviously. But to the extent that it's frozen for two years and they have any cost growth, they're going to have to deal with that without a rate increase. So, you're putting pressure on them and saying, we're moving ahead, but not as aggressively, but we're moving ahead, and you need to reform this PPS, and then we're trying to put a back-end piece and say, Mr. or Ms. Secretary, you need to report out on what you've done here.

We can obviously report out on it, too. That would just be a matter of course for us to do that as part of our work. But we're trying to send some clear signals. Move ahead. Secretary, you need to report a stronger message. This should move. That's how we're trying to accommodate the comments we heard.

MS. UCCELLO: Okay. Thank you for that clarification. I had forgotten the way that we had ordered it before. So, this makes complete sense. I think our priority -- the priority should be restructuring the PPS,

because I am very concerned about particular types of beneficiaries who are having trouble getting access. So, I think this gets at that, and if this helps us get there faster, fabulous.

DR. CROSSON: Thank you. Moving up this way, clarifying comments. So, I think -- I'm sorry. Kathy.

MS. BUTO: What, roughly, do we think our recommendation would have been for the updates in the absence of recommending that they be frozen for two years to put increased pressure on --

DR. CARTER: Well, we have --

MS. BUTO: Would we have been at zero anyway? I'm just curious --

DR. CARTER: Well, we have a -- I guess the question would be, our standing recommendation was to freeze the rates in one year --

MS. BUTO: Yeah.

DR. CARTER: -- which I guess would be this year, and to take a four percent cut next year. So, one question would be, if we weren't doing this, would we fall back to our standing recommendation or would we consider something else.

MS. BUTO: Right. I'm just trying to figure out why a two-year freeze, then, as opposed to a freeze and a reduction --

DR. MILLER: [Off microphone.] Well, that's kind of what we were doing before --

MS. BUTO: The freeze and the reduction, yeah. And why --

DR. CROSSON: A freeze and a significant reduction.

MS. BUTO: Right. So, why would this recommendation put more pressure on?

DR. MILLER: I mean, the real shift in the pressure is we're no longer saying -- assuming you guys agree, and we're trying to respond to what we thought you guys were saying -- don't wait around to take the rebasing. But at the same time, you have expressions over here, but I'm concerned that we don't sink the not-for-profits or whoever, and so it's a way to kind of move a little more cautiously in the short run, but to move as opposed to wait and then move. So, it's a subtle difference, but we're trying to balance the concern that it not put one part of the industry underwater, but to have forward motion.

And before, we dealt with that concern by saying, don't rebase until you have reformed the PPA. Now, we're saying we're moving ahead, but we're moving ahead less aggressively. You might not view that as yet aggressive enough, but --

The only other thing I would say is we made the original recommendation before the sequester came into effect, and so that might be another reason to sort of --

DR. CROSSON: Jack.

DR. HOADLEY: What's the current statutory scheduled reduction, or, I mean, update factor for --

DR. CARTER: They get the marketbasket minus productivity.

DR. HOADLEY: And what does that amount to in this --

DR. CARTER: Two and change.

DR. HOADLEY: So --

DR. CARTER: I mean, it varies. The productivity factor has ranged from kind of 0.4 to 0.8 over time --

DR. HOADLEY: So, it's still to be determined --

DR. CARTER: -- and it's kind of in the two, two-plus range in terms of update.

DR. HOADLEY: But, presumably, if -- so, to go to a no update, Congress would have to act to do that, but even if Congress didn't act to do that, the Secretary could respond to this recommendation and say, start the process of changing the PPS things. Without the pressure of a zero update, it would still start to move things around in the direction we thought would be useful.

DR. MILLER: Which she could have always --

DR. HOADLEY: Could always do.

DR. MILLER: -- could have always done. I think -- and again, this is maybe too subtle to have the effect, but the other thing this is saying to that portion of the industry that's on the lower side of the margins, you know, if the Congress acts here and starts to freeze for two years, your margins, or your payments, are going to be the first that -- you're going to feel it the fastest.

And, so, the other way to look at this is maybe it gets that portion of the industry to go to CMS and say, why aren't you moving on the reforms, and I think this was some of --

MS. BUTO: [Off microphone.] That's more of what -- yeah.

DR. MILLER: -- what was being said a year ago about this topic.

DR. CROSSON: Okay. I think -- this is obviously a new recommendation. This is not a repeat of a recommendation from before. So, we can either bring this back in January again, and I'm willing to do that, or not, but rather than do an informal thing, I'd like, on this particular case, I'd like to go around and hear from everybody in terms of whether this is supported, if so, why, briefly, or if not, why not, so we can get a sense of where we are.

Jon, do you want to start.

DR. CHRISTIANSON: Yeah. I think the Commission has been very frustrated by this for a while and some new strategy is needed and I think this is a reasonable new strategy, so I would support it.

DR. CROSSON: Sorry. Alice.

DR. COOMBS: I would agree with supporting this, given the data that we have with the margins and that we fulfill all of our questions in terms of access and access to capital and how the industry has been doing. So, I would support it.

DR. CROSSON: Thank you. Kate.

DR. BAICKER: I am supportive, as well. I think the retorquing is particularly important.

DR. MILLER: Thank you.

DR. BAICKER: It's our collective favorite word of the day. It's particularly important in balancing payments equitably. The right strategy for then dialing up or down simultaneously is a little less clear to me and this seems like a perfectly good strategy, but I don't feel strongly that others wouldn't also potentially work. But with the rebalancing, it seems like the important first step.

DR. CROSSON: Thank you. David.

DR. NERENZ: Yeah. I can support. I particularly like the emphasis on the reformed PPS and then the subsequent effects on sort of the differential wins and losses.

DR. REDBERG: I also support the recommendation and the retorquing of the PPS.

DR. CROSSON: Are we inventing new words?

DR. MILLER: Now I think they're just piling on.

[Laughter.]

DR. MILLER: And I would encourage --

DR. CROSSON: I'm getting a little confused here between tweeting, twerking, twocking --

DR. MILLER: Don't go there --

[Laughter.]

DR. HOADLEY: So, I support the retorquing and I support the recommendation, and I think, if nothing else, the fact that we will have a new recommendation and we're not just sort of reprinting in and of itself is a statement that we're making, and I think that's very useful.

DR. CROSSON: Cori.

MS. UCCELLO: As long as I understand this correctly, which is a big "if" --

[Laughter.]

MS. UCCELLO: -- I strongly support this. And, I just -- I just really think the priority needs to be restructuring the PPS on this. So, however way that is made clear, I am a hundred percent behind it. As long as I understand it.

MR. THOMAS: I support the recommendation.

DR. CROSSON: Thanks. Mary.

DR. NAYLOR: I support Cori. As long as I

understand what she understands, I'm good.

[Laughter.]

MR. GRADISON: Way to go.

DR. CROSSON: Bill?

DR. HALL: I support the recommendation.

DR. CROSSON: We can't put two Bills --

MS. THOMPSON: As do I.

DR. CROSSON: Sue. Scott.

MR. ARMSTRONG: Yeah. I support this direction, too. I think the -- it's one of those great examples -- by the way, I also endorse this idea of impatience and would second that emotion, I guess.

[Laughter.]

MR. ARMSTRONG: But, this is also one of those where a part of the tricky part is that skilled -- investing in skilled nursing facility services is good. I mean, we like this. And yet, it's kind of out of context when you're just looking at the payment for that experience. And, so, it's one of those where you want to solve it. There are probably better solutions than retorquing PPS, but given that we're working inside of that, I really think that's the right approach to take.

DR. CROSSON: Thank you. Herb.

MR. KUHN: I support the recommendation for many things, as I said, but I do really like the fact that this is an updated and refinement of past policies and I think that makes it fresh and current and will be helpful.

DR. CROSSON: Good. Thanks. Kathy.

MS. BUTO: Yeah. I strongly support this, in the spirit of inpatients. I would like to -- would encourage us to think about adding some language that encourages the Secretary to move ahead on the retorquing or refinement of the PPS, even as Congress deliberates as to what to do about the update factor. So, I'd just like to see something like that that, again, acknowledges that we know she has some flexibility to move ahead.

DR. CROSSON: I'm just a little confused, though. We're saying direct the Secretary to revise the PPS. Are you saying we need stronger language than that, or am I missing something?

MS. BUTO: Well, it's -- because that direct relates to Congress directing the Secretary, right?

DR. CROSSON: Oh, you want us to directly direct?

MS. BUTO: To point out -- or not so much that,

but to encourage the Secretary to move ahead even as Congress thinks about this, or doesn't do anything, or whatever it is they're going to do.

DR. CROSSON: We need some wordsmithing here. Herb, you got it?

MR. KUHN: I don't know if I have it. The only thing I would just say is kind of a friendly amendment to what Kathy is saying, is if we were to go that direction, the other thing we do need to kind of assert here, and maybe in the other recommendations where we're asking for more energy and activity with the Secretary, CMS does need the resources to implement this stuff. I mean, these are not easy to put in place. You've got to get contractors. There's a lot of work. So, if we do add something like Kathy is speaking about, let's also make sure that we reiterate the need for CMS to have sufficient resources to implement.

DR. MILLER: And to your question is would it be -- and particularly if it's going to be more commentary, about them, you know, the Secretary and CMS getting this done, I wonder if that sits better in the text following the recommendation, where we say, again, more eloquently

than this is about to happen, but, you know, we've made this recommendation for many years. We are very concerned about the disparities. Urge you again, if there are resources, you know, that kind of thing. And it allows you a lot more flexibility than trying to get this, where it could be kind of brutal trying to get all that in there.

MS. BUTO: One last comment. Because we are also thinking in the larger context of things like waiving the three-day prior hospitalization requirement, things like that, I think we can acknowledge, or maybe we do this but it's more subtle than I think, that we think these institutions are going to play an incredibly important role going forward, and the Commission has looked at a number of ways in which that role may expand. And, so, it's really, really important to get it right, or get it better, in terms of the way they're paid and paid fairly and equitably. So, some language like that, without getting too emotional about it, I think that's where we're headed, is that we think these institutions are going to play a much more significant role going forward, even vis-a-vis IRFs and other entities.

DR. CROSSON: Right.

DR. MILLER: And I think I can see, you know, three, four paragraphs following the recommendation that kind of captures what just happened here.

DR. CROSSON: Right. Very well said.

Okay. Thank you, Carol.

And we come to our dialysis services update.

[Pause.]

DR. CROSSON: Okay. Nancy and Andrew. Nancy, it looks like you're going to start off?

MS. RAY: Yeah.

DR. CROSSON: Go ahead.

MS. RAY: Good afternoon.

Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2014, there were about 383,000 Medicare fee-for-service dialysis beneficiaries treated at roughly 6,300 facilities. Total Medicare spending on dialysis services was $11.2 billion in 2014.

This presentation is composed of three parts. First, 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 2017 payment rate. Next, Andy will discuss regulatory changes to the dialysis prospective payment system that CMS will implement in 2016 and two aspects of the PPS that may continue to need attention.

So moving to our payment adequacy analysis, here are the factors listed on this slide that you've seen for the other sectors.

We look at beneficiaries' access to care by examining industry's capacity to furnish care as measured by the growth in dialysis stations, treatment stations. Between 2013 and 2014, growth in dialysis treatment stations grew slightly faster than beneficiary growth. Between 2013 and 2014, there was a net increase of about 235 facilities. Few facilities, roughly 40, closed in 2013., and the closed facilities were smaller, more likely to be hospital-based and non-profit compared to all other facilities.

Few patients, less than 1 percent, were affected by these closures, and there is no indication that affected patients were unable to obtain care elsewhere.

Another indicator of access to care is the growth

in the volume of services. We track volume growth by assessing trends in the number of dialysis treatments and dialysis beneficiaries. Between 2013 and 2014, the total number of dialysis beneficiaries and treatments grew by 2 percent. Treatments per beneficiary remained steady in both years.

We also look at volume changes by measuring growth in the volume of dialysis drugs furnished. Dialysis drugs are an important component of care. Since the PPS was implemented in 2011, dialysis drugs have been included in the payment bundle. Consequently, providers' incentive to furnish them, in particular the two erythropoietin stimulating agents, ESAs, has changed. ESAs are the leading dialysis drug class in terms of utilization.

Before implementation of the dialysis PPS in 2011, there were both clinical and financial reasons for their overuse. As anticipated, after the PPS, ESA use went down significantly. Between 2010 and 2014, their use declined by about 45 percent per treatment. This outcome was expected and has occurred without any sustained change to beneficiaries' health status.

As you can see from the figure, most of the

decline occurred during the initial years of the PPS. Between 2013 and '14, use has remained relatively constant.

Next, we look at dialysis quality by examining changes between 2010, the year prior to the dialysis PPS, and 2014. CMS compiled these data. Mortality and hospital admissions are trending down while emergency department use has modestly increased.

The percent of dialysis beneficiaries using home dialysis, which is associated with improved quality of life and patient satisfaction, has modestly increased between 2010 and 2014.

Your mailing materials discuss a shortage that began in fall of 2014 of the solutions necessary to perform one type of home dialysis. We will be watching the effect of this shortage on patients' access to home dialysis.

Regarding access to capital, the 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.

So moving to our analysis of payments and costs, in 2014, the Medicare margin is 2.1 percent. This reflects the sequester in 2014.

The biggest difference across freestanding facilities is the difference between rural and urban facilities. The aggregate Medicare margin for rural facilities, which account for about 20 percent of facilities, is negative 2.7 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. They have fewer stations and provide fewer treatments. And smaller facilities on average have higher cost per treatment than larger facilities.

Like the other sectors, we also calculated the rate of marginal profit; that is, the rate at which Medicare payments exceed providers' marginal cost.

In 2014, the marginal profit is nearly 18 percent, suggesting facilities with available capacity have an incentive to treat Medicare beneficiaries.

So the 2016 Medicare margin is projected at 0.8 percent. This margin reflects statutory changes in 2015 and 2016 that are listed on the slide and regulatory changes implemented by CMS in 2015. It also includes the small estimated reduction in total payments due to the ESRD

Quality Incentive Program, the QIP. This projection reflects the sequester.

Policy changes to occur in 2017 include the statutory update of the base payment rate reduced by the productivity adjustment less 1.25 percentage points. They were also -- in 2017, CMS estimates a small reduction in total payments due to the ESRD QIP.

So here is a quick summary of the payment adequacy findings. Access to care indicators are favorable. Quality is improving for some measures. The nearly 18 percent marginal profit suggests that facilities with available capacity have an incentive to treat Medicare beneficiaries. The 2016 Medicare margin is projected at 0.8 percent.

The Chairman's draft recommendation reads that the Congress should increase the outpatient dialysis payment rate be by the update specified in current law for calendar year 2017. Under current estimates of the market basket index and productivity adjustment, this would result in an update of 0.75 percent.

This draft recommendation has no effect on spending relative to the statutory update. 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.

So now we are going to shift gears and discuss changes that CMS has finalized to the dialysis PPS and two continuing concerns.

DR. JOHNSON: Thanks, Nancy.

In 2016, CMS will implement a revised version of the ESRD PPS for the first time since the expanded ESRD bundle was introduced in 2011. The American Taxpayer Relief Act required the Secretary to analyze the case mix adjustment and make changes as necessary. These changes do not affect the Commission's consideration of a payment update because they will be implemented in a budget-neutral manner.

The revised PPS will include recalibrated adjustment factors based on data from 2012 and 2013 as well as three significant changes to the structure of the adjustment factors. Overall, the recalibration and refinement of the PPS will reallocate about 4 percent of total facility payments from the base rate per treatment

amount to the aggregate payment amounts generated by the adjustment factors.

Dialysis providers have expressed many concerns with the PPS revision. We generally share these concerns and in August provided further detail in a comment letter to CMS.

For the structural changes, first, CMS will drop two of the six comorbid conditions identified for ESRD patients. CMS found that the documentation required for facilities to receive the adjustment did not match the diagnostic and clinical practices related to those conditions. Dialysis providers have told us that the other comorbid conditions remaining in the PPS may have a similar situation.

Second, CMS is making adjustments to the facility low-volume adjustment, which applies to facilities with fewer than 4,000 treatments in each of the 3 prior years.

And, third, CMS will also implement a new adjustment for rural status, which will increase the payment amount for all facilities located outside of an MSA. We expand on these last two changes on the next slide.

The adjustment for facility low volume is the first of two ongoing PPS issues we will discuss today that have open recommendations from the Commission. These two recommendations will be reprinted in this year's update chapter.

The Commission has long held that an adjustment for facility low volume should protect facilities that are critical for beneficiary access to dialysis.

For 2016, CMS will make changes that affect the targeting of this adjustment. When determining low-volume status, CMS will now take into account whether facilities under common ownership are within five miles of one another. However, for facilities under different ownership, CMS does not consider distance to the nearest facility. Although we believe this is an improvement over the prior policy, further changes are needed to better target the low-volume adjustment. We reiterate our prior recommendation that the Secretary should consider distance to nearest facility when determining status for the low-volume adjustment.

Finally, in creating an adjustment for rural facilities, CMS cited the Commission's support of

protecting isolated facilities that are critical for beneficiary access. The rural adjustment, however, will be applied to all facilities located outside an MSA. Again, we believe this adjustment has good motivation but does not properly target isolated facilities.

The second PPS issue with an open Commission recommendation concerns that accuracy of cost reports. This sector has experienced major policy changes in the past few years, and the accuracy of cost reports has not been examined under the new PPS. The last audit was conducted more than 10 years ago.

Prior ESRD audits have found that facilities' allowable costs ranged from 90 to 96 percent of submitted costs. If providers' costs are overstated, then the Medicare margin would be understated and policymakers may be willing to increase payments as a result of the faulty data. It would be good fiscal management to assess the accuracy of cost reports under the new PPS.

This concludes our presentation, and we look forward to your discussion. Thank you.

DR. CROSSON: Thank you, Nancy and Andrew.

Let's take clarifying questions. I see Bill.

MR. GRADISON: On page 16, you referred to the change in the use of certain medications from 2013 to 2014, and you referred to that in your presentation as well. I don't mean to quibble, but I wouldn't use the word "modestly increase," as this does with something that one went up 33 percent and one went up 59 percent. What am I missing?

MS. RAY: The units are small, so it makes the change look bigger. So for one of the drugs, which is darbepoetin, for example, that increased by 33 percent, it went up from .56 mcg, which is that drug's unit, to .75.

MR. GRADISON: Yes.

MS. RAY: So, yeah, we can change the text accordingly.

MR. GRADISON: Thank you.

And the prior page, one other thing. It refers to the average number of treatments per beneficiary, 117. That puzzles me because the typical treatment is three times a week. Is that not adjusted for -- does this take into account beneficiaries that aren't necessarily entered for the full year or what?

MS. RAY: It does not. So beneficiaries who are

not in it for the full year, who start dialysis late in the year, who pass away, whatever, when they're admitted, it does not take that into account. You're correct. It would be about, what, 156 treatments a year?

MR. GRADISON: It would be 156, yes.

MS. RAY: Yes.

MR. GRADISON: Why is not -- it's closer to 156 than 117.

MS. RAY: Right. Again, because it's not -- it's not annualized.

MR. GRADISON: Oh, okay.

MS. RAY: And we can add a footnote to that.

MR. GRADISON: Thank you.

DR. CROSSON: Yes, Alice.

DR. COOMBS: Thank you very much. I was very interested in this.

On page 25, you talk about the ESRD comprehensive care initiative, and I've been kind of curious as to what the breakout is. The renal folks have given estimates of 80 grand a year for care of an end-stage dialysis patient. what I was thinking about is if they do the nephrologist in with this bundled payment here, do we have a breakout of

the cost, the dialysis separate? I mean, there must be a way in which you can actually appropriate cost to the individual components of the bundle.

DR. MILLER: I would take another pass at the question.

DR. COOMBS: So if you were to look at the cost that you've actually mentioned on page 1 of the chapter summary when you talk about $11.2 billion as a part of the dialysis piece.

MS. RAY: Yes. That's just dialysis.

DR. COOMBS: Right.

MS. RAY: Right.

DR. COOMBS: So when we look at that, commonly you'll see a wedge that says dialysis patient, this, but the true cost of dialysis patients include their comprehensive physician fees and nursing fees and things like that. With that ESRD bundle project, are we able to separate that out to see what additional costs do to the other components of the bundle?

DR. CROSSON: Alice, are you asking how much is paid to the physician or physicians and other caregivers, or is it the facility?

DR. COOMBS: Well, yes. What are the non-dialysis costs of a dialysis patient?

MS. RAY: Right. So, in your briefing material on page 43, we gave -- I provided some information at least for Parts A and B on the breakout of services by type of service.

DR. COOMBS: Right. So I was just wondering if we had -- from this initiative, we had some dollar amounts in terms of --

MS. RAY: I don't have any dollar figures from the ESCO initiative yet.

DR. CROSSON: So would that be specified, or would that be up to the individual institution to decide how that money is divided?

DR. MILLER: Yeah. I have to admit -- I'm looking at Nancy -- I'm confused by the -- well, you don't need this on the record. I'm confused.

[Laughter.]

DR. MILLER: I need you to re-torque that question.

DR. COOMBS: Okay. So --

DR. MILLER: So let me take one shot.

DR. COOMBS: Okay.

DR. MILLER: There may be two pieces of questions floating around. One question, which I do think is very answerable, if this is what you're asking -- and I'm not clear on this -- what's the total cost of an ESRD patient? There is the ESRD portion, but they go to the hospital; they see a physician. We can produce that. In fact, I think we've got the breakout here, and we could sign the dollar amounts to each piece and make it much more clear. If that's one of your questions, we can do that. If that's not your question, then I'm confused.

DR. CROSSON: I thought she was asking in the bundled payment.

DR. COOMBS: So, within the bundled payment, what the breakout is, which is similar to what you're saying, but the reason why I'm asking that question is because I have another question that I want to follow up with.

DR. CROSSON: Do we have to answer the first one?

[Laughter.]

DR. CROSSON: Yes. Kathy?

MS. BUTO: I don't know if this might help, but in constructing the bundle in the first place, CMS had to

make certain assumptions about what's in the bundle and roughly what the allocation is, and that might be informative, if we can get that information.

I don't think it's possible. The concept of the bundle was that given a fair bundle, if you will, of what was to be included, the actual expenditure within that bundle would be up to the provider.

DR. CROSSON: The entity --

MS. BUTO: The entity that's managing that ESRD patient, but you could probably figure out what they assumed going into a bundling -- initially a bundling demonstration.

DR. CROSSON: Is it possible, Nancy, to get a couple of examples? I mean, do you have a connection with the --

MS. RAY: So just to clarify just a little bit, the ESCO, the end-stage renal disease -- it's also called the CAC and referred to in the paper -- it's like, it's similar to other of CMS's ACOs and shared savings programs, and that an ESCO, which is composed of a dialysis provider and a nephrologist agree -- have submitted applications, and CMS has proceeded, beginning this past October. And

they will be responsible for the care of the -- held responsible for all of the spending of their dialysis beneficiaries.

And it's described in the paper in a little bit more detail. If a beneficiary gets attributed to a facility based on a first touch, prospectively first touch, and then the three large dialysis organizations will be held at both gain and -- or are taking full gain -- a gain and -- it's a two-sided design. Whereas, the one small dialysis provider, it's only shared savings.

DR. CROSSON: So, Nancy, let me try this because I think the question is, so what does the physician get or other providers and what does the facility get? And I think -- tell me if I'm right here, that fundamentally, specifying that ahead of time is kind of the opposite of a bundled payment, right?

MS. RAY: Right.

DR. CROSSON: Isn't the essence of a bundled payment that you provide the money to this, in this case, a physician and facility and then they determine, based on the nature of the patient or whatever business arrangements they have, how that money is divided? Or am I wrong?

MS. RAY: That's correct, and to be clear, both the dialysis organization and the one or more nephrologists are at shared or at risk for shared savings, and the three big large dialysis organizations are also -- and their nephrologist partners are also on the hook for shared risk loss.

DR. COOMBS: And that's the question because you could have a conceivable bundle demonstration wherein you have fee-for-service within that.

DR. CROSSON: I see what you're saying.

DR. MILLER: And that's why I was kind of going back to the claims point. Like an ACO, in an ACO, and I need you to do the ESCO piece, but in an ACO, it's fee-for-service and your actual fee-for-service level depends on what you draw-off patients are. And so, you know, it would be whatever the fee-for-service on average is for the group of patients that you took. And so, we need to do it specifically for any ACO or ESCO would depend on it happening and then us being able to say, Oh, you had these ten patients. So doing it in advance, I think, would be somewhat difficult until we knew who was attributed and who was in.

But the concept would still be, I think, that whoever is in, you would be looking at the totality of their ESRD, their hospital, their physician, that type of thing.

MS. RAY: Right. It's all A and B spending and then it will be compared to the benchmark spending and then they determine potential savings or losses and then it will be adjusted by their quality score and that ends up as their final. Either they get shared savings or not.

DR. CROSSON: And you had a second question, Alice.

DR. COOMBS: Well, my second question related to the risk of the nephrologist within the --

DR. CROSSON: And that would presumably depend upon the methodology of payment in that particular setting. Okay. Rita, Jack

DR. REDBERG: Thank you. Very nice chapter. I was struck that it looks like mortality is going down, which is good, and ESA drugs, the bundle, seems to be working. We're using less and patients are doing better, although I would comment that I think internationally, our mortality rates are higher than anywhere else and that we

spend more on dialysis.

But I wanted to understand better what was going on with the Part D drugs and why they're outside of the bundle. In Page 30 in the mailing materials, the calcimimetics and phosphate binders, which we spent $1.3 billion on, which was an increase of 22 percent per year, I'm not aware of data. I don't know if anyone is showing improved quality of life or outcomes associated with. It seems like a lot.

And it went on to say, the Secretary intended that these drugs be included in the bundle, but the Stephen Beck, Jr. Achieving a Better Life Experience Act of 2014 delayed bundling these drugs until 2025. What was going on there?

MS. RAY: That's what Congress --

DR. MILLER: I'm going to let you guys go ahead. You know the look that you guys give me where you go --

MS. RAY: Well, that's what the Congress decided to do.

DR. REDBERG: And this was done for what reason?

DR. MILLER: Remember the tactic here, right? You just reiterate the facts. Okay? So, you know, I think

in building the bundle, and also, Nancy, remind me. I think we made comments to this effect when this was all kind of being churned around. What you want in a system like this is capture what relates to the care, and I know you guys all know this, care to the patient because if there's some important part that's not included in the bundle, then obviously you can just kind of shift the cost to the bundle outside the bundle, a cost outside the bundle.

So there was some thought that decisions were going to be made, there was going to be a capture and these drugs would go into the bundle. My recollection is CMS kind of came along and said, Okay, this is what we think happens. There were strenuous objections and decisions were made.

DR. CROSSON: Rita.

MS. RAY: So when CMS, in proposing the broader bundle in 2010, proposed to put the oral-only dialysis drugs, the phosphate binders and the calcimimetics, into the bundle. Based on comments they got in the rule-making process, they decided to defer including them in the bundle until they had obtained more utilization data and they said

that they would put them in the bundle beginning in 2014.

In the meantime, Congress then acted to delay including those oral-only drugs in the bundle at least on two different opportunities.

DR. CROSSON: So, Rita, just to check in, you and I are both in Washington right now. We're not where we live. Cathy?

MS. BLONIARZ: Jay, I just want to point out that Part D drugs are also not in the ACO. I think we all know that, right? So that's to me a much bigger deal in the sense that we're talking about comprehensive care for many more beneficiaries, and that's not been done.

DR. CROSSON: Right.

MS. BLONIARZ: So it doesn't surprise me that it didn't make it into the ESRD bundle.

DR. CROSSON: Jack

DR. REDBERG: On the two wrongs don't make a right.

DR. HOADLEY: I mean, at the very least, there are practical questions on how do you take drugs out of a Part D where there's a lump -- you're taking just the drugs for this treatment out and then what do you do to adjust

the Part D plans? So, I mean, same issue comes on ACOs. How do you go about doing it? It's a problem that could be figured out, but it is not as simple as some of the other pieces.

That wasn't actually what I was going to comment on. Did you want to add more?

MS. RAY: I just want to say one other point. In the rule that CMS just finalized, they did finalize the process of one and oral-only drug is not oral-only. And so, if an injectable form of that drug is approved by the FDA, then that will be -- both the injectable and the oral-only will be included in the bundle.

DR. HOADLEY: Interesting. So the question I was going to ask is much smaller. You mentioned in that same section that Alice was talking about, that there are some ESRD special needs plans, and I was just curious how many of these SNPs are there? Are there any significant number of people in them, do we know?

MS. RAY: You know, it's not a huge number.

DR. HOADLEY: That's what I was assuming.

MS. RAY: And they're in specific geographic areas, I believe, California. I can get back to you on

that for sure.

DR. HOADLEY: Yeah, thanks.

DR. CROSSON: Other clarifying questions? So here we again, we have a recommendation which is essentially unchanged. I think we've had -- we have a couple of considerations going on here that led to this. Number one is that there are already regulations in place that are being enacted in 2016 that are going to change the landscape. We don't know how yet.

And then we have this underlying concern about the accuracy of the cost reports and whether or not the margins that we actually are looking at are accurate or not. So that has led us to suggest that we essentially stick with current law at the moment. So I'm not hearing in the discussion a whole lot of discussion about that itself. So I'm again taking this as support for the recommendation and hearing no objection will move this forward also in January through the expedited process. Good. Thank you, Nancy. Thank you, Andrew.

So we have come once again to the time for public comment. If there are any in the audience who would wish to make a comment, please step to the microphone so we can

see who you are.

Seeing none, we are adjourned until 8:30 tomorrow morning. Thank you very much.

[Whereupon, at 4:04 p.m., the meeting was recessed, to reconvene at 8:30 a.m. on Friday, December 11, 2015.]

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 11, 2015
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
KATHERINE BAICKER, PhD
KATHY BUTO, MPA
ALICE COOMBS, MD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
HERB B. KUHN
MARY NAYLOR, PhD, FAAN, RN
DAVID NERENZ, PhD
RITA REDBERG, MD, MSc
WARNER THOMAS, MBA
SUSAN THOMPSON, MS, RN
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Okay. I think, if everybody can take their seat, we can get started.

This morning, we finish up the initial update discussions, and we are going to start off with home health care.

Evan, you have the microphone.

MR. CHRISTMAN: Good morning. Now we will review the framework as it relates to home health, and before I dive into that, a quick overview of this presentation. It's going to have three parts. I'll take you through a brief summary of the benefit, a review of the current issues, and then I'll dive into the payment adequacy framework.

As an overview, Medicare spent $17.7 billion on home health services in 2014. There were over 12,400 agencies, and the program provided about 6.6 million episodes to 3.4 million beneficiaries.

Before we look at the framework, I just want to remind you of some of our standing issues with the home health benefit. Home health is an effective service when

appropriately targeted and can be an important service for frail community-dwelling Medicare beneficiaries. However, eligibility for the benefit is poorly designed and does not encourage efficient use.

As I will note in a minute, there has been rapid growth in episode volume, which raises particular concerns in the current fee-for-service environment that rewards providers for additional volume.

The benefit also has an unfortunate history of program integrity problems. The Secretary and the Attorney General have made a number of efforts to address fraud in the benefit, but many patterns of unusual utilization remain.

We have also noted significant geographic variation in the use of this benefit, which program integrity and the poor definition likely contribute to.

In terms of the payment system, the Commission has noted two problems. First is an issue with the incentive in the current system. The current PPS uses the number of therapy visits provided in an episode as a payment factor. Payments increase as more therapy visits are provided in an episode, sometimes increasing by

hundreds of dollars for a single additional visit.

The share of episodes qualifying for these payments has increased every year in the PPS. This trend and the fact that more profitable home health agencies tend to favor therapy episodes raise concerns that financial incentives of the payment system may be influencing the type of care provided.

The second issue is the high level of payments. Medicare has overpaid for home health since the PPS was established. The fact that home health can be a high-value service does not justify the excessive overpayments. As discussed in the paper, Medicare margins average better than 16 percent in the 2001-to-2014 period. These overpayments do not benefit the beneficiary or the taxpayer.

The Commission has made a few recommendations to address some of these problems in prior reports. We recommended a copayment for home health episodes not preceded by a hospitalization. The Commission recommended this because the standards for the use of home health appear to be less clear when it is not being used as a post-acute service. These types of episodes have also

grown rapidly in the last decade, and again, as noted in the paper, they now constitute the majority of home health episodes.

We also recommended that CMS expand its fraud efforts. CMS has taken action, but several areas with questionable patterns of use remain.

As a reminder, here is our framework. It is the same one you saw yesterday for the other sectors

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. Eighty-two 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 2012. There was a net decline of 152 agencies in 2014, but we're still near the all-time supply of agencies hit in 2013.

The decline in 2014 is concentrated in a few areas, such as Texas, Florida, and Michigan. I would note that these areas experienced rapid growth and utilization and supply in prior years. And, overall, the supply of agencies in 2014 is 65 percent higher than 2004.

Next, we look at volume. Episode volume in 2014 declined slightly, relative to the prior year. However, this comes after several years of rapid growth, and the decline is primarily concentrated in five states that had disproportionately fast utilization growth in earlier years and have been the focus of activities to reduce fraud.

I will say more about these five areas in a minute, but turning back to 2014, we note that the number of users and episodes per user decreased slightly. The share of fee-for-service beneficiaries was 9.1 percent in 2014, a slight downtick from the previous year, and though we have seen a recent slowdown in utilization and spending, I would note that over the 2002-through-2013 period, you can see that all of these measures have increased significantly. Spending has almost doubled, and utilization has increased by 60 percent.

This figure gives you a better sense as to how utilization has changed since 2002. Turning first to the yellow line in the middle, the national average, you can see that utilization increased through 2011 on a national basis and has declined slightly in subsequent years.

I would note that this decline occurred at the

time that several other downward pressures on volume hit, including an economy-wide slowdown in health care spending for most payers, continuing declines in hospital discharges, and an increased effort to fight fraud, waste, and abuse in home health.

In addition, it appears that states that experienced the most rapid declines since 2011 had higher growth than other areas prior to 2011, as shown by the orange dashed line at the top. While many factors contributed to this decline, it is notably that these five states have been the focus of efforts to fight fraud, waste, and abuse.

The dotted line at the bottom shows utilization in the other 45 states. As you can see, utilization grew relatively fast through 2011 and since then has remained level. Overall, this graph suggests that the decline in volume since 2011 has been relatively concentrated, and home health utilization in most parts of the country has remained pretty steady since 2011.

Our next indicator is quality, and I just want to note for the Commissioners that some of these rates have been updated since we sent you mailing materials.

This table shows the risk-adjusted rates of functional improvement among those patients not hospitalized at the end of their home health episodes. Patients are assessed at discharge by the home health agency for their functional improvement.

As you can see, across the three years, you can see that the rates of improvement for transferring and walking have increased.

In contrast, hospitalization rates remained mostly 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.

Next, we look at capital. It is worth noting that home health agencies are less capital intensive than other health care providers. Also, few are part of publicly traded companies. Financial analysts have concluded that the publicly traded agencies have adequate access to capital.

We have seen a recent uptick in acquisition activity, with two health care firms buying home health providers to expand their capacity in this sector.

Next, we turn our attention to margins for 2014. You can see that overall margins for freestanding providers were 10.8 percent. For-profits had higher margins than non-profits, and urban agencies had higher profits than rural. And these margins include the effect of the sequester that went into effect 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 2011. If reported margins were adjusted for this error, our home health Medicare margins reported for 2011 would have exceeded 20 percent. While it is speculative to apply the 8 percent to other years, the results suggest that the margins we report for home health could be higher.

Similar to the other providers you heard about yesterday, we computed the marginal profit for home health agencies, which equaled 13.3 percent in 2014, and this indicates that agencies have an economic incentive to serve additional patients.

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 on cost and the best performing third of quality for three consecutive years and never in the worst performing third on either measure. About 15 percent of agencies met this standard.

Relatively efficient providers had a median cost per visit that was 11 percent lower than other agencies and Medicare margins that were about 10 percentage points higher. Relatively efficient providers were typically larger in size, with the median efficient provider about 28 percent larger than the median for other agencies.

The relatively efficient provider 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. However, the efficient providers tended to serve more urban patients than rural ones.

We estimate margins of 8.8 percent in 2016. This is a result of several payment and cost changes. There is a 3 percent add-on in effect for rural areas in both years. Payments will decrease slightly to reflect rebasing,

currently required by the PPACA, and we assume cost growth of less than 1 percent in 2015 and '16 in line with historical rates of growth. And we also assume some nominal case-mix growth, and these estimates assume the sequester remains in effect.

As a reminder, rebasing is a payment reduction for home health and PPACA designed to bring payments more in line with costs. As I noted earlier, home health margins have averaged 16 percent a year since 2001. While PPACA intends to lower payments, we have been concerned that the reductions are too small, and this table shows why.

Every year, rebasing will reduce payments by about 2.8 percent. However, this decrease will be offset each year by a payment update of 1.9 to 2.3 percent each year that will add much of what is cut. Across the years, the net payment reduction for the 60-day episode will be about 3 percent.

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, reaching over 12,600 agencies in 2014. The

number of episodes declined slightly after several years of rapid increases, and the number of users decreased slightly.

Quality measures have not changed significantly. Access to capital is adequate, and the margins for 2015 are projected to equal 10.8 percent. The marginal profit is estimated to be 13.3 percent, and the estimated margins for 2016 are 8.8 percent.

And I would note that these are average margins, and our review of the quality and financial performance for relatively efficient providers suggest that better performing agencies can achieve good outcomes with profit margins that are higher than other agencies.

Since our indicators are positive, the Chairman has proposed that we recommend no update for 2013 and further rebasing. The recommendation includes a provision to eliminate the use of therapy visits as a payment factor. The recommendation reads: The Congress should direct the Secretary to eliminate the payment update for 2017 and implement a two-year rebasing of the payment system beginning in 2018. Congress should direct the Secretary to revise the PPS to eliminate the use of therapy visits as a

factor in payment determinations concurrent with rebasing.

The impact of this change would be to lower spending relative to current law. The impact of beneficiaries should be limited. They should not affect provider willingness to serve them. Eliminating therapy as a payment factor would be budget-neutral in the aggregate but redistributive among providers. Non-profit agencies would see their aggregate payments increase, while for-profit agencies would see a decrease.

This completes my presentation, and I look forward to your questions.

DR. CROSSON: Thank you, Evan.

And just to be clear to the Commission, this is a rerun of our previous set of recommendations.

So we'll take clarifying questions. Mary and then Bill.

DR. NAYLOR: Thanks, Evan, for a great report, reminding us of all the work of the Commission over the last couple of years.

I was interested in page 29 of the report. You talked about lower margins for hospital-based home health agencies, and one of the factors might be reallocation of

cost to home health agencies, but the other that you indicated was some evidence of shorter lengths of stays in hospitals that might be moving patients more quickly to home health. And I'm wondering if you could comment on that, whether or not you're seeing that, how much we're seeing in hospital-based systems and whether or not that's also evidence in any of the other freestanding or other owned home health agencies.

MR. CHRISTMAN: I guess the -- I'm trying to -- I'm not quite sure. Is there a part of the paper where we implied that was shorter stays?

DR. NAYLOR: Yes. It says the lower inpatient cost --

MR. CHRISTMAN: Oh, okay. Yes. I think --

DR. NAYLOR: -- due to shorter hospital stays --

MR. CHRISTMAN: Right.

DR. NAYLOR: -- compensates for losses from operating.

MR. CHRISTMAN: Right. So I guess the thinking is that it's better to lose money on a day of home health than a day of inpatient care. To the extent that hospitals can -- even if they're losing money on the home health

side, if they can avoid further losses, if they have to hold somebody in the hospital longer, the --

DR. NAYLOR: So there's no evidence that this is happening?

MR. CHRISTMAN: Right.

DR. NAYLOR: This is a kind of hypothesis.

MR. CHRISTMAN: Right. Yes.

DR. NAYLOR: You may just want to change the wording because it led me --

MR. CHRISTMAN: Okay.

DR. MILLER: And we can change that.

I think you've heard this dynamic come up in other conversations where you'll find the hospital base, and you find a freestanding industry that seems to have costs that are -- or does consistently have costs that are lower and then hospital-based that's higher. Some of it is the cost of hospitals and the allocation issue.

But the other thing that we've done, although I'm not quite sure in the home health setting, but I know in the SNF setting, we've shown that even though there are what appear to be high losses on a line of business in SNF, you have higher margins on your inpatient side. And the

thinking is that having the hospital-based SNFs helps them manage their costs on the inpatient side.

DR. NAYLOR: I understand.

In the SNF work, though, there was no evidence at all that hospitals are shortening lengths of stay to move people more quickly to SNFs, and I was just wondering if we were beginning to see this in home health based on what --

DR. MILLER: I think it's inference rather than anything else, and we can make that clear.

DR. CROSSON: Bill.

DR. HALL: Evan, a very nice report, as usual.

Could we look at page 11?

MR. CHRISTMAN: Slide 11?

DR. HALL: Slide 11. I'm sorry. In your handout.

So, a couple of things, when we start talking about the use of quality measures, when we're going to be reducing incentives for therapy services, which is what the recommendation is offering. So we look at those, and we look at things that look pretty good. Transferring and walking seems to have improved quite a bit over a short period of time. What do those percentages mean?

Let's take walking, which is the biggest one. Does that mean that 63 percent of the patients were walking? And maybe they were walking before they went into the facility? I think this is more than academic.

MR. CHRISTMAN: Sure. Yeah, the language makes it a little tricky to do succinctly, but it's improvement in walking. So you'll get assessed on, say, a five-point scale at the beginning of your home health stay, and then this is saying that in 2014, wherever they started on that five-point scale, 63 percent were at the -- at least the next rung up on the scale when they were discharged.

Now, these numbers, there's a few things to know about them. First of all is that, obviously, you can only assess a patient at discharge for function if they're there. So patients that have been hospitalized are not reflected in this data. It flushes out a lot of the bad cases.

Now, the other summary level of responses are a patient could have no improvement, which is about the other remaining 35 percent. The number of patients that have a reported functional decline in these measures is tiny, and so I think that that's sort of how this measure worked.

DR. HALL: Okay.

MR. CHRISTMAN: Does this answer your question?

DR. HALL: Yeah. We're going to be using measures like this with increasing frequency, and so I think it's very important that we qualify what we're talking about. I think that helps.

In terms of the readmissions, is there any chance that we could look at what the attribution is, what were people readmitted for?

MR. CHRISTMAN: We can -- I can definitely pull that. I don't have it off the top of my head. It is a lot of the usual suspects, and it's been a while since I've looked at that, though.

DR. HALL: I would bet that what we'll see, as is true with almost all readmission data, is that at least half of the readmissions have nothing to do with the primary diagnosis, and I think those clarifications might help us if we are going to use these measures.

MR. CHRISTMAN: Yeah. I agree with that.

I think the challenge to a certain extent with home health is it builds itself as a multidisciplinary benefit, and they're certainly trying to keep somebody out

of the hospital for their primary diagnosis, assuming there was an acute trigger to the episode, but they essentially are trying to -- they certainly can't control for everything. But I think they're usually trying to treat whatever the broad range of issues are the patient has and not just their primary indication.

DR. CROSSON: Okay. Let's start this way. Alice, David, Rita -- no, Alice, Rita.

DR. COOMBS: So, I had a similar question that Bill had, and I thought we did something a few years ago, Evan, that actually looked at hospitalizations from home health. I'm not sure that we did at that time. Maybe it was one of the other industries. But my question was, you know, hospitalizations to acute care versus PACs and what the differential is in terms of what the different diagnosis. Is there a different type of hospitalization for the PACs in this group?

MR. CHRISTMAN: I'm sorry. Are you speaking of hospitalization rates for sort of the community-admitted patients versus the post-acute patients?

DR. COOMBS: For the community-admitted patients.

MR. CHRISTMAN: Yeah. They're not that

different, as I recall. They're usually within two to three percentage points of each other, sort of the national rates. The biggest difference, the community-admit patients tend to have a few fewer chronic conditions, on average, but a little bit more of the sort of the degenerative- Alzheimer's-dementia type of conditions.

DR. CROSSON: Rita.

DR. REDBERG: I was going to build more on -- Bill got me thinking about the quality measures, and in the walking, can you tell us who does the assessment of the walking.

MR. CHRISTMAN: It's done by the home health agency. It'll be, you know, by generally a nurse be doing the discharge, and there'll be an assessment at admission and an assessment at discharge and they're both done by the home health nurse, generally.

DR. REDBERG: So -- and do you know a little bit more about what scale it was, and also, is this just for people who the reason for home health admission was for walking, or --

MR. CHRISTMAN: No, this will be all patients. This is an all patients measure. It uses -- you know,

again, it's a five-point scale. It's been a while since I've looked at it, but I can get you some more on that.

DR. REDBERG: And, just, if we want to look at quality measures, we probably should think a little more about what makes the most sense. It is very helpful.

And the other point that you mentioned, about when you take everyone out of the denominator who isn't there, not usually the way we look at outcomes.

MR. CHRISTMAN: Well, and that's a fair point. I guess it's just something to keep in mind, that functional measures are such an important part of post-acute care. That's a difficult problem in all settings. You know, you can't assess somebody that isn't there, but it certainly -- I think it is something to think about, whether there's a way to control for that. You know, if an agency loses a lot of patients, do you somehow adjust the functional measure.

DR. REDBERG: Or at least add it to the measures, you know, X-percent were not there, or --

DR. MILLER: It's probably real obvious. I mean, I think part of the reason that we also look at hospitalization out of -- is for that very reason, and that

at least has the characteristic of being identifiable in the claims data and so it's not as subject to some of these other issues that you guys are going back and forth on.

DR. CROSSON: Warner.

MR. THOMAS: So, I just had a couple of questions on the quality measures and the compensation that's tied to quality measures. How large is that in the scale of their payments, roughly? Is it a percent? Is it three percent? Is it any --

MR. CHRISTMAN: It'll start at three percent, and by the end of the current effort, it scales up each year. So I believe it starts at three percent of their base payment kind of goes into the pool beginning in 2018, and then by the end, which I think is 2022, it's gone up to eight percent.

MR. THOMAS: And it seems like with the measures you're talking about, walking, I mean, those are self-assessed measures. Are there specific outcome measures that you think are more appropriate to be --

MR. CHRISTMAN: Well, I guess the, you know, the hospitalization measures. There's also an ED use measure. There's even a hospitalization measure that kind of

controls for ED use and so you're not double-counting it. Because those are such key parts of home health, I've always thought that if there was a way to kind of emphasize those measures in an approach, this would be good. Those are definitely signs of something that beneficiaries should seek to avoid. I think it's something that the home health industry generally agrees is a primary reason for the benefit.

You know, it's difficult, because I think the functional measures are also important. As one advocate put it to us, you don't want it to keep people out of the hospital by discharging to their couch --

MR. THOMAS: Right.

MR. CHRISTMAN: -- so, they do have to be in there. But there are other measures that CMS, under this one -- I can't even list them all off the top of my head, something like two dozen measures, including things like immunization and things like that, but something that focused -- I think when we've commented, you know, something that focuses more on the outcome measures like hospitalization --

MR. THOMAS: Right.

MR. CHRISTMAN: -- and ED use would be best.

MR. THOMAS: Right. And then, seeing how I'm from Louisiana, it's probably up there as one of the high utilizers --

[Laughter.]

MR. THOMAS: It strikes me, at least what I see in our state, is that there's a wide variability in quality in these entities and a lot of it has to do with size and scale. And I don't know if you can comment on that or if you could comment on, as you look at the efficient providers, is there a certain break point of size where you see performance change in these entities?

MR. CHRISTMAN: I mean, I guess -- you know, I've never really gotten down to sort of a precise quantification of when there's some sort of delta where you just see things snap.

MR. THOMAS: Right.

MR. CHRISTMAN: But, it definitely is true that bigger is generally better. The larger agencies generally have lower costs per visit and better quality. And the market design of home health agencies really varies widely across the country. If I recall correctly, Louisiana is

generally a state where I see more but smaller agencies --

MR. THOMAS: Right.

MR. CHRISTMAN: -- and I can see the reverse in other areas, like Massachusetts.

MR. THOMAS: Right.

MR. CHRISTMAN: And, so, to the extent that the Medicare program could do anything about this, I think that the quality incentive is the way to do it in the sense that it rewards providers who are providing better outcomes, ideally, and that would -- you know, if the data is correct, that would probably shake out some of the smaller agencies and reward those that were providing better quality, generally, the bigger ones.

MR. THOMAS: Have we assessed or looked specifically at -- just targeted small agencies and looked at their performance specifically?

MR. CHRISTMAN: Not in great detail, no.

MR. THOMAS: Okay. All right. Thank you.

DR. CROSSON: Jon.

DR. CHRISTIANSON: I guess this is just sort of a tangential question. On these agency-assessed measures, does CMS have any process for auditing, or is that even

feasible to think about?

MR. CHRISTMAN: They primarily count on provider education. They, you know, will put out materials designed to help agencies understand what the correct way to code a patient is, and that's, to the extent of my knowledge, that's sort of what they rely up. And to the extent that these issues are addressed directly, I think when CMS will do field sessions of different types with agencies and have conversations with them and say, you know, when we see this, you do that, and I'm sure there's a conversation about whether they're actually doing that. So, it's 13,000 agencies, so it's tough to do any other way.

MS. BUTO: Evan, I noticed in the paper on page six that right from the get-go when they established the PPS, there was a flawed assumption about the average number of visits per episode that would decline. Is that a major factor in the need for rebasing? I mean, how big a factor is that? And I guess I'm wondering whether we should call out those key issues where -- and I'm also wondering whether CMS could -- has the authority already to at least go back and adjust that assumption.

MR. CHRISTMAN: Yeah. I mean, I think that the,

you know, the -- I guess the way I would answer this question, as you're probably well aware, the late 1990s were a period of rapid change for the home health industry --

MS. BUTO: Yeah.

MR. CHRISTMAN: -- when they had to form up this payment system, and so they had data for 1998 and they kind of had to guess how much it was going to change between 1998 and October 1, when the payment system was supposed to go live. And they, if I've got all this right in my head, they assumed the utilization would drop down by 15 percent. And, again, it was anybody's guess at that point, and it was about double that amount.

And, so, in 2001, there were also some payment policies running, but they had margins of 23 percent, so they kind of just completely overshot what the costs of a typical service were going to be.

We've made this point for several years, and instead of sort of going back -- and again, I hope I'm not trying to talk around your question here -- instead of going back and rearguing what they should have done in 2000, we're saying, you know, take the latest data, take

the latest costs, take the latest payments and align payments with those costs, you know, instead of trying to get into this original sin kind of argument --

MS. BUTO: Right.

MR. CHRISTMAN: -- about what happened in 1999.

MS. BUTO: No, I think that's -- you know, that's appropriate for us. I'm just thinking -- and we can get into this in round two -- but sometimes it's easier to adjust a flawed assumption than it is to rebase the whole system. That's my --

MR. CHRISTMAN: Right, and they don't have -- they're basically -- I think the budget neutrality requirements don't let them go any lower unless the law opens it up.

MS. BUTO: Okay.

MR. CHRISTMAN: They've got a little bit of authority in PPACA to lower rates, but as we point out, we don't think it's enough. So, I guess, if you're asking if they have the administrative authority to go further, they don't.

DR. CROSSON: Other clarifying questions? So -- sorry.

DR. MILLER: Can I just say one thing? There is -- a lot of your questions on the quality are this underlying tension of, you know, sizes of measure sets and types of measures that has gone on in this Commission a lot of times. The exchange between Warner -- I think it was Warner and Evan, you know, we tend to say if there are a smaller set of outcomes that have less game-ability to them, that that's the direction to move in. So, just as a philosophical and a larger issue, it hangs over lots of these conversations.

But, the other little thing that got implicated there was, well, how much flexibility in coding when it happens on the ground and how do you deal with that, and I would just give you a heads up. We're going to get into that in the next section when we talk about IRF, because there are some patterns there that start to look odd. So, that was just a commercial.

[Laughter.]

DR. CROSSON: Stay tuned. So, similar to some of the discussions we had yesterday, most of the questions, although excellent, were tangential to the recommendations. So -- except for Kathy's. So, what I was going to propose

-- in a minute or two, I'm going to propose that we, if we have a consensus to move forward with the previous and now current recommendations, that we put this into expedited voting in January. But, Kathy, I want to give you another chance to, if you want, to elaborate on your suggestion, because it might affect the recommendation.

MS. BUTO: I would just, since we'll probably come back to this in January, I assume, even though in a probably expedited way, something Jon mentioned. I think -- I'm assuming we're picking up the prior recommendations --

DR. CROSSON: That's correct.

MS. BUTO: -- about fraud and abuse, that it would be good to elaborate a bit more, rather than expand efforts to reduce fraud, abuse, and waste, and similarly on the issue of rebasing, we do point out some areas that need to be particularly looked at. I just think the specificity helps, because there may be pieces of this that can be adopted more easily and Congress would be more willing to take them. And then, of course, the copay for episodes not preceded by -- that's a big deal.

So, I think we could do a lot more in the fraud

and abuse area, targeting the states where there's high volume growth, and maybe even going so far as to recommend that there be a more targeted review of kind of medical necessity that goes along with the cost report audit that's done periodically, because I don't think we have a handle on that. Putting quality aside, I don't think we know if a lot of these visits are even -- the individuals really quality for home health services.

DR. CROSSON: So, it strikes me, Kathy, that some of what you said could be an elaboration within the text and some might be a little more specificity in the recommendations?

MS. BUTO: Without changing the recommendations.

DR. CROSSON: Yeah.

MS. BUTO: I would just get more specific.

DR. MILLER: And I know Warner has his hand up --

DR. CROSSON: I'm sorry.

DR. MILLER: -- but when we say, take the fraud and abuse recommendation, I mean, here, obviously, we're being extremely terse just in the interest of presentation, and I'm trying to reconstruct when we made the recommendation. We were saying, the Secretary has these

new authorities. The Secretary got some new authorities in the PPACA law, and Evan knows this better than me, and what our recommendation said is, she has these authorities and we are urging her to use them. And then we presented data in the chapter, which I'm not sure we recapitulated all that here, and said, here are patterns around the country. We would suggest these are places, as long as you've got this new authority, you should look first.

Then the other thing I'll say, to Evan's credit and the work that he's done, is some of the geographic variation stuff he's presented and we ended up publishing in the chapter, and it does draw attention on the Hill. The staff regularly refer to parts of the country based on the work here.

So, there is -- what I want to say to you is there is more of an elaboration when we put the recommendation together. We summarize it in this chapter, but we can certainly put more of that back in there to make it clear.

DR. CROSSON: Warner.

MR. THOMAS: And this, once again, may just be an elaboration, but I just think tying more dollars to outcome

measures may help to raise the bar on some of these smaller entities. Or maybe they need to demonstrate a certain proficiency before they're -- I mean, I know, and I'm not comparing home health to transplant, but, like, in transplant, you have to demonstrate a certain proficiency before you're Medicare-eligible, period.

And, I just wonder if -- because it seems like these very, very small entities are, I think, a challenge from a utilization perspective. And once again, if they're hitting great outcome quality measures, fine, but I wonder if that's necessarily the case. So, that could just be in the text, but that's just a comment about the general direction of the payments.

DR. CROSSON: So, let me ask Evan, then. Is what Warner is suggesting, that is, it sounds to me like more specificity in the conditions of participation or whatever the entry criteria is, is that something that's been explored?

MR. CHRISTMAN: That's certainly been talked about. I mean, I think I initially heard him to say, definitely, VBP incentive that focuses on outcomes starts to take you down this road by itself. But then another

question becomes, you know, do you have a -- to be in the program, do you say, you know, after your first three years, you've got to be at this level of performance to remain, and that's something we could certainly talk about. I think the only -- I think there's some language in there, you always want to assure access, but once that concern is addressed, I think you could certainly say it might be worth exploring minimum quality standards, particularly in markets that are saturated.

DR. CROSSON: Yeah. So, it sounds like perhaps for January you might take a look at that for us.

And Mary.

DR. NAYLOR: So, I support continuing the recommendations, all of them. Where Evan started was -- and we talked about this yesterday related to skilled nursing facilities, how critically important home health is, and I think somebody used the language yesterday, we want to get the payment right and so on. But, on the quality measures, I'm wondering if the chapter in elaboration could really push the effort to use measures across the sectors -- skilled nursing, home health. I know this is more than an update, but it is the work -- I'm

wondering if the efforts to say, for example, promoting measurement of function or mobility using the care continuity tool, for example, gives us a chance to look differently across sectors.

So, I think this effort to think about the work that's going on in post-acute care and trying to get a whole system of post-acute care might be something that could be brought in in support of our recommendations.

DR. CROSSON: I think that is doable, yes. Okay. Given those additions that we'll see in January, do I see general comfort with taking this to the expedited voting process in January? Okay. Good.

Thanks very much, Evan. Very nice.

[Pause.]

DR. CROSSON: Okay. Now we're going to take on the issue of the update for inpatient rehabilitation facilities, the IRF world, and Dana, take it away.

MS. KELLEY: Okay. Good morning.

After illness, injury or surgery, many patients need intensive rehabilitative care, including physical, occupational, or speech therapy. Sometimes these services are provided in inpatient rehabilitation facilities. In

2014, Medicare spent $7 billion on IRF care provided in almost 1,200 IRFs nationwide. There were about 375,000 IRF stays in 2014, and on average, Medicare paid more than $18,000 per case. Per case payments vary based on patient's condition, level of impairment, age, and co-morbidity. Medicare accounted for about 60 percent of IRF's discharges.

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 pre-admission screening process to determine that each patient is likely to benefit significantly from an intensive inpatient rehabilitation program.

An IRF also must demonstrate that it's primarily focused on treating conditions that typically require intensive rehab. 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 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.

For beneficiaries to qualify for a covered IRF stay, they 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'll start by considering access to care. We first looked at the supply of IRFs. In 2014, there were about 1,180 IRFs nationwide with more than 39,000 beds. IRFs tend to be concentrated in states that have large Medicare populations, but each state and the District of Columbia has at least one IRF.

As you can see in the facilities column on the chart, only 21 percent were free-standing facilities. The vast majority of IRFs, 79 percent, were distinct units located in acute care hospitals. However, because hospital-based units tend to have fewer beds, they accounted for just about half of Medicare discharges from

IRFs in 2014.

As you can see in the last two columns, the number of hospital-based and non-profit IRFs has been declining, but both these categories saw a small increase in numbers between 2013 and 2014. Growth in the number of free-standing and for-profit IRFs, which has been ongoing, picked up in 2014. The average occupancy rate has been steady for several years at about 64 percent, indicating that overall capacity is more than adequate to meet demand.

This slide shows the number of IRF cases on a fee-for-service basis. Beginning in 2004, 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.

To assess the quality of care furnished in IRFs, we used six risk-adjusted measures developed for MedPAC by a contractor. Overall, we found that the measures have been stable. On average, IRF patients continue to gain about 23 points in motor function during the IRF stay and about four points in measured cognition. The risk-adjusted

community discharge rate was about 76 percent, while the rate of discharge to SNF was almost 7 percent.

The risk-adjusted rate of potentially avoidable readmissions during the IRF stay was 2.4 percent in 2014 and 4.5 percent during the 30 days after discharge. These rehospitalization rates are low compared with those of other PAC settings, but that's not unexpected. Remember that IRF patients are selected because they can tolerate and benefit from intensive therapy, which means they tend to be less frail than, say, SNF patients, and IRFs themselves are certified as hospitals.

Turning now to access to capital, as I noted earlier, more than three-quarters of IRFs are hospital-based units which access needed capital through their parent institutions. As you heard yesterday, hospitals maintained good access to capital markets in 2014 and 2015 due to hospitals' high level of profitability and continued low interest rates. Hospital construction has recently shifted away from inpatient and towards outpatient ones, but about-inpatient projects and toward outpatient ones, but about 25 new hospital-based IRFs did open in 2014.

As for free-standing IRFs, one large chain

dominates the free-standing market, accounting for 41 percent of all free-standing facilities. Continued acquisitions of other post-acute care providers and expansion of capacity through construction of new IRFs reflect good access to capital for this chain. Most other free-standing IRFs are independent or are local chains with a small number of facilities, and the extent to which these providers can access capital is less clear.

In 2014, the Medicare margin increased almost 1 point to 12.5 percent. As you can see, financial performance varies across IRFs. The aggregate margin for free-standing IRFs, which again accounted for about half of all Medicare discharges, was 25.3 percent. Hospital-based IRFs had an aggregate margin of 1 percent. There was a similar spread between non-profit and for-profit IRFs. Of course, these two categories are highly correlated. The aggregate marginal profit was 30.4 percent.

The disparity between hospital-based and free-standing IRF margins could be caused by a number of factors. 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 total cost, hospital-based IRFs have lower indirect costs than free-standing IRFs do.

Hospital-based IRFs are, as I said, far more likely than free-standing IRFs to be non-profit, and so may be less focused on reducing costs to maximize returns to investors. Economies of scale are also likely a factor. hospital-based IRFs tend to be much smaller and have fewer total cases. Their occupancy rates are also somewhat lower.

But we can't rule out unmeasured differences in case complexity. We've noted differences in the mix of cases in hospital and free-standing IRFs. Hospital-based IRFs also have many more high cost outliers which could, in part, reflect unmeasured case complexity. Despite their comparatively low margins, Medicare payments to hospital-based IRFs exceed marginal costs by a substantial amount, 19 percent in 2014. This compares to a marginal profit of over 40 percent for free-standing IRFs.

We project an aggregate Medicare margin of 13.9 for 2016. This projection includes the effects of current law such as the sequester and PPACA adjustments, as well as

statutory updates and changes to high-cost outlier payments in 2015 and 2016. We assumed a historical rate of cost growth that has been below market basket levels. Overall, we project that payment growth will continue to exceed cost growth in this industry.

So to summarize, we observed capacity that appears to be adequate to meet demand. Our risk-adjusted outcome measures are stable. Access to capital appears adequate. We estimate that the margin was 12.5 percent in 2014 while marginal profit was 30.4 percent. We project a margin of 13.9 percent in 2016.

The Chairman's draft recommendation reads as follows: The Congress should eliminate the update to payment rates for inpatient rehabilitation facilities for fiscal year 2017. Eliminating the update for 2017 will reduce spending relative to the expected statutory update. We don't anticipate this recommendation would have any adverse impact on beneficiaries or on providers' willingness and ability to care for patients. Even without an update, we expect providers will have more than enough revenue to cover costs.

Before I conclude my presentation, I want to

address some concerns we have about the IRF PPS. As you've seen, the aggregate margin is high and projected to increase. This situation often prompts discussion of the need for rebasing. However, in the case of IRFs, the wide variation of margins gives us some pause. As I mentioned previously, the low margins we see among hospital-based IRFs may be because they are less efficient. If that's the case, one might be less troubled by their low margins.

But given the differences we've observed and the mix of cases in hospital-based and free-standing IRFs, we wanted to dig further and determine if there was any reason to think that other factors might be behind those margins such as patient selection or coding.

We first wanted to look more closely at the relationship between IRF's mix of case types and financial performance. We sorted IRFs into five equal sized groups, or quintiles, based on their margins. The IRFs in quintile five have the highest margins, while those in quintile one have the lowest margins. There are both hospital-based and free-standing IRFs in every quintile, although quintile one is predominantly hospital-based.

As you can see here, the shares of cases with

stroke and neurological disorders varied considerably across the margin quintiles. Looking at the red bars, IRFs with the highest margins have a smaller share of stroke cases. Perhaps more striking, they have a much larger share of cases with neurological disorders, shown here in green. It's not shown on the chart, but we also found differences across the margin quintiles in the types of stroke and neurological cases they admitted.

I want to note that this analysis looks only at post-acute cases, those that were discharged from the acute care hospital to the IRF. We've also noted differences across IRFs in the shares and types of cases that are admitted from the community without a preceding acute care stay, and that's something we plan to look into further.

We also noted some interesting patterns of coding in IRFs. When we looked at IRF patients' preceding acute care hospital claims, we found that patients in high margin IRFs appeared to be less severely ill during their preceding hospital stay compared with patients in low margin IRFs. High margin IRFs cared for patients who had lower average hospital case mix index. Their patients were less likely to have been in an ICU or CCU. Patients who

had been in an ICU had shorter stays there, on average, than patients in low margin IRFs. Patients in high margin IRFs were also less likely to have been high-cost outliers during their preceding hospital stay.

But once patients were admitted to and assessed by IRFs, the patient profile appeared to change, with patients in high margin IRFs appearing to be more impaired on average. Patients in high margin IRFs had lower motor and cognition scores and they were more likely to be coded with co-morbidities that increased payment. In fact, we found that at any level of patient severity, as measured in the acute care hospital, patients in high margin IRFs were coded with greater impairment.

This slide helps to illustrate the kinds of differences in coding we're seeing. Here we're looking at average motor function scores at IRF admission for patients with three types of stroke, stroke with left body involvement, right body involvement, and stroke with no paralysis. For ease of reading, I've removed the middle quintiles to show data only for the lowest margin quintile and the highest margin quintile.

If you look at the scores for the lowest margin

IRFs, quintile one in the middle column now in yellow, you can see that patients with strokes with left body and right body involvement have average motor scores of 28.6 and 29.7, while stroke patients with no paralysis have a higher average motor score of 35.3, indicating better function. This is not surprising because we would expect stroke patients with no paralysis to have better motor function than patients with paralysis.

Now look at the scores on the right-hand column for quintile five, the highest margin IRFs. In the highest margin IRFs, just as in the lowest margin IRFs, we see that patients with no paralysis have a higher average motor score than patients with left body and right body involvement. But note, in the highest margin IRFs, stroke patients with no paralysis have an average motor score of 29, which is almost exactly the same as the average motor score for patients with paralysis in the lowest margin IRFs. Assuming no differences in co-morbidities, Medicare's payment for these stroke cases would be the same.

We also note, as I mentioned before, that stroke cases -- that there are differences in the type of stroke

cases admitted to these facilities. Stroke cases with no paralysis are more than twice as common in IRFs with the highest margins.

These findings raise concerns about assessment and coding in IRFs. If similar patients are being assessed and coded differently, then payments for some cases may be higher than warranted. Historically, CMS has addressed unwarranted coding changes in its payment systems by making across-the-board adjustments to payments. CMS made coding adjustments to the IRF-based payment rate in 2006 and 2007.

But here, our concerns about coding practices are not industry-wide. Making an across-the-board adjustment to payments would affect all IRFs, not just those who are engaging in up-coding. More work is needed to assess whether and how a targeted adjustment could be implemented.

Our findings also raise concerns about patient selection. Some IRFs may be selecting patients who they anticipate will be less costly to care for. There also may be variation in the relative profitability of the IRF case mix groups. These are issues staff plans to explore over the coming months.

In the near term, Commissioners may wish to

consider another option that would help redistribute payments within the IRF PPS. Because high margin IRFs have very few outlier cases, expanding the outlier pool while keeping total payments budget-neutral, would have the effect of directing additional payments to IRFs with the costliest cases. Commissioners may also wish to discuss the need for additional program oversight in this area.

That concludes my presentation and I'm happy to take any questions.

DR. CROSSON: Thank you very much, Dana. Now we'll be open for questions. David, would you?

DR. NERENZ: Yes, thank you. This is great. Slide 15, please. This is just absolutely striking to me, particularly the bar on the right. I notice in the footnote that we're talking here in the high margin places a relatively high fraction of patients with MS, Parkinson's disease, ALS, and polyneuropathy. I don't know this area very well clinically. What do the rehab facilities do for patients with these conditions? Because clearly, they're not recovering from an acute event or, at least, I'm presuming so. What's going on day-to-day in session-by-session there?

MS. KELLEY: So all these patients in this analysis were post-acute patients, so they had had an acute care hospital stay before being admitted to the IRF.

DR. NERENZ: Now, does that mean that actually an acute clinical event necessarily or just that they were in that site of care? Do we have any way to know that?

MS. KELLEY: These were IRF claims matched to a preceding acute care hospital claim.

DR. NERENZ: Well, but just because you're in the hospital doesn't mean you've had an acute clinical --

MS. KELLEY: True.

DR. NERENZ: -- emergency.

MS. KELLEY: Most of the neurological cases had preceding acute care hospital stays for conditions that, in my non-clinical opinion, did not seem to be associated necessarily with their neurological condition. For example-

DR. HALL: I would guess that a lot of those acute admissions were for respiratory problems.

DR. NERENZ: Okay. Then sort of back to the original question, if those patients then with that reason for the acute hospitalization go to IRF, what is done for

them? Because again, it's just so visually striking here. The high margin places are taking care of a lot of these folks relative to the low margin places, and it begs the question, you know, what are they doing?

MS. KELLEY: So that's something we need to look into further, I think. The other thing to note that may be of interest to you is that, as I said, there's differences in the types of neurological cases that are accepted across these margin quintiles. The highest margin IRFs, the quintile five margins, the majority of their neurological cases are cases with neuromuscular disorders, with ALS or muscular dystrophy, things like that. I think we need to look further into the types of therapy that's provided for those patients.

DR. COOMBS: So thinking along those lines, a lot of patients that we may admit to an IRF may have had pneumonia or some other kind of factor that is actually worsened by their prevailing chronic neurologic problem that they have. So the diagnosis for which they were admitted to the acute care hospital is going to become very important in dictating, is this just an anchoring diagnosis that is put in because it carries a certain degree of

threshold for morbidity or resource utilization.

Because there are some patients with MS that, because of the very nature of MS, they might even be in remission, but they still have the diagnosis of MS. And so, I think it's really important for -- because patients will be admitted to an IRF with a multiplicity of diagnoses. They may even be post-procedural and they may be in the phase of rehabilitation and needing some therapy after a certain type of procedure as well.

DR. CHRISTIANSON: On this side, let's --

MR. KELLEY: Could I just respond to Alice?

DR. CHRISTIANSON: Oh, sorry. Go ahead.

MS. KELLEY: I just wanted to remind you that when Carol and I spoke with clinicians and discharge planners at hospitals, at a number of hospitals around the country last spring, we reported to you that we heard very different things about when an IRF is appropriate, and there were parts of -- regions where it seemed that IRFs were used much more for cases with high medical needs because of the greater -- the skill mix in IRFs; whereas, in other places that we spoke to, it was much more focused on rehabilitation. So, to some extent, this may be a

regional phenomenon too.

DR. CHRISTIANSON: Kate.

DR. BAICKER: Thanks.

I thought the information on the variability of costs as well as profitability across the different types of IRFs was really helpful. I also thought the information on quality was helpful.

I don't remember seeing in the chapter a breakdown of quality by those high margin versus low margin or for-profit versus not-for-profit or high-cost versus low-cost IRFs, and it would be -- I infer that they're pretty similar, but it would be helpful. Obviously, the case-mix adjustment would be really important in light of what you've shown us about the very different people showing up, and I understand that it might be harder to interpret if you think the coding is really different, so that you're comparing apples and oranges, even after you risk-adjust. But it would still, I think, be helpful to at least, if not see whole charges, have a few sentences on what those functional improvement metrics look like in those two different types of sites.

DR. CROSSON: Clarifying questions?

Cori.

MS. UCCELLO: Is there any auditing done currently in terms of coding?

MS. KELLEY: Yes. IRFs are subject to medical review by the MACs, as any other provider might be. There are sometimes questions of whether -- for example, if an IRF looks to be having difficulty in meeting the 60 percent rule, there will be a more focused medical record review for those IRFs.

But there hasn't been sort of a kind of wholesale investigation of the type I think you're --

MR. KUHN: So on the coding behavior or perhaps coding intensity, don't you know what's going on there yet? Typically, at times when we see something that you kind of describe or is kind of more isolated and not kind of system-wide, it means that you either have one particular consultant who has come up with something and moving in that direction or perhaps a particular health care system has devised something and moving in this direction.

And so when something like that happens, you'll see maybe assertions. When they do earnings reports on Wall Street, they'll talk about this new way of coding, or

consultants will even put on their websites that this is what they're doing, here is how to sell their service. Are we detecting anything like that in terms of conversations and earnings performance, or in any consultants talking about this new opportunity for coding and behaviors?

MS. KELLEY: I have not seen that, but I can look more deeply into that.

DR. MILLER: I thought you were going to give us a name.

[Laughter.]

DR. MILLER: But you are absolutely right, and it's just bandwidth, and Dana has other things she has to do. But there have been times, actually now that I think about it, in other settings where we kind of went out and looked at websites, and you could see statements here. And we can go and do some of that.

DR. CROSSON: And just to be clear, nothing here is to be taken as investment advice.

Jon.

DR. CHRISTIANSON: Well, that was my -- no.

[Laughter.]

DR. CHRISTIANSON: So I am -- back to your last

slide.

So there was the Chairman's recommendation, and then I'm not quite sure I follow what's going on here. So, on the possible short-term fixes, so is short term. Are you going to come back in January and say the Chairman's recommendation plus some of these fixes?

DR. CROSSON: I'm sorry. I probably should have clarified that.

So we kind of have a split thing going on here. We have this recommendation, which we will bring back in January, but the intention is to come back with more information, particularly about the coding issues, the difference in coding between the level of the case mix at the discharge from the acute care hospital and the apparent case mix on admission to the IRF as well as other coding issues that may be referable to, as Herb said, one or more organizations or one or more techniques, and bring forward additional recommendations.

So, when we're finished with the clarifying questions, what I'd like to do here is to have a more traditional Round 2 to pick up ideas about where we might focus that, and of course, Dana has already given a couple

of suggestions here. Sorry.

DR. MILLER: I'm sorry. If I can just say one thing, just to make sure that I understand what you just said there.

January is -- and particularly for turning the papers around for us -- is just a couple of weeks away, and then -- so we'll bring additional information.

There's probably other work and other recommendations at some point down the road that are probably deeper than we're going to be able to get back on the table in January. So the thing I would focus you on -- and particularly with the last slide -- is we can always urge the Secretary -- and it is not inconsistent with things you were just saying a minute ago, Kathy -- on there's some areas here we think you should look at these types of -- as opposed to just a general admonishment, "Go do some stuff, we could say, "We see these patterns. We would urge the Secretary to look there," and if she was going to engage in medial review.

And then what we were trying to say on an outlier pool, that is something that I do think I could bring back in January, and I think give you at least some sense of the

distributional impact. And what you'd just be doing there -- not just, but what you would be doing there is if you have 3 percent of the dollars go into the outlier, which I think is the right number, somewhere in there, and you start with 3, you distributed on that basis -- and 3 percent of the dollars tend to go to the low margin and of the IRF providers. If you were to take that percentage and expand it, then more of those dollars would travel out through the outlier and, given current behavior, go to the low-margin IRFs. And that's redistributive, budget-neutral, and relatively simple to bring for January.

If you wanted to fix the PPS, understand all the coding issues, that's not going to happen by January and then have a recommendation attached to it, that type of thing.

DR. CROSSON: Right. But just to be clear, because of this, this one, IRFs, we're not going to do an expedited voting. We will come back and have a discussion.

Mary.

DR. NAYLOR: Just one question on the outlier pool. I was looking for it now, but can you help -- what's the difference in length of stay in low-margin versus high-

margin IRFs? I'm assuming length of stay contributed to cost.

MS. KELLEY: On average?

DR. NAYLOR: On average.

MS. KELLEY: They're actually quite similar.

DR. NAYLOR: They're quite similar. So the cost then is what's happening in those days.

MS. KELLEY: Yes.

DR. NAYLOR: Thank you.

DR. CROSSON: Still on clarifying questions.

[No response.]

DR. CROSSON: Seeing none, to the extent that people want to discuss particularly what Mark described or have more elaboration on how changing the outlier pool might help the situation that we've got in terms of these widely divergent margins or other ideas, either on that topic specifically or topics for future work -- for example, one idea that had occurred to me would be whether -- and this is not for January recommendation, but whether it would be possible to look at that and actually measure that difference by institution between the average case mix of the discharged patients and then the case mix, average

case mix of what the admission criteria is to the IRF and understand whether an adjustment -- similar to the inpatient readmission policy, whether an adjustment could be made there. That's just one notion that may be administratively -- it is, administratively, much more complex than simply expanding the outlier pool.

But to those of you who have had more experience in post-acute care, if you have some additional thoughts as to where we might go, either in the short run or long run, this would be the time to do that. And there will be another opportunity in January.

MS. BUTO: I don't have more experience in the post-acute care, but I do have experience in looking at distortions in payment, and it strikes me that the neurological disorders category is more game-able. It looks like you can add -- and the high margins IRFs have added, comorbidities or lower cognitive skills, scores, or whatever it is. And I think that bears some looking at by the agency. I don't think we could do it necessarily, but it's just a game-ability and the fact that there's so much one can do to enhance payment by adding in this category that's already somewhat amorphous.

MS. KELLEY: Right. And I think the other complicating factor there is that neurological cases also count towards the 60 percent rule. So it's -- I think it could be a category of patients that, as you suggest, might be more game-able, might be sometimes more profitable to care for, and also satisfy the compliance criteria.

MS. BUTO: Right.

I just think there's some work that could be done there to tighten the accountability to what those patients are, and I don't know what it is, but I know the CMS staff could probably do a better job.

DR. CROSSON: Other comments? Bill.

DR. HALL: I suspect what we'd find when we do that is that, you know, people with a stroke have a permanent disability that they didn't have before. They're going to require more care, and they're not going to recover as quickly. All the neuromuscular disorders are kind of a -- not a wastebasket, but they're kind of a generic diagnosis, which is in the backdrop of why they were admitted to a hospital.

So the question is, are we, in some way or another, disenfranchising people with stroke by saying that

you will have to be at a hospital-based inpatient facility as opposed to freestanding or for-profit? I don't know the answer to that, but I think it's going to be fairly simple.

Another thing we might want to look at is, are we in any way disenfranchising rural areas and smaller communities? The for-profits tend to aggregate in large communities; is that right?

MS. KELLEY: There are not a lot of rural or IRFs, it's true. Off the top of my head, I don't know how the profit status works out rural-wise. I'd have to look into that. I'm sorry.

DR. CROSSON: Other comments? Jon.

DR. CHRISTIANSON: Well, I guess I would like to see us try to come to some recommendation in January that's beyond just freezing the payment. I mean, we've got more information about the problem. We've known about the problem for a while, and you've gone and done the research. And I don't know whether it's something like Mark was raising in terms of the outlier pool, but it seems to me we could put a little more oomph behind this than just saying freeze the payment at the past levels. At least that would be my preference right now.

DR. CROSSON: Yes. And I think I would definitely agree with that, and I think Mark pretty much implied that we would do that.

Let me just ask Mark. Would we be looking at a range of expansion of the outlier pool and the impact of that?

DR. MILLER: Yeah. And I wasn't meaning to imply that decision for you. I just wanted to avoid the heart attack of somebody saying "Let's do this" and me not being able to show up in January, so I want to just say --

DR. CROSSON: You were trying to get me under control.

DR. MILLER: Yes. Yes, I was.

[Laughter.]

DR. MILLER: In addition to these guys.

So, yes, that is what I'm saying, and I am trying to point out to you that there is some relatively remedial fixes we believe we could come back to in a rationale way in January, put on the table. You guys could take a vote on it. We can continue a longer run research.

To try and directly answer your question -- and again, I'm looking at Dana, and we've having a discussion

about her workload in public, so this will be awkward.

[Laughter.]

DR. MILLER: And I will pay for it.

MS. KELLEY: It's the holidays, Mark.

DR. MILLER: So I could imagine us coming back with, all right, if you move from 3 to 5, 3 to 10 --

MS. KELLEY: Yeah.

DR. MILLER: -- you know, here's the amount of dollars, here's the rough distributional impacts across the categories, that type of thing, in addition to trying to answer the more detailed questions that you asked as best as possible, and then some language for -- I don't know why I keep referring to Kathy, but some language for the secretary about more directed program integrity activities would be the idea.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: I guess I was trying to think through a little bit a hear you think a little bit more about the kinds of information you'd be able to give on this sort of expanding outlier pool options.

I mean, is it -- there's one thing that it would be an effect on different kinds of institutions, and you've

hinted at that already, and another is sort of the kinds of cases. And you may have already given us at some point -- and I don't remember at the moment -- sort of what are the cases that tend to fall in the outlier pool. And, again, somebody talked about the game-ability of it and trying to understand which cases tend to fall there, if that's just more of the above if you expand the pool or at some point do you get into a different type of case. That might help us think through the things like the game-ability.

MS. KELLEY: Yeah. I think we can get that as well.

DR. HOADLEY: Okay.

DR. CROSSON: Okay. If there are no more comments, then thank you very much, Dana, and we'll return to this topic again in January.

So our last presentation is Stephanie.

[Pause.]

DR. CROSSON: Good. Our last presentation for our December meeting is on long-term care hospitals, updates. Stephanie.

MS. CAMERON: Good morning. Today, we are here to discuss how payments to LTCHs should be updated for

fiscal year 2017. We will discuss changes in policy that are current law. Then, using the established framework, we will evaluate the adequacy of Medicare payments and LTCHs.

First, I will summarize some background information that was included in your mailing materials. To qualify as an LTCH under Medicare, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average Medicare length of stay of greater than 25 days.

Care provided in LTCHs is expensive. The average Medicare payment in 2014 was over $40,000. Similar to a short-stay acute care hospital, Medicare pays LTCHs on a per discharge basis with an upwards adjustment for cases with extraordinarily high costs. Unlike acute care hospitals, LTCHs also have a downward payment adjustment for cases with extremely short lengths of stay.

Beginning this year, an LTCH discharge must meet several criteria to qualify to receive the full LTCH payment rate. First, the case must not have a principal diagnosis relating to a psychiatric diagnosis or to rehabilitation. Second, the LTCH admission must be immediately preceded by an acute care hospital stay.

Third, 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. As you'll recall, the criteria to qualify for the full LTCH standard payment rate are consistent with the direction of the Commission's 2014 and 2015 recommendation for chronically critically ill beneficiaries.

The Pathway to SGR Reform Act also changes the calculation of the 25 day average length of stay requirement to exclude cases paid the site neutral rate as well as cases paid by Medicare Advantage. The legislation also created a moratorium on facilities and additional beds, with some exceptions, through September of 2017.

Although this policy begins in 2016, most hospitals will not be affected until the latter half of the fiscal year. We don't expect to see changes in the claims data reflecting the start of this policy for several years.

I will now turn to the question of how payments

to LTCHs should be updated for fiscal year 2017. 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 on changes in capacity and use. As you know, historically, this product has not been well defined and it's often not clear what Medicare is purchasing with its higher payments. The absence of LTCHs in many areas of the country makes it particularly difficult to access the adequacy of supply.

While about 60 percent of fee-for-service beneficiaries live in counties without LTCHs, over 95 percent of beneficiaries live in counties with at least some LTCH use. 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 top ten percent of counties use 21 days per 100 fee-for-service beneficiaries. Further, almost three-quarters of these counties are located in just three states.

Given this high concentration of LTCH use, most

beneficiaries receive care at 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 capacity. Capacity is difficult to determine, given the variation across markets and LTCH occupancy rates that average 65 percent. Here, we show the cumulative growth rates that average -- excuse me. Here, we show the cumulative growth rate of LTCHs in beds since 2006. The moratorium began in 2007, but took several years to slow the growth of LTCH expansion given the exceptions provided by law. We found a reduction in the rate of growth of LTCHs starting in 2009.

You'll note the dash lines between 2012 and 2014. Because of inconsistencies in the cost report data, we analyzed Medicare's Provider of Services file. We estimate that the number of both facilities and beds decreased by about one percent between 2012 and 2013 and further estimate that there was as 1.7 decrease in beds and a 2.2 percent decrease in facilities between 2013 and 2014.

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 after 2011, when volume peaked at 38.3 cases per 10,000 beneficiaries. Volume further declined 2.6 percent between 2013 and 2014 to equal 35.7 cases per 10,000 fee-for-service beneficiaries. As you've seen, this decrease in volume has been observed across other inpatient settings, as well.

In terms of quality, LTCHs began submitting quality data on a limited number of measures to CMS using the LTCH care data set and the CDC's National Health Safety Network on October 1st of 2012. None of these data are currently available for analysis. However, we expect CMS to begin releasing this data publicly beginning in the fall of next year. In the meantime, we continue to rely on claims data to assess gross changes in quality of care in LTCHs.

Between 2010 and 2014, 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, about one-quarter 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 46 percent for patients with septicemia and prolonged mechanical ventilation to a low of three percent for patients treated with after-care with major complication or comorbidity.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of Medicare payments, since Medicare accounts for about half of LTCH total revenues. Historically, however, the availability of capital said more about the uncertainty regarding the regulations governing LTCHs as well as the effect of the prior moratorium than it did about payment rates.

Since the phase-in of the payment criteria began in October, we expect LTCHs to be working toward patient compliance over the next several years. Ultimately, we expect LTCHs 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 rules governing the LTCH payment policy would typically increase the availability of capital, the new moratorium significantly reduces opportunities for expansion and, thus, the need for capital.

Turning now to LTCHs' per case payments and costs, 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 costs 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 2013 and 2014, the average cost per case increased 2.2 percent. Starting in 2012, Medicare payments increased more slowly than the rate of increase of provider costs. This slow payment growth can be attributed to the second year of the application of a budget neutrality adjustment and to sequestration.

Margins tracked the trends you see here, rising rapidly after the implementation of the PPS to a high of 12

percent in 2005. At that point, as growth in payments leveled off, margins began to fall. However, after 2008, with cost growth well under control, LTCH margins began to increase again until 2013. In 2013 and 2014, cost growth exceeded payment growth. The reduction in cost growth between 2013 and 2014 resulted in a 2014 aggregate Medicare margin of 4.9 percent, reflecting the effect of sequestration.

As you've heard from other presentations, this year, we are providing another piece of information to consider in evaluating the adequacy of payments, the marginal profit. This measure assesses whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. Because the average LTCH marginal profit was 20 percent in 2014, we contend that LTCHs have a financial incentive to increase their occupancy rates with Medicare beneficiaries.

Now, to provide more detail regarding the aggregate Medicare margin. As you can see, there is a wide variation in the Medicare margins similar to what we see in other settings, with the bottom quartile of LTCHs having an average margin of minus-15.3 percent and the top quarter

having an average margin of 18.9 percent.

In contrast to other sectors, the average margins are similar between rural and urban facilities this year. However, consistent with other sectors, the for-profit facilities have the highest average margin, at 6.9 percent, while nonprofit facilities have the lowest average margin, at negative-2.8 percent. There are a number of reasons why LTCHs have lower costs and higher margins that we will discuss on the next slide.

We look more closely at the characteristics of established LTCHs with the highest and lowest margins. This slide compares LTCHs in the top quartile for 2014 margins with those in the bottom quartile. As you can see in the top line, high-margin LTCHs tend to be larger and have higher occupancy rates. They also likely benefit more from economies of scale. Low-margin LTCHs have standardized costs per discharge that were 35 percent higher than the high-margin LTCHs.

High-cost outlier payments make up a 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 payment. Lastly, high-margin LTCHs are much more likely to be for-profit.

We previously discussed the 2014 margin for all Medicare LTCH claims. Now, we turn to a second margin calculation that includes only cases that would qualify to receive the full LTCH standard payment rate. To calculate a margin for only qualifying cases, we use the most recently available claims data combined with revenue center specific cost-to-charge ratios for each LTCH.

Using this methodology, we calculated a pro forma 2014 margin of 7.4 percent. While this finding may seem counterintuitive when compared to the 4.9 percent aggregate margin we reported earlier in this presentation, these findings are consistent with an RTI and Kennell Associates report on the chronically critically ill LTCH population. Nonetheless, we will continue to evaluate our methodology over the policy's transition period.

We project that this LTCH margin will decline in 2016. Updates to payments in 2015 and 2016 were reduced by a PPACA-mandated adjustment. CMS also made a budget neutrality adjustment in 2015 that further reduced the payment update.

There is a high degree of uncertainty regarding changes in admission patterns and cost per case associated with implementing the new patient-specific criteria. Because of this, we will be providing a margin range as part of our analysis. We expect cost growth to be higher than current law payment growth for the qualifying cases as the LTCH dual payment structure is implemented.

Using the projected growth in the LTCH marketbasket, we project that LTCHs' Medicaid margin for qualifying cases paid under the LTCH PPS will be between 3.2 percent and 5.8 percent in 2016. Again, this margin projection reflects only cases that qualify to receive the full standard payment amount. LTCHs' aggregate Medicaid margin could differ to the extent that providers continue to provide care to beneficiaries who do not qualify to receive the full LTCH standard payment.

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 or improving. The effect of the current moratorium combined with adjustments to meet the patient specified criteria

will likely limit growth at this time. Our projected margin for qualifying cases paid under the LTCH PPS in 2016 is between 3.2 and 5.8 percent.

We make our recommendation to the Secretary because there is no statutory update to the LTCH PPS. As a reminder, this recommendation applies to the LTCH standard payment rate.

With that said, the Chairman's draft recommendation reads, "The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2017."

CMS historically has used the marketbasket as a starting point for establishing updates to LTCH payments. Thus, eliminating the update for 2017 will produce savings relative to the expected regulatory update, even assuming the PPACA-mandated reductions. 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 qualifying cases in LTCHs for fiscal year 2017.

With that, I turn it back to you.

DR. CROSSON: Thank you, Stephanie. Very clear.

Can I just ask one question? Compared to what we often look at, which is savings relative to current law, savings relative to expected regulatory update is, obviously, different. Is that a scorable thing, or is that just not?

MS. CAMERON: It is. So, CBO sets its baseline based on historical patterns of what the Secretary or the statute has done. Because the Secretary has given LTCHs an update and has a marketbasket update for the LTCHs, that is part of the baseline. So, CBO does assume the Secretary will provide LTCHs with an update with, of course, the marketbasket update adjusted for productivity as well as the additional PPACA adjustment. So, it would result in scorable savings.

DR. CROSSON: Thanks. Thanks very much.

Okay, clarifying questions. David, Warner, Jack.

DR. NERENZ: Thanks, Stephanie. A couple times, I think you used the phrase "higher payment." Can you just clarify, what are we comparing to what there under that phrase?

MS. CAMERON: So, in context of the cases that qualify relative to the cases that would be paid the site

neutral rate, cases that qualify receive the -- qualify to receive the LTCH standard payment amount.

DR. NERENZ: Yes.

MS. CAMERON: Cases that don't receive an IPPS comparable amount or 100 percent of cost, and that is typically much lower than the LTCH standard payment rate.

DR. NERENZ: Okay, so in -- all right. So, that is good. So, it is those two things being compared.

MS. CAMERON: That's right.

DR. NERENZ: Thank you. Okay.

DR. CROSSON: Warner, and then Jack.

MR. THOMAS: So, just a couple of questions. One, so you had mentioned that there's quality metrics that have been reported, but they're not public yet, is that correct?

MS. CAMERON: That is correct. In the last rule that CMS published, they said that there was an expectation that the quality data would become available in the fall of 2016. That said, I think we will have to see what is released at that time to determine if we can work that into future analyses.

MR. THOMAS: So, at this point, there's really no

payments in LTCH tied to any sort of quality metrics?

MS. CAMERON: There are payments tied to quality reporting. There's a 2 percent reduction to facilities that don't report on a series of quality measures.

MR. THOMAS: But are those outcome-oriented measures?

MS. CAMERON: They are not. It is pay for reporting.

MR. THOMAS: Okay.

And then on page 13, where you talk about the revised Medicare margin based upon this new payment methodology, have we projected, or do we have any sort of understanding of what the impact would be on the overall profitability of -- because it looks like this is Medicare profitability, correct?

MS. CAMERON: That is right.

So, on Slide 13, the margins presented there are Medicare margins specific to the cases that the 2014 data would have met the criteria to qualify for the full LTCH standard payment dates.

Given the amount of uncertainty in the industry, we don't know at this point exactly how the LTCH, either

admitting behavior or changes in cost, will ultimately end up, and therefore, we have a lot of -- there's a lot of uncertainty of where that margin would be. So we felt more comfortable providing a margin for the cases that we assumed would continue at the costs that have been historically reported.

MR. THOMAS: So, at this point, it's difficult to really project an overall Medicare margin or an overall industry margin at this point?

MS. CAMERON: For 2016, that's right. Yeah.

MR. THOMAS: Or even going forward with this new payment methodology. It sounds like this is a pretty material change.

MS. CAMERON: It's a very material change for the industry. Over time, I think once this policy has been implemented, once the behavior has been -- and once LTCHs have adapted to this new change in payment, I suspect we will be able to again provide you the total margin and project on the total margin going forward, but in this transition, our focus has been the cases that qualify for the full standard payment rate.

MR. THOMAS: Great. Thanks.

Mr. Chairman, will we have a Round 2 or not on this topic?

DR. CROSSON: Good question, Warner. I wanted to sort of get a sense of where we're going in terms of whether the questions are material to the recommendation or not. Some have -- we just started, but yours is. So I think if you want to expand on this question and suggest a different update, then we'll have a Round 2.

MR. THOMAS: I have a separate comment not related to the recommendation.

DR. CROSSON: Then we'll do that at Round 2.

MR. THOMAS: Okay. Thank you.

DR. CROSSON: Jack?

DR. HOADLEY: Yeah. You gave us a lot of text boxes and things in the chapter to talk about our past recommendations in the legislation. What's the main thing that is in our past recommendations that has not been incorporated in the legislative changes? What's still on the agenda of our old recommendations?

MS. CAMERON: So I think there were two kind of fairly significant differences between the legislation and a recommendation. The first was the legislation provided

for three days of ICU use where our recommendation was eight days.

On the other side, our recommendation did not tie the cases that did not meet the criteria to a lesser-of calculation of payment. So we had said that the cases should be paid in IPPS comparable rate, not this lesser of IPPS or cost.

The third tier to our recommendation was that there would be an increase in payments for these CCI cases in the acute care hospitals, and that was not written into law either.

DR. HOADLEY: Thank you.

DR. CROSSON: Bill Gradison and then Kathy.

MR. GRADISON: I found it very helpful in the preceding presentation with regard to the IRFs, the appendix, which compared the use of that type of facility by MA plans versus fee-for-service.

Is it possible, not necessarily by January, but is it possible to develop, looking forward, comparable information by comparing MA use versus fee-for-service use in the counties which have LTCHs?

DR. MILLER: The way we did that, if I remember,

we had to kind of go out and especially find that information, if I remember.

Do you want to come over here, Dana? Talk into the microphone.

MS. KELLEY: So the IRF analysis uses the assessment tool, the IRF pie, which facilities are required to perform for both Medicare Advantage and fee-for-service patients. So we have full information on Medicare Advantage use of IRFs. We don't have any assessment tool in the LTCH, and so any use by LTCHs would be -- any use of LTCHs for Medicare Advantage would be in the encounter data, I guess.

And the other thing I would add is that in the past -- this is a while ago -- we spoke with a number of Medicare Advantage plans about their use of LTCHs an generally found that they use them relatively rarely and predominantly for ventilator-dependent patients.

MR. GRADISON: Thank you very much. Thank you both.

MS. CAMERON: And we'll add to that as well. Where we do know Medicare Advantage uses LTCHs, the publicly available data we have on this, it's very low,

about 10 percent.

DR. CROSSON: I'm sorry. It's 10 percent of what?

MS. CAMERON: Medicare Advantage makes up about 10 percent of some LTCH days.

DR. CROSSON: I see. Thank you. Okay.

Kathy?

MS. BUTO: I'm just trying to understand the recommendation a little bit. If the Secretary eliminates the update -- first of all, our margin, the range that we've estimated the margins would be would obviously be lower, correct?

MS. CAMERON: That's right.

MS. BUTO: I mean, this assumes current law, so you've taken whatever the Secretary has done in the past and tried to estimate what that margin would be.

MS. CAMERON: Right. And for 2017, the data indicate that LTCHs would have otherwise received about a 1.7 percent update.

MS. BUTO: Okay. So are we basing eliminating the update on -- because given the estimate we have is 3.2 percent to 5.8 percent, because there have been some

impacts on what the margin would be going forward -- so are we basing that recommendation on the Medicare margin for qualifying cases? Is that sort of the way we're approaching this?

The other thing that you said that really struck me was their ability to adjust to whatever the payment is has been incredibly -- so they're very flexible in the ability to adjust their cost to accommodate any payment adjustments, it sounds like.

MS. CAMERON: Historically, that's what we have seen. This update does in fact speak to only the cases that would qualify to receive the full LTCH standard payment rate.

MS. BUTO: Okay. And the margins that we're estimating are higher, so --

MS. CAMERON: Right.

MS. BUTO: Thank you.

DR. MILLER: Sort of the way I think about it and the way we've tried to work through this -- and Stephanie has sweat a lot over this because we have this industry right in the middle of transition and sort of how to talk about this. And if this helps you, the way I think about

it is if you look at it the hold way, across all cases, it's about five. Our best current -- and, of course, we don't make the decision entirely on the margin, but to deal with your margin point. The best Stephanie can tell with the cases that would qualify with current data, it's actually higher. And then projecting forward, we expect a lot of change in this industry, and so she's giving you her best range, from 3 to 5 or whatever the actual final numbers were.

But whether you looked at this strictly as a CCI -- or sorry -- the qualifying cases using current data or all the cases using current data, it's 5 to 7, and I think that's the comfort range of saying no update, I think is the logic. Is that --

MS. CAMERON: That's right. I mean, we really don't know exactly how this, cases and the industry, will change.

AT this point, this quarter, only 12 percent of facilities will begin the implementation. There was an earnings call one month into the implementation for one of the for-profit chains, who reported that three of their facilities had converted to this new payment system, and

that each of those three facilities were in fact able to replace the patients, the site-neutral, the non-qualifying patients with patients that qualify.

Now, I will say this chain was very, very cautious in providing this information out of concern that maybe this won't be reflective of all of the facilities. That is one indicator, though, that there could be a lot of movement of beneficiaries.

DR. CROSSON: We're still on questions. Alice.

DR. COOMBS: Round 2?

DR. CROSSON: Well, we can go to Round 2. Are you on Round 2? So I think actually Warner was first, and then we'll got Alice and then Rita.

MR. THOMAS: So my Round 2 comment isn't specifically at LTCH. It really is specifically at post-acute in general, and one of the things that we're doing actually with one of the rehab providers is constructing a facility to put all of our -- new facility that's putting all post-acute in one facility. And I would just encourage us -- this may be outside of the realm of the payment update, but to take on or to look at the possibility of a post-acute payment because, essentially, what you have is

it's very difficult to ascertain where patients should go. Should they go LTCH? Should they go SNF? Should they go IRF? And it's very difficult.

And the regulations are problematic for folks that are in this each and every day. I know it's not necessarily for this meeting, but I would encourage us to put that on our agenda to think about how we could provide some advice and guidance as to what that might look like going forward.

DR. MILLER: And you'll see it next month, so we do have this conversation going about trying to look across, you know, getting a more unified payment system for post-acute care broadly. We had some conversation starting in the fall, and the next one comes up in January, unless I'm forgetting. So we'll be right back to this.

MR. THOMAS: So I teed it up right for you, Mark?

DR. MILLER: It was perfect.

MR. THOMAS: Perfect timing? Good.

DR. CROSSON: So, given your predictive accuracy, I will accept investment advice from you.

[Laughter.]

DR. CROSSON: Okay.

DR. COOMBS: Thank you very much, Stephanie. Excellent presentation.

As we have talked about the CCI cases and site neutrality, one of the questions I had was, going forward, how much of this LTCH population is going to be in that site-neutral versus what we would have anticipated if we got a recommendation of eight days of intensive care, and I think that recommendation was a very good recommendation.

Part of the missing piece of the puzzle in terms of being more persuasive would have been if we could have said that by going to that benchmark of eight days, it would have decreased the likelihood of overpayment or more appropriate payment for X number of patients, and I think that would be a more persuasive argument.

As you know, LTCHs serve a definite role. I being an ICU person understand that the role that they play is really cardinal for mechanically ventilated patients and also the ones with wound vacs -- and we talked about them -- because of the protocols that are in the LTCHs, which are different than what you would see in a SNF or an IRF. So they have mastery in terms of protocols for those type of patients. However, we all agree that they have other

patients there, that this overlap is tremendous.

So I was looking at two things. One is, what is this big patient population at the LTCH? How big is it? And then how better can we persuade that going to an eight-day ICU length of stay is a better benchmark rather than a three-day?

MS. CAMERON: The eight-day ICU stay requirement would have encompassed, I believe, about 36 percent of the LTCH fee-for-service beneficiaries.

We base the eight-day ICU stay on several reports to CMS that were done by Kennell and RTI, and the eight-day was the number that they showed only -- I believe the LTCH setting was the only setting in the post-acute care realm that saw patients with eight or more days in the ICU, and ultimately, that's how we ended up with the eight-day recommendation.

DR. COOMBS: So one of the things I'm thinking about is that three-day ICU stay encompasses all kind of cases. I mean -- and some that are not really appropriate for an LTCH, and so to steer those patients, I mean, in some settings, they might be steered to an LTCH when they didn't need to have that kind of level of intensity.

MS. CAMERON: I mean, I think -- yes. I think the Commission picked eight days for a reason. The legislation picked three, so there is kind of a differential there where one could say the eight days as a more strict requirement does better capture the population that we feel should be in LTCHs.

As we do look even at the three-day differential, we find that the types of cases are much more concentrated in the top kind of 25 diagnoses. So, as you remember, if you look at all of the Medicare cases in LTCHs, the top 25 diagnoses make up about two-thirds of those patients. When we only look at the cases that qualify -- so I'm only using the three-day definition -- we're basically looking at almost 80 percent of those cases.

So, even going from kind of a no criteria to three-day, you do get some increased concentration. I haven't looked at that, however, for eight-day, so that is something I can see if I can get to you.

DR. COOMBS: Okay. My only comment is that we're looking at things that we do for the general population, but I'm thinking that if you can internally change the behavior of what gets sent to the LTCH, that's probably

more powerful than just saying whatever we're recommending for this year's uptake.

DR. CROSSON: Rita.

DR. REDBERG: Thank you, Stephanie, for an excellent chapter on a really complex -- you know, with changing legislation and moving targets.

So my comments really are similar to things we have discussed before, but I have a lot of concerns that long-term care hospitals fit into the whole sort of goals of higher quality, better value, and better outcomes because these are clearly very expensive places to care for people. The outcomes seem very poor. The third most common LTCH DRG was septicemia without ventilator support, which had 46 percent mortality. I mean, all the mortality rates are incredibly high. We don't do it, but I suspect patient satisfaction is low because people don't like to die in institutions on ventilators. They prefer to be at home, if possible.

And I think some of this is quite predictable that the mortality rates would be high. Clearly, these people are sick, but I think -- yesterday we talked about hospice care, an increasing use of hospice care, and I

think there you have -- perhaps the outcomes would be similar. These are very sick people, but putting them in a very expensive, unpleasant, uncomfortable place without really realistic hope of improvement, I'm not sure is good for the patient or the program. The fact that there's such variation in use of LTCHs without difference in outcomes doesn't make one question how are these contributing at all to improving care. It's a lot of money that going into these programs.

DR. CROSSON: So I think a couple things. As Mark said and Jim confirmed, in January we are going to be looking at sort of a site-neutral post-acute care policy, which could resolve some of that, and we're still left in this particular case with the fact that, as you know, in many parts of the country, it's very hard to find a place to place someone who needs ventilator care, and so that part of the problem.

DR. MILLER: So the other thing I would say -- and we do this at this particular time of the year, and the Commissioners regularly express some frustration with it. We're talking about -- by law, we have to talk about what to pay the IRF. Don't forget -- and this is what Alice was

saying -- we've made a separate recommendation that the right way to target patients for this -- and I'm not being very articulate, but this particular setting -- is this eight-day ICU, and then we also made exceptions for ventilator patients, which I couldn't articulate that rule right off the top of my head. But I know Stephanie could.

So while we're not talking about it aggressively at the moment, don't forget we've also said in this setting that there is a much more targeted way to go at this in a set of patients that might make more sense to be there, although even in that population, I imagine many of your comments still stand about where somebody should spend the last days of their life. I don't mean in any way to reject that, but the notion of trying to get the best spend for the dollar is decidedly tied up in this eight-day thing.

And I didn't make the comment when Alice was making it because it was a real cheerleader comment, which I'm not really particularly good at. The way I see the situation is the Commission came along and said it should be eight, and in a relatively short framework, the Congress went to three, which in some ways, given the way things work, is pretty huge. But, as Alice says, we're still not

there, and that's what I'm also trying to say to you.

DR. NERENZ: Well, just to follow on Rita's comment, I think as we have this discussion of a broader post-acute care model, and this would also tie to Warner's, up until your comment, I hadn't thought about life expectancy or severity of illness as a key part of that, and I think we'll just need to explore, particularly with leadership from the clinicians here, about how much of a branch point or a grouping point that could be. Because I understand sometimes you don't know or it's not clear.

But the last line of discussion was kind of about LTCH versus hospice, but I'd been thinking about LTCH versus acute care as something else. I think what underlies that is the sense of, are we talking about someone who's very unlikely to survive or are we talking about somebody who's very likely to survive? So that's just an observation. I think it enriches the discussion.

DR. MILLER: I'm sorry to run this on and I'll stop, but early on, and it's been many years now, we did site visits to LTCHs when we first, very first, years ago, tried to break ground on this area. And I remember specific conversations going from LTCH to LTCH with medical

directors saying precisely what Rita was saying. Many of the people in here probably should be in hospice, and either just didn't understand their options, conversations that we've had here about kind of even how physicians deal with it, and of course, families who want to deal with their relatives in a particular way. But decidedly, this came up repeatedly in those conversations with medical directors.

DR. HOADLEY: Just following on that point, I remember some of those interviews where people would say, you know, because we have an LTCH, it gives us the basis to avoid that conversation. When we don't have an LTCH, if you're in a particular community LTCH, okay, there aren't good options, so let's talk about what hospice could mean and let's have that end-of-life conversation. And so, you know, the presence of different kinds of sites gives incentives or disincentives to have those conversations in kind of subtle and maybe not to subtle ways.

DR. CROSSON: Good discussion there. Other comments?

So where we are here is we have a recommendation to eliminate the update, and I think Stephanie has been

very clear that there's a little bit of a level of uncertainty going on, particularly because of the application of the regulations passed in the Affordable Care Act. Nevertheless, in the conversation I didn't hear a lot of suggestion that we should do something different with respect to the update at this point in time.

So I just want to test that and see if that's, in fact, the case, if people are comfortable going ahead with this recommendation and then put it into expedited voting in January. I'm getting general agreement. Got these frozen in place, but other --

MS. BUTO: I mean, the way you described it is the way I feel, which is there's a lot of uncertainty about this. On the other hand, I'm very sensitive to the fact that I think many of us think there's an over-utilization of LTCH services for some patients. So I guess I'm glad in this case the Secretary will have to decide this and will probably have to go out with notice and comment before she does anything. I don't think we really know what the impact is of no update, but I'm comfortable with it. I think since we're recommending to the Secretary that she consider it, I think that's an appropriate thing.

DR. CROSSON: Okay. So seeing no objection, we'll go ahead with that in January. So if I have counted properly, it looks like in January we'll be coming back for more in-depth discussions on Medicare Advantage, on hospital and on IRFs. The other seven will be an expedited voting. We're going to talk about APMs. Jim, remind me. And then we're going to talk about unified payment for post-acute care. Anything else in January? Jim doesn't like to be surprised.

DR. MILLER: Well, Jim doesn't like to talk to people. Those will be two of the big things. I don't have January's agenda right up in my mind either. We're basically going to move on to our other issues. I think we're going to move on to our other issues, but two of them will be at least those.

DR. CROSSON: Okay. Having said all that, thank you. We are ready for our public comment period for this morning, so if there are any members of the audience who wish to make comments, now is the time to come to the microphone and identify yourself so we can see who you are.

[No response.]

DR. CROSSON: Seeing none, we are adjourned for

our December meeting. See you all next year.

[Whereupon, at 10:33 a.m., the meeting was adjourned.]