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 8, 2016
9:43 a.m.

COMMISSIONERS PRESENT:

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JON B. CHRISTIANSON, PhD, Vice Chair
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KATHY BUTO, MPA
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AGENDA PAGE

P R O C E E D I N G S

[9:43 a.m.]

DR. CROSSON: Okay. I think we'll get going now.

I want to direct a few remarks to our audience. Many of you are veterans of MedPAC discussions. Some of you may not be. Every December and January, we turn our attention here at the Commission to recommending, mostly to the Congress, payment updates for the various areas for which Medicare is the payer. Then those are directed at the fiscal 2018 budget.

When I say payment updates, of course, update may mean a recommendation to keep the payment the same, to recommend that current law be the recommendation, or in some cases to increase payment or in some cases to decrease payment based upon the analysis and the facts that are presented to us by the staff.

The recommendations are presented twice: here at this meeting in December, where we have a robust presentation and a discussion, and then a second time at the meeting in January where we will have a formal vote on the recommendations.

That said, it has been the tradition over the

last few years that where we see a broad consensus, where I see a broad consensus on the part of the Commission for the recommendation that's on the table here at the December meeting -- and I will ask the Commissioners if that is, in fact, the case -- then we will not repeat the detailed discussion, the detailed facts in January; but for those particular items, we'll have a facilitated, shortened presentation and a rather immediate vote on those issues. So you may see by the time of the January meeting that the substantial discussion of issues has taken place already at this meeting.

I guess the only other comment I'd like to make, because in the past we've had questions about this, as we make our determinations, as we look at the factors -- quality, capital adequacy, access to capital adequacy, and other things -- as we go through that rather formulaic discussion, the question sometimes comes up: Well, you know, what about the sequester? Because there is, in fact, still a sequester in place, a 2 percent reduction across the board. And I want Mark to just make a point there.

DR. MILLER: Yeah, the quick point is that the -- we work with all of our claims and cost report data. The

sequester effects are reflected in all of that data. So in all of the numbers that we present, the effect of the sequester has already been baked in or is already part of the analysis -- is sort of the way I would put it.

And the only other thing I would say, we do this each year because by law we're required to go through and make the recommendations that Jay is talking about.

DR. CROSSON: So we will today and tomorrow be making recommendations in nine areas of Medicare payment, and also it is our custom at this time to do a review of the Medicare Advantage program, whether or not there are recommendations to be made or not. And so the Medicare Advantage presentation is the first order of business. Scott Harrison and Carlos Zarabozo have the floor.

DR. HARRISON: Good morning. I'm going to present our analysis of the Medicare Advantage enrollment and bids for 2017, and I will present a Chairman's draft recommendation for you to discuss. Then Carlos will give you an update on MA quality.

In 2016, MA enrollment grew to 17.5 million enrollees; 31 percent of all Medicare beneficiaries are enrolled in Medicare Advantage plans.

Since 2007, enrollment has more than doubled and plans project continued growth for 2017.

Overall MA growth in 2016 was about 5 percent, and by plan type, enrollment in HMOs grew 6 percent, local PPO enrollment grew 3 percent, and regional PPO enrollment grew by 7 percent. And while still significantly higher than the growth in fee-for-service enrollment, I should note that the 5 percent growth figure is lower than the average 7 percent annual growth we have seen over the prior few years.

In 2017, Medicare beneficiaries have a large number of plans from which to choose, and MA plans are available to almost all beneficiaries.

On this chart you can see trends over the last seven years, but to save time let's just walk down the 2017, or right-hand, column: 99 percent of Medicare beneficiaries have at least one plan available; 95 percent of beneficiaries have an HMO or local PPO plan operating in their county; 74 percent have a regional PPO available up from 73 percent as there is now a plan being offered in the Maine/New Hampshire region; 45 percent have a private fee-for-service plan available, down

slightly from the last couple of years, and a continuation of the expected decrease resulting from pre-PPACA legislative changes.

The average number of plans available in each county increased slightly to 10. 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 2011 levels is due to the decrease in private fee-for-service offerings.

Finally, the average rebate that plans have to invest in extra benefits in 2017 has increased to $89 per member per month for non-SNP, non-employer plans -- the highest level during this time period.

So we see here that over the period where the benchmarks were brought down by PPACA, plan availability has not eroded, except for the expected decline in the private fee-for-service plans. Availability has remained constant for coordinated care plans, and rebates have been rising.

Using the plan bids, we estimate that in 2017 Medicare Advantage benchmarks, bids, and payments, including quality bonuses, will average 106 percent, 90

percent, and 100 percent of fee-for-service spending, respectively. These numbers are down from 2016, and down is usually good.

While plan bids average 90 percent of fee-for-service, that number is kept down because HMOs are bidding 88 percent of fee-for-service on average. The other plan types bid much higher, and local PPOs are bidding 101 percent of fee-for-service.

Now, in 2017, the quality bonuses add an average 4 percent to the benchmarks and 3 percent to payments. So even though the bids are often well below fee-for-service, on average Medicare is still paying about 100 percent of fee-for-service because the benchmarks, including quality, average 106 percent of fee-for-service. And without the quality bonuses, they would average 102 percent. Carlos will shed some light on the quality benchmarks shortly.

Now, here, finally, note that all the numbers on this slide assume that risk differences are properly accounted for, and remember last month Andy found that coding intensity increased MA risk scores by an average of 4 percent more than CMS' adjustment.

So payments would average 104 percent of fee-for-

service if coding intensity differences were included rather than the 100 percent on the slide.

So to sum up the current MA program status in broad terms:

In 2016, MA enrollment grew at about 5.5 percent, which is double the overall Medicare enrollment growth. And currently at least 31 percent of all Medicare beneficiaries are enrolled in MA plans.

There has been improvement in some measures of plan availability, especially an increase in the rebates that provide extra benefits.

The pressure on the benchmarks has led to pressure on the bids, and they have declined to 90 percent of fee-for-service on average.

As a result, there has been progress toward financial neutrality with Medicare fee-for-service. If there were no risk coding differences, MA plans would be paid on average roughly the same as fee-for-service in 2017.

But there are still some payment and equity issues. There is the 4 percent in coding differences unaccounted for, and there are some inter-county benchmarks

inequities that could be addressed.

One equity issue we discussed last month, and today we have a Chairman's draft recommendation on it for your consideration.

Hopefully, you remember this issue from last month. CMS calculates average risk-adjusted per capita fee-for-service Part A spending and Part B spending for each county that is used for setting county benchmarks.

The calculation includes spending for all fee-for-service beneficiaries in Part A and/or Part B. All are included whether they have both Part A and Part B or they have Part A only or B only.

For shorthand today, let's just refer to these beneficiaries as all fee-for-service beneficiaries.

The main problem with this approach is that MA enrollees must be enrolled in both Part A and Part B. And our most recent data show that only 87 percent of fee-for-service beneficiaries are enrolled in both Part As and B.

And we have found that beneficiaries who are in enrolled in both Parts A and B have higher spending than other fee-for-service beneficiaries.

There are several issues arising from the

inclusion of all beneficiaries in the fee-for-service spending calculation.

The big spending difference between all fee-for-service beneficiaries and those with both Parts A and B arises because 12 percent of all beneficiaries have Part A only, and they are much less costly for Part A than those with both A and B. This results in an underestimate of fee-for-service spending comparable to MA spending and thus an underestimate of the MA benchmarks.

I should note here that those with Part B only do not significantly affect the average spending numbers.

Across the country, the Part A only effect on the benchmarks varies because there is a lot of variation in the percentage of Part A only beneficiaries in the fee-for-service population. The share of A-only beneficiaries reaches 25 percent in some counties and is as low as 3 percent in others. And recall from last month that Part A only beneficiaries are growing nationally as a share of fee-for-service beneficiaries.

So what if CMS were to use only beneficiaries with both Part A and Part B in the fee-for-service spending calculation?

We found total average fee-for-service risk-adjusted spending for beneficiaries enrolled in both Part A and Part B is about 1 percent higher than the average spending for all fee-for-service beneficiaries, so almost all counties would have higher benchmarks.

However, counties with the highest share of their fee-for-service beneficiaries in Part A only would likely have higher increases, up to 3 percent. Areas such as Pittsburgh, Denver, Albuquerque, Portland, Oregon, Hawaii, and several areas in California have 20 percent or more of fee-for-service beneficiaries in A only. These areas all have very high MA penetration rates, and the estimated effects of using only beneficiaries with both Part A and Part B on fee-for-service spending could have a significant effect in areas like these.

Alternatively, counties with significantly lower shares of A-only enrollment may see little or no change.

As MA penetration continues to grow, we expect these calculation issues to grow. Higher MA penetration leaves fewer, and perhaps less representative, beneficiaries on which to calculate fee-for-service spending.

Because by law beneficiaries must have both Part A and Part B to enroll in MA, it might be more equitable for CMS to calculate the county-level fee-for-service spending on which the MA benchmarks are based, using only fee-for-service beneficiaries who have both Part A and Part B. This way the calculations would be more reflective of MA enrollment.

So the Chairman's draft recommendation reads: "The Secretary should calculate MA benchmarks using fee-for-service spending data for only beneficiaries enrolled in both Part A and Part B."

Compared with the current CMS process of calculating the county-level fee-for-service spending based on all fee-for-service beneficiaries, we believe that using the average fee-for-service spending of only beneficiaries with both Parts A and B in the benchmark calculations would increase benchmarks by about 1 percent nationally.

There could be some redistribution of plan payments, but most plans would see increased payments, depending on the counties they serve. Beneficiaries' access to plans and enhanced benefits may increase based on plan reactions to those changes.

Now Carlos will give you an update on quality in MA.

MR. ZARABOZO: Before getting to the update on quality, we would like to address two questions from a prior meeting that Rita asked. One question you raised was regarding response rates for the CAHPS patient experience measures. In your mailing material, we show recent CAHPS data indicating that such measures were about the same for fee-for-service as they were for MA. The response rate for the fee-for-service CAHPS survey in 2014 was 41 percent. For the MA plans, each plan contracts with a survey vendor to survey the plan's members, and the response rates vary by plan. In 2014, the median response rate among plans was 45 percent.

The other question you asked, Rita, was how many beneficiaries were enrolling in plans that CMS identified as low-performing plans, which are contracts with three consecutive years of star ratings below three on the five-star scale. As of October 2016, there were 67,000 enrollees in six contracts with a low performance indicator. One of those contracts has been terminated under CMS' authority to terminate low-performing

contractors; one left the program; another improved to three stars; and, finally, three of the contracts were consolidated with other, higher-rated contracts to avoid possible termination -- which is a practice we'll discuss more in a minute.

Now, turning to this year's analysis on quality in MA, we found that quality indicators generally remained stable over the last year, with fewer than one-third of measures improving and a small number declining.

A subset of the quality measures that we examine form the basis of plan ratings in the five-star rating system. Plans at four stars or higher received the bonuses that Scott mentioned. Over the past year, there was a net decline of about 1 million in the number of beneficiaries in plans rated at four stars or higher, based on the October 2016 enrollment distribution -- that is, based on the current enrollment distribution. Over the past few years, the net number has generally increased year over year. The decline in bonus-level contracts is due to several measures having a higher threshold for achieving four-stars status, and in the case of one particular company, the company's poor performance in an audit of

administrative aspects of the company's Medicare contracts -- in particular, the processing of appeals.

For bonus payment purposes, in 2017 plans will receive bonuses based on their ratings from last year, not the current ratings. Something that affects the share and number of beneficiaries in bonus plans is contract consolidation, where a company will fold one contract's enrollees into another contract, which is then the sole surviving contract that combines all enrollees. When there are contract consolidations, the contracts involved can have different star ratings. In 2017, about 700,000 enrollees are being moved from a contract that would not have been in bonus status to a contract that is in bonus status. This practice has been going on over the past several years.

In your mailing material, we raised some continuing concerns about the star rating system. One of the purposes of the star ratings is to give beneficiaries information about the level of quality among the plans in the area where the beneficiaries reside. The current practice is to have plans measure and report quality at the level of the Medicare contract. Medicare contracts can

cover very wide geographic areas because of contract consolidations over the years. Currently, one-third of beneficiaries are in organizations that have substantial enrollment in non-contiguous states.

As a result, contract-level star ratings that a beneficiary sees in his or her community may not represent the performance of the plan in that particular geographic area. Instead, what the beneficiary sees is the national average performance for the entire contract.

Generally, with regard to systems for rewarding improved quality, the Commission has favored the establishment of predetermined thresholds. A target threshold can be established that represents an improvement over past quality. The star system is a method for determining relative quality among contracts in a given year. Plans are able to receive bonuses even if there has been no improvement in quality in the MA sector compared to past performance. Establishing predetermined thresholds may be a better way of ensuring that what is rewarded constitutes improved quality within the sector.

Given the concerns we have with the star system, over the next cycle the Commission could work on developing

policy options to address the concerns.

This concludes our update presentation. We look forward to your questions and comments and your discussion of the Chairman's draft recommendation.

DR. CROSSON: Thank you, Scott and Carlos.

We'll take clarifying questions. Paul.

DR. GINSBURG: As far as the contract consolidations, I can see the very large effect that some recent ones have had on star ratings. Is this a one-year effect, or is this something that could happen for any particular consolidation, affected for many years?

MR. ZARABOZO: Well, the example given in the mailing material where there's a large influx of low star-rated members --

DR. GINSBURG: Yes.

MR. ZARABOZO: -- you would think that in the following year that they would swap the results of the highly rated contract. So it could be a one- or two-year effect. It doesn't mean there could be subsequent consolidations.

DR. CROSSON: Okay. Bill Gradison.

MR. GRADISON: In the mailing material, there's a

table on page 14, which has a breakdown of the MA plans and the percentage coverage. This is a general comment, but it does apply to this chapter and to our report to Congress. I think we ought to separate the percentage of the 65 and older from the disabled. It's significantly different.

And, frankly, that 30 percent as a result somewhat understates when people -- when you say 30 percent are covered, I think a lot of people think, well, that's just the elderly. I mean, I think it's very easy to fall into that, and it's somewhat higher, obviously, because there's a substantial proportion of Medicare beneficiaries who are there on the basis of disability rather than age. So I don't know if it's Part 1 of Part 2, but I just wanted to suggest a change or adding that to the table on page 14, however is easiest for you. Thank you.

DR. CROSSON: Thank you, Bill.

Jack.

DR. HOADLEY: Yeah. We may have covered this in the previous meeting, but it's forgotten. The recommendation is aimed at the Secretary. So I gather the Secretary has discretion within the statute to do these kinds of adjustments?

DR. HARRISON: We believe so, yeah.

DR. HOADLEY: Okay.

DR. CROSSON: Jon.

DR. CHRISTIANSON: In the paper on page 18, you comment, which I think is very important, on the percentage of enrollment that are in the top four plans -- not plans. I shouldn't use that word. The top four organizations. And the trend there has been an increasing percentage of the enrollment over time in the top four organizations. I think this is really important for the stability of the MA program, and I would like to see that highlighted more.

I've also seen other sources of data for publicly traded plans talk about the percentage of profit that some of these plans -- that these plans make that come from their Medicare Advantage contracts, and I think that would be useful information to have in this report too.

Overall, I think you two do wonderful work in terms of tracking the Medicare Advantage plans and identifying the things that are in this paper. I don't know anybody that does this as well or as comprehensively as you people do. It's great work, as always. I'd just like to see it expanded in those areas because I think long

term, it's pretty important for the Medicare Advantage program to have those facts.

DR. CROSSON: Jon, I may have been distracted for a second, but when you said -- what was it you said was important for the stability, long-term stability?

DR. CHRISTIANSON: Increased concentration of enrollment in a small number of plans means that the decision of any one of those plans regarding whether to participate in the program or not has a big effect on Medicare beneficiaries, and so I think it's important for the Commission to sort of see what those potential effects could be.

DR. CROSSON: All right. By saying important, you mean impactful?

DR. CHRISTIANSON: Yeah. One decision affects a lot more beneficiaries in terms of whether they are going to be able to keep or have to leave their plan.

DR. CROSSON: Got it. Got it. Thank you.

Brian.

DR. DeBUSK: Regarding the consolidation of plans, again, where the beneficiaries are rolled over, is there anything that would prevent us just through a simple

rulemaking process to require the new or the emerging plan to have a star rating that's the weighted average, say, between the enrollees? Because I do see -- I see almost this ongoing system where you could simply start up a new plan, enroll 20,000, 40,000 people, get a high star rating. I mean, it just seems like this could go on and on, and if you used the weighted average approach on the front end, there would be no benefit to gaining the system, then.

As a follow-up, too, could you also speak to -- and I apologize, but as they consolidate these plans, we lose granularity into the specific regions because, again, these plans get bigger and bigger and cover larger geographies. Could you propose some ideas on how we could preserve granularity of reporting?

MR. ZARABOZO: Well, on the granularity point, we previously recommended that reporting should be done at the market area level. I mean, that's the longstanding recommendation of ours. The direction we've been going about consolidation matters, and you have these multistate entities, and so you really can't judge quality. That recommendation still stands as to what do you do about this issue. You could make it a local level reporting. A

little bit of a problem there is that some of the measures are based on medical record sampling, so you would have to do a higher level of medical record sampling than you do across an entire contract.

On the consolidations, the decision how to treat those was a CMS decision of what do you do in terms of the star ratings. So, presumably, they could take a different approach and say, well, you only get the bonus for those members that were actually in this kind of plan, so there are various things that you could do to address that, I think.

DR. CROSSON: Pat and then Bill.

MS. WANG: Following up on the previous two comments, do you have any sense whether or not consolidation for purposes of boosting star ratings into bonus territory is a driving factor behind some of the consolidation that Jon raised a concern about?

MR. ZARABOZO: No. Because this consolidation for star ratings is within the same company. This is what your -- yeah, it's not.

DR. CROSSON: Bill.

DR. HALL: The 12 percent of the population

that's only Part A, could you remind me are there other variables other than the increase in MA penetration? I'm not quite sure what that population represents.

DR. HARRISON: So you want to know who is A-only?

DR. HALL: Well, the increase. Yeah. Right.

DR. HARRISON: All right. Well, one possibility is let's say there's a group of A only, and they make up some percentage of the fee-for-service population. As you take out people for MA that are both A and B, you're leaving more people that are A only.

DR. HALL: So that's the reason. It's not that it's some other phenomenon going on like private insurance.

DR. HARRISON: Well, we're not sure, and we actually plan to do a little bit more work on this over the year.

DR. HALL: We've talked about making sure that all of our Medicare participants are well informed about their choices, and that there's no chance that some of the A-onlys really don't comprehend about the --

DR. HARRISON: I think there might be some chance.

MR. ZARABOZO: In terms of the penalty issues, it is a possibility.

DR. HALL: The reason I bring this up, the Medicare book, the "Welcome to Medicare" that just came out, it is about 250 pages, and I tried to page through some of that. And I really couldn't see anything that would say, "By the way, Part B might be a good thing for you, even if you're not in an MA plan."

DR. HARRISON: So, I mean, you know about getting --

MR. ZARABOZO: Well, for some people, this is a discussion when they apply for Social Security benefits. They're also applying for Medicare at that time, so you have that discussion there, but for other people, it's not the case. So there may be an issue with not fully understanding. Particularly the penalty issues, if you don't enroll initially, you have this penalty.

DR. CROSSON: So correct me if I'm wrong, but is it not true that some people who continue in employment, right, pass --

MR. ZARABOZO: Yeah. Some of these Part A-only people are people who have current employer-based coverage,

either through themselves or through a spouse, and making Medicare secondary, and those people do not have a penalty if they choose not to elect Part B. Once they leave the coverage, they can elect Part B without penalty.

DR. CROSSON: And so as we've seen, partly due to the recession, but then just due to more robustness in those of us who are considered seniors, who remain employed, we might see that as a consequence of that. Is that --

DR. HARRISON: Yeah. That's certainly one of the cases.

DR. GINSBURG: I think the trend is exacerbated by growth in Medicare Advantage as a percentage. It means that the remaining population is a heavier percentage of Part A only.

DR. CROSSON: Brian.

DR. DeBUSK: Does this also -- you know, you mentioned you were going to study this at some point. Does this also let us titrate the impact of an income-related premium? Because I would think this may be one of our few best chances to measure the effect of that perturbation.

DR. HARRISON: That's our intention. We're not

sure what data is available for this, but we're beating the bushes now.

DR. MILLER: The one data source that comes to mind is MCBS, but the sample sizes are kind of not what you would want, so we're looking around town for others.

DR. CROSSON: Alice.

DR. COOMBS: I was curious. Just a question on the side, does the switching back between Part A beneficiaries with Part A and B, the fee-for-service, does that change significantly? In other words, a few years ago, we looked at the shift from beneficiaries who were in MA plans to fee-for-service. Does that alter what subset of those patients who go back and forth?

DR. HARRISON: I think we would be surprised if people left MA and then also dropped B, but that's not something we've noticed, but something we could look at.

DR. CROSSON: Okay. Seeing no further clarifying questions, we'll now move to the general discussion. The topic on the table is the recommendation. We have Slide 10 there. So the discussion is support, changes, et cetera, to the recommendation. I see Kathy and Bill Gradison and Jack and David.

MS. BUTO: So I would support the recommendation. I'd also like us to consider a recommendation to the Secretary on the whole issue of reconsidering the way they do the consolidation quality bonuses. As Brian mentioned, either something like a weighted average or maybe it's just split the difference between the bonuses they would have received. There ought to be some way to calculate a bonus that's more appropriate, given at least the example you gave. Now, maybe that's an atypical example -- I don't know -- or maybe it's quite typical. So I'd like to see us look at a recommendation in that area.

DR. CROSSON: Bill.

MR. GRADISON: Maybe this is Part 1. Let me do it very quickly.

I wish we had data here -- and maybe in the future, you could develop some -- about the methods of compensation that are used for providers, especially physicians, in MA plans. I continue to hear a lot of them are paid basically fee-for-service on an RVU basis, with certain bonuses, and it has never been quite clear to me, even when I have conversations about it, just what are the bases for those bonuses.

But I think this is important. That it bears upon the question I know that's been in the minds of members here that we talked about before about whether a physician, for example, participating in a significant way in MA, whether that should be considered part of the APMs. So this is really a request for more data on that going forward.

Thank you.

DR. CROSSON: And, Bill, the recommendation support?

MR. GRADISON: Excuse me. Yes.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: So I do support the draft recommendation. I think that's moving us in the right direction.

Like Kathy, I think we should really be looking at some way to address the contract consolidation and the quality ratings, and this probably spills over into Part B as well, though there's not a payment bonus. So it hasn't necessarily come as much there.

And I know we've talked before about the notion of -- and you said this a few minutes ago about doing more

of the ratings below the contract level, at market level. Is that something we've done as a formal recommendation in the past or just as a text?

MR. ZARABOZO: That was a formal recommendation, yes.

DR. HOADLEY: Okay. So I wonder if it's worth sort of re-printing that recommendation within the context of this discussion. It seems like that would be useful.

And I guess as we think more about the star ratings and as they have this importance, I was wondering if we've looked specifically at the empirical relationship of ratings to the premium bids. This is something that obviously others can't really look at because you can only look at the net premiums after the rebate effect, but really to look at them relative to the bid premiums. I don't know if that's something that you've ever explored, but it seems like if not, that would be a useful thing to do.

Also, it sort of links back to the discussion we had about the relationship of quality ratings to premium support and those other kinds of issues from a previous meeting.

DR. CROSSON: Okay. Paul and Pat and Craig.

DR. GINSBURG: Yeah. I support the recommendation, but I just wanted to know, is this the time to talk about bigger picture concerns about quality ratings, or should I wait?

DR. CROSSON: So far, where I'm seeing this discussion going is -- so far, there's a general support for this recommendation, which is a narrow recommendation. But a number of comments, starting with Kathy, that there are other issues affecting the MA program, particularly with respect to manipulation of star ratings or other things that need the attention of the Commission. So I'm going to try to set my mind for how we conclude this discussion, but in the meantime, bring up your point.

DR. GINSBURG: Sure. This is a general point. When you think about ratings for quality, there are two ways that they can improve quality. One is by changing the incentives of the plans to work harder to deliver higher quality, and the other is to steer beneficiaries into higher quality plans where they'll have a better experience. I don't know about the latter.

Clearly, there's been a response by the plans to

the quality start rating system, but I have some concerns about whether the way it's been done is a very efficient way to use taxpayer resources to promote quality. And I think about the various things that have been done in recent years on physician payments, where there have been incentives, too, without the electronic records, to reports to CMS on quality. And, usually, the physician recommendations have been bonuses for a few years to do these things turning into penalties, long term, if you don't do the things. And I'm wondering whether we should be thinking along the same lines in Medicare Advantage.

We've gotten a great quality response from giving very large incentives to achieve higher star ratings. Maybe it's the time to start thinking about transitioning this so that the star ratings become more of a negative thing if you don't get sufficient star ratings and also do some more research into the degree to which beneficiaries are actually acting on the star ratings. Is it helping them choose a plan that they believe might meet their needs better?

DR. CROSSON: Okay. Pat.

MS. WANG: I support the Chairman's

recommendation. I also agree with Kathy's request that we have a recommendation to do -- to recognize something in the way that consolidation is happening, that once the incentive to chase a higher star rating and bonus and would note that that could have a cost offsetting impact to the increased cost that's projected from the A/B proposal. To the extent that plans are full out getting an increased four-star, five-star quality rating coming from a non-bonus situation, there could be some offset there.

There was a recommendation in here that is a smaller issue, but I do want to raise it. I thought it was actually a very good idea that had to do with membership stability. It was in that context for folks with a special election period, continuous 12-month enrollment to create an option to allow switching, but only back to the fee-for-service system, as opposed to among plans. And the reason I thought that it was good, it falls under the category of trying to launch incentives that may not be the ones that the Medicare program necessarily wants to launch, because what happens today with people with continuous enrollment opportunities is that plans are in kind of an arms race to offer higher and higher and higher extra benefits. And

people switch from their plans to take advantage of the higher benefit. They exhaust it. Then they come back to their plan, back to their old care manager. I don't really get the point of that. I think that from a beneficiary perspective, keeping somebody with their care manager. If they're not happy with that, they can go back to fee-for-service, but the idea of shopping for plans, because there is a 12-month opportunity to switch from plan to plan to plan, it really happens, and I don't think it's in the interest of the program or the member.

I realize that the Commission in the past has made recommendations of achieving greater equity among plans in the way that the coding intensity adjustment is applied. I look at the chart on page 38 that shows the distribution of coding intensity over the year and the sort of uniform application of coding intensity adjustment, and I would ask that we, either this time around or the next time around, reiterate the importance of achieving greater equity in the way that that coding intensity adjustment is distributed among plans.

DR. CROSSON: So, Pat, I don't know if we made it as a formal recommendation before, but the notion of the

three tiers, so we have brought that forward, as you may remember. I'm not sure that's the perfect solution, but we did.

Okay. Let's go ahead. I think I lost track. I had Craig, David, then Brian and Bruce. Did I miss somebody?

DR. MILLER: No. David -- he was on that list, right?

DR. CROSSON: I said Craig, David, Brian, and Bruce.

DR. SAMITT: So I also support the Chairman's recommendation. I want to comment on two things that are in the chapter and one that's not that I'd love to learn a little bit more about.

The first is the text box about telehealth and the inclusion of kind of costs of telehealth within the basic benefit versus as part of a rebate methodology, and one of the things that struck me was that we kept describing telehealth as a non-covered benefit, and I don't see it that way. I see it as an alternative care delivery methodology that may be more efficient than our existing methodology. And so the whole rebate suggestion really

didn't resonate with me. I disagreed with it. It felt to me that if we envision telehealth as an offsetting strategy that would reduce alternative utilization costs and the costs of telehealth should be included in the basic benefit package. And I don't know to what degree we would want to underscore that in the chapter, but I would advocate for changes there.

The second was in the stability section of the chapter. Another suggestion was two-year contracting cycles, and I just had a bunch of questions about that. I'd love to really study the implications of that before we step forward and make that as a suggestion. It raises all kinds of questions like: How does the star bonus program work in a two-year contract? What do we do about MLR thresholds? For market expansion, how do plans do market expansion mid-cycle if it's a two-year contract? Do they need to only pursue market expansion at the beginning of a two-year cycle? Which obviously constrains growth of MA. So I'd love to learn more about that before we step forward and make that suggestion.

And then as you could predict from me, the one part that I didn't feel was addressed in the chapter was

about encounter data, and what more we've done there or what we found, and whether that educates or informs how we can strengthen the MA program even further. And to tag onto Bill's comments, I would very much be interested in understanding the question of how providers are reimbursed from MA plans and do we see differential performance, whether it's in the encounter data or not, between those payments to providers that are more aligned around value versus those that are paid fee-for-service from risk-bearing MA plans.

DR. CROSSON: Rita, on this point?

DR. REDBERG: Yeah. On the telehealth point in particular, because I think part of the problem is telehealth encompasses such a wide range of services, and some of them could be, as you say, value, part of value-based services, and some of them are not part of -- have unclear or no value. And so it's very hard, I think, to group the whole bunch in, and it's also, I think important to get some more data on existing telehealth services, because what we've looked at has really been all over the map and not as much impressive benefit as we would hope. And there's certainly potential for more, but I think the

problem is a very big field.

DR. SAMITT: Well, even if the focus is on a subset of telehealth services that we do believe add value, whether it's the types of services or subsets of the MA population to which they would be most value creative, that it just feels like it should not be part of a rebate methodology. But if we feel that these telehealth strategies really work, then it should be baked within a benefit package itself.

DR. NERENZ: All right. Thanks. I'm inclined to support the recommendation. It's got a good logical foundation for reasons that I don't need to elaborate. We've talked about it in the last couple meetings. I just have a couple questions about implications of if this is done and looking for a bit of reassurance, either this morning or as we carry this to January.

I'm thinking specifically about the text on page 30, and then, Scott, you mentioned this when you were showing Slide 9. It's not actually on Slide 9, but you mentioned Albuquerque, Denver, Portland as areas that have particularly high numbers of people who are A-only. Those are the regions who would benefit financially, and I wonder

why that is important. Why do we want to do that? MA penetration is high. They're successful. As far as we know, the plans are doing well. So I'm worried about a bit of a windfall effect in those areas.

And then I extend the thought to the program in general. As we point out here, the effect across the whole program is that it would increase benchmarks, and then I think -- but tell me if I'm wrong -- would then as a result increase payments a little bit.

Now, in many other of our discussions of MA, we've talked about how we want to actually try to ratchet payments down to get them equal to fee-for-service, and the data you showed, Scott, seems to suggest that has now finally occurred. We used to see numbers like 105 percent, 104 percent, relative to fee-for-service.

So I guess I have these two. One is: Do we want to create these regional windfall effects, and do we want to have the net effect of raising payments relative to fee-for-service?

Now, if I'm hallucinating both of those, that's great, please tell me that's so. But if we're going to do that, I guess I'd like reassurance that there's a really

good reason for doing it.

DR. CROSSON: So, you know, we're a little bit in the philosophical range here, because I agree with everything that you've said. Those are our intentions. But as you know, we have also periodically, when we've looked into the details of Medicare Advantage payment, we've looked to improve equity. You know, so where we find that -- not the overall payment, but that there's something about the payment structure that appears to be inappropriately advantaging certain groups of plans as opposed to others, in some cases we make a judgment that results in a net reduction of payment, and in a few cases, we've made a judgment that has -- or made a recommendation that has had that effect of increasing payments.

Overall, if you go back to when we first started doing this as a Commission back in 2000, 2004, and 2005, the general thrust of our recommendations has been as you describe, which is to try to bring about a payment level to MA plans which is as equivalent to what's paid in fee-for-service as we possibly do.

But having said that, within that larger context, there sometimes are recommendations which have the net

effect of increasing payments as you describe.

MR. GRADISON: On that point, may I?

DR. CROSSON: Yes.

MR. GRADISON: What's the argument for doing it this way rather than making the change but requiring it be revenue neutral or expense neutral?

DR. CROSSON: Yeah.

MR. GRADISON: I mean, what is the argument for that?

DR. MILLER: So my best manufacturing of an answer here -- and just to give one response -- and I think you went through in what you said, I think you're all on point. You may be hallucinating.

[Laughter.]

DR. NERENZ: It happens.

DR. MILLER: But in this instance, it all came out right. So one reason that you might want to -- and then I'll come to you, Bill. One reason you might want to take this on is if this phenomenon is going to grow, it's not going to be just, you know, these few counties. The inequity will attribute to more.

The second thing I would say -- and I think this

does kind of scoop up Bill's comment, too, in the process -- you could do this budget neutral, but what we've been saying -- and, again, in your hallucinations you said this as well -- we're trying to get a payment system that's more financially neutral to fee-for-service. We're sort of there, and so in a sense, it's like what we do in a lot of sectors, where we might say the payment level is X, but we think the underlying payments are going too much towards therapy versus not -- you know, that type of -- I see it as sort of an issue like that. You don't have to see it that way, but it could.

The other thing I would say to you, Bill, is if it's a cost and you feel like it needs to be offset or the Congress decides it needs to be offset, we've gone to great pains to remind people there's still this four-point coding adjustment, which, you know, a point of that, you're back to being neutral. So you can kind of think about the moving parts that way if you wanted to.

DR. CROSSON: Amy, on this point?

MS. BRICKER: I may have missed it in the chapter. What is the budget impact?

DR. MILLER: It's about a point on spend, and

spend is about 190...?

DR. HARRISON: About three-quarters of a point on spend --

DR. MILLER: Right.

DR. HARRISON: This would be on the benchmark, a point on the benchmark.

DR. MILLER: A point on the benchmarks, and then what the bid would be would be something less than that. So among friends, let's call it a billion and a half?

DR. CROSSON: Okay --

DR. MILLER: Annually, Amy.

DR. CROSSON: On this point, Paul?

DR. GINSBURG: I was just thinking that I think it's wise for us to call things as they are so that -- I mean, I think the Chairman's recommendation makes just a lot of sense in isolation, but a sense the way things are calculated really, you know, doesn't make logical sense. And I see this as a correction of that. But I also know that when we discussed MA at a prior meeting this fall, we came up with lots of ideas that would actually lead to lower MA payments. This was the one that stood out as leading to higher MA payments. So just to reinforce, I

think there are lots of opportunities for Congress to offset this is they so choose, as long as we're giving them some of the options to do that. And I think the star bonus area is one as well as the coding.

DR. DeBUSK: I, too, support David's comment about trying to achieve overall parity in payment between the programs, and I do also support the Chairman's recommendation.

To Kathy's point, I do think we need to address the consolidation in the star rating system, but then, also, I think there's another opportunity. Paul mentioned the bonus payments. From what I understand right now, the bonus payments are purely additive. We could, for example, as we use A plus B spending in the benchmark -- I think you said it's about three-quarters of a point. Could we use some of that money to rebalance the payment system so that this underlying star system is budget neutral? Instead of being purely additive, Paul, I think your recommendation was to make it a deduction. I would counterpropose that maybe we make that neutral, because I think there's an underlying principle there that we could adopt even in a broader way that says we feel like quality penalties and

bonuses should always net out to be neutral, whether it's in MA or ACO benchmarks or any -- or ACO settlements or anything, this idea that to us quality is a neutral provision and we're going to work around bonuses and penalties. So I think that may be a great place to take up some of that slack.

DR. GINSBURG: I like Brian's amendment.

DR. CROSSON: Yes. And, you know, another -- we don't want to try to do the thing here, but one of the issues that's occurred since the notion was first established ten years ago or so -- well, no, it's not that long. When did we start talking about bonuses for quality? It's almost that long.

DR. MILLER: 2005.

DR. CROSSON: Yeah, 2005. And then, eventually, when it was incorporated into law, it was envisioned as kind of a narrow reward thing. In other words, there would be a small number of plans, you know, very high quality, who would be hitting -- getting this bonus. And then for a variety of reasons, political and otherwise, we now have a situation where it has expanded and it's continuing to expand, so those who are getting higher star ratings and

payments is a much larger proportion than I think was envisioned when this idea first took place.

So in order to -- I can't do the math in my head, but in order to make it budget neutral, you know, if you've got large numbers of plans that are qualifying for bonuses and a very small number who aren't, you'd essentially be potentially wiping out those other lower plans -- unless that was, of course, the intent.

Now, having said that, taking a whole -- and I'm going to get to this in the end. Taking a whole other look at how the star rating program is working, what was intended to be the impact of it and what's now happening is exactly on the table, I think.

DR. DeBUSK: I think if we had an underlying philosophy that all quality should be net neutral, then as policy decisions are made, you know, to take a payment in one direction, there would be a complementary offset, so we wouldn't have this issue of drift in payments.

MR. PYENSON: Thank you. I support the Chairman's recommendation, and my compliments to the staff for a very rich report. I wanted to pick up on a couple of other topics on the report.

There was discussion this morning on the consolidation in contracts, and I think that's a very fruitful area, but it's in a broader context of the management of a Medicare Advantage plan that includes avoiding losses in contracts or maximizing gains. And so I would not -- I would recommend against looking at consolidations in isolation. There's a broader set of issues that plans have to manage in the course of their activities, including which areas on a year-to-year basis they may want to expand into or to avoid. And related -- or to leave. And a related issue is how the limits on benefit changes from one year to the next.

So there's a series of interrelated issues that I think it would be fruitful to examine them in whole rather -- more fruitful than particular aspects of that in isolation. And part of that could involve the issue that Craig raised of multi-year contracts and consideration of the advantages and disadvantages and how to do that.

On the telemedicine issue that Craig also raised, I'd identified that, you know, in the bid process within Medicare-covered benefits, plans all the time consider things like moving people and utilization from a SNF to

other Medicare-covered benefits such as home health or just home care or outpatient rehab. But what's different as we get into things that for whatever reason Medicare is not covering, how to get -- if a plan is willing to offer those as an offset, I think that's a potential area of experimentation where Medicare Advantage could perhaps teach the fee-for-service program how things could work or not.

So I think the third option that you presented there has its appeal in how to build that in as though it's a Medicare-covered benefit, but the plan is taking risk for it.

Those are my comments. Thank you.

MS. THOMPSON: I won't make a lot of additional comments because many of them have been made and remade, but I want to go on the record in support of the Chairman's recommendation on this topic.

I do also agree with most of the comments that have been made about further study around contract consolidation. And in telemedicine -- and we've had a lot of discussion around telemedicine, but, yes, I agree with comments made over here by someone in terms of it being an

additional benefit. Telemedicine is a means of communication, and I think we need to look at what's the service behind the telemedicine that needs to be evaluated as appropriate or not.

Those would be my comments.

DR. HOADLEY: I already spoke on the recommendation, but I just wanted to follow up on a couple of the comments that have come up.

One, Craig raised the two-year lock-in, and I agree it's an interesting idea, but one that there are still some questions to be answered. And you raised some from the sort of plan side. I think there are similar questions from the beneficiary side of, you know, what are they guaranteed. You know, today they're guaranteed a premium and benefits that for the most part don't change, the potential for networks to change even more within the two-year cycle, and we've already had some issues within the one-year, so I think it's an interesting possibility but just some more questions.

Second, I think there are a lot of interesting issues on the stars, most of which have come up. I'll mention two others just briefly. CMS I think has an RFI, a

Request for Information, out on the issue of the intersection between sanctions and stars. You know, they change their policy on a temporary basis and now are trying to find out, so I don't know that that's something we've ever -- if we've ever commented on that. And then the ability to exclude consistent poor performers, which has been addressed in the recent legislative package.

And then, last, Craig also mentioned the MLR. It seemed to MOE you had given us some data on MLRs in a previous round, and I didn't know whether there were new data on MLRs that we were going to look at at some point or what else we know that's new.

MR. ZARABOZO: Yeah, we did not do that analysis this round.

DR. CROSSON: Okay. Alice, and then we're going to proceed.

DR. COOMBS: So I support the recommendation, and when it comes to the stars, I was looking at Table 9. The performance for the four-star threshold is a little disappointing in that. You look here, and this is not what you would expect. Most of the literature for fee-for-service would not -- these would not be commendable results

per se. So I wonder if, you know, the establishment of predetermined thresholds might be something as a more positive accomplishment. But I also wonder what the components of -- what the beneficiaries look like in these star ratings and why there might be variability between the star ratings for whatever reason.

I am more apt to say that movement of penalties early on is not something that I would favor because I'm not quite sure what this constituency looks like overall. For instance, we talk about other factors that may impinge upon MA star ratings, and we actually -- I think a few years back we looked at the number of minorities within MA plans, and we looked at them specifically in the SNP plans, and found that overall there didn't seem to be that much of a difference. But when you subtracted the special needs plans, there was a disproportionate number of minorities in those plans.

So, you know, the question is whether or not there's something else underlying why this performance is, I would say, somewhat inadequate if you look at the numbers in Table 9.

DR. CROSSON: Okay. So here comes the part that

is risky for me --

[Laughter.]

DR. CROSSON: -- because I'm going to first of all say this was a very robust discussion. We had a whole variety of issues brought up about the MA program. I think probably the one I heard the most commonly was a variety of questions about MA stars -- the consolidation issue, the question of budget neutrality, the question of whether it should be reward-only, which it's not, actually, but --

We also heard, I think, comments about beneficiaries switching within a year, reiteration of problems with coding intensity, the question of telehealth, both in MA and fee-for-service, I would have to say, the question of two-year cycles, encounter data, limits on benefit changes, the notion of, again, in MA the idea of a threshold.

Having said that, I heard general support for the recommendation that's on the floor, with the possible exception of the question of whether it should be budget neutral or not, but I had the sense that that was resolved pretty much in the subsequent discussion to that.

So I'm thinking, number two here, in terms of the

MA paper that we have and the recommendation, what I'm hearing is a general consensus, which could lead me to believe that we could handle this in expedited process in January. However, I think there have been enough issues brought up that we need a process to address them, and I would have to say, you know, while all of these are worthy of further work, and they have been the -- many of these areas of content we have discussed here as well, and we have, if not bold-faced recommendations, we do have opinions, MedPAC opinions, within previous commentaries on Medicare Advantage.

It could be the case -- I think it might be the case that we want to move towards harder recommendations in some areas, and I think that the issue of the Medicare stars, which appears to be of concern broadly on the Commission, would be on the top of that list.

So I am going to suggest, and see if we have a consensus, that with respect to the December/January process -- remember, in order to vote in January we have to have recommendations twice, so we would have to have a recommendation now if we were going to take on the Medicare stars issue, which we don't have, to vote on that in

January, so we can't do that. We could discuss it in January but I think the staff would need a little bit more time to thoroughly analyze all the range of options here.

DR. MILLER: Yes.

DR. CROSSON: So I am going to suggest that we take this as a consensus item for what we have now, and that then I will work with Mark and Jim in the context of the spring, to see how many of these Medicare Advantage issues we can take on within that time frame, realizing that some of them may have to come after that, but at the top of the list would be the Medicare stars issue.

So do I see a general agreement there?

[No response.]

DR. CROSSON: Hearing no objections, then we -- Bruce?

MR. PYENSON: I agree with the general outline. I would just -- I tried to make the point that what we were talking about with the consolidation was perhaps not a stars issue but a contract-and-bid issue, and we can do a lot of work in stars as well, for sure, in how the different measures are defined, and are they meaningful for what beneficiaries care about, and those sort of things.

But I think the issue of concern that I heard was not particularly the stars metrics but was, as I interpreted it, it was a contract-and-bid issue.

DR. CROSSON: Truthfully, I think we heard both, but thank you for that clarification.

So what I'm hearing is a consensus that we will go forward in expedited review and voting in January. However, we will work with Mark and the staff to bring forward these issues, re-emphasize some discussions and recommendations we already had, so everybody is clear on that, but in areas where we have not been perhaps as aggressive, if you want to call it, as we might have been, then we will tee those up in priority order, starting this spring.

I see a general agreement there so thank you, Scott and Carlos. You want to make a point?

MR. ZARABOZO: Just a couple of clarifications that we've used the term "consolidation" here in two ways. One is John's consolidation of, you know, we could have eventually, let's say, one company in America that provides health insurance. That's one kind of consolidation. The other one was with respect to the stars -- the same company

consolidates various contracts, so that's a different kind of consolidation that we were talking about.

And then on the telehealth issue, the Cures Bill, I believe, asks MedPAC to study the kind of issues that we have been discussing today, so MedPAC apparently will have to look at those.

DR. CROSSON: And sets a time frame that's not next March.

[Laughter.]

DR. CROSSON: Good point.

DR. MILLER: Yeah, and the only other thing I would add is we will have this conversation. Some of the issues is some other issues that we want to take up in the spring, the same staff are implicated. And so --

DR. CROSSON: Okay. So --

DR. MILLER: We'll talk.

DR. CROSSON: Right. Right.

DR. MILLER: Right. So we are going to have to split some --

DR. CROSSON: Right. So, I think I got through that in one piece. I'm not quite sure yet but we'll see.

[Laughter.]

DR. CROSSON: Carlos and Scott, thank you very much and we will move on to the next presentation.

[Pause.]

DR. CROSSON: Okay. So we are going to move on to the first payment update issue, which is hospital inpatient and outpatient. Zach Gaumer, Craig Lisk, and Jeff Stensland. It looks like, Zach, you're beginning.

MR. GAUMER: Yes, sir.

Okay. Good morning. This session will address issues regarding Medicare payments to hospitals.

We will cover both hospital inpatient and outpatient payments, and we will discuss whether payments are currently adequate. As a part of this, we will provide you with the Chairman's draft recommendation for updating hospital payment rates for 2018.

In addition, at the end of the presentation, we will also follow up on our session at the November meeting concerning stand-alone emergency departments. We will provide you with the Chairman's draft recommendation on collecting data on off-campus EDs.

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 2015, projected margins for 2017, as well as all-payer margins and those of relatively efficient hospitals.

Okay. As you can see on the bottom row of the table above, in 2015 Medicare hospital spending amounted to approximately $178 billion in fee-for-service hospital payments and a 3 percent increase in spending per beneficiary from 2014 to 2015. The components of this include a 2 percent increase in inpatient spending, a 7 percent increase in outpatient spending, and the anticipated decline in uncompensated care payments of roughly $1 billion. And that's due to the decline in uninsured patients.

Access to hospital care is good, and although the hospital industry appears to be changing, we do not see any issues that would affect beneficiaries' access to care. The use of inpatient discharges increased for the first time in eight years. Admissions increased .4 percent per beneficiary, contrasted with 3 percent declines in each of

the past three years.

The volume of outpatient services increased 2.2 percent per beneficiary, and this is slower than the 4 to 5 percent increases in prior years.

In previous years, we have seen a shift of services from the inpatient to the outpatient setting, and part of that was driven by observation in surgical services. However, in 2015, that shift appears to have slowed. We now see inpatient services increasing very slightly and outpatient services increasing a bit slower than they did before. The point here is that both inpatient and outpatient utilization increased in 2015.

The hospital industry maintains excess inpatient capacity. The aggregate hospital occupancy rate was 62 percent in 2015, up slightly from the year before. Rural occupancy rates were lower, at 41 percent, and they really didn't increase from 2014.

In 2015, there were slightly more hospital closures than openings, and among the 24 closures, half were rural and half were urban.

Access to capital is good for most hospitals. Interest rates remain relatively low, and this led to

hospital bond offerings jumping from about $25 billion to $36 billion in the first 11 months of 2016.

Within the last year, the major ratings agencies cite strong all-payer profits. Revenue growth has stemmed from increases in inpatient and outpatient volume and increases in prices paid by private payers. Cost reductions have stemmed from increases in overall uncompensated care costs and the number of self-pay patients.

Hospital construction spending remained high and was consistent with previous years. Hospitals, generally, are still more focused on developing outpatient capacity.

Merger and acquisition activity has been consistent with recent years, which I would describe as active.

And, finally, from 2014 to 2016, we saw hospital employment growth was faster, at 6.5 percent, than the rest of the health care sector combined and the rest of the economy.

So now Craig will walk you through the rest of our work.

MR. LISK: All right. Good morning. So the

quality of hospital care has been improving, as a growing proportion of Medicare 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 potentially preventable readmission rates for Medicare patients continue to fall, with reductions in potentially preventable readmissions for conditions covered by the readmission reduction program and for all conditions through 2015.

In addition, this year we developed a new all-condition 30-day post-discharge mortality measure using 3M's APR DRGs and its risk of mortality measure along with adjustments for age and gender.

Using this new measure, risk-adjusted mortality rates for Medicare patients have fallen steadily over the past five years, falling .9 percentage points.

Unadjusted mortality rates, though, have increased due to a shift of low-mortality patients to outpatient settings. So it is important to recognize that we are simultaneously seeing reductions in both potentially

preventable readmissions and risk-adjusted mortality.

Hospital cost growth remains relatively low, as can be seen in the last column of this table. In 2015, inpatient cost per case grew by just 2.2 percent. This low cost growth occurred despite a .8 percent increase in case mix, most of which we believe is due to hospitals treating more complex mix of patients.

If we adjust for this increase in case mix, case-mix adjusted-cost growth was only 1.4 percent in 2015, which was .4 percentage points less than underlying input price inflation of 1.8 percent.

This current pattern of low cost growth compares to 2001 to 2008, before the recession, when costs were increasing much 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. We include Medicare payments for all outpatient care services and uncompensated care and compare them to allowable cost for providing services to Medicare fee-for-service beneficiaries.

We find that the overall Medicare margin is

trending downward in 2015, falling from minus 5.7 percent in 2014 to minus 7.1 percent in 2015, after having held relatively steady since 2009.

This decline in the overall margin is due to a number of changes in Medicare payments, including declines in EHR incentive payments, declines in uncompensated care payments, with a drop in the number of uninsured, and increases in penalties under the hospital readmission reduction program, with the addition of the hip and knee procedures to the program, and the start of penalties under the HAC reduction program.

While the average margin was minus 7.1 percent in 2015, rural and for-profit hospitals had relatively higher profit margins.

Next, we look at marginal profits, a concept we introduced to all of our update frameworks last year, where we basically ask the question of whether providers have an incentive to take another Medicare patient. If payments are more than marginal costs, a provider has a financial incentive to take the patient, but if marginal payments do not cover the marginal costs, 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 costs of providing those services. Marginal cost excludes expenses for building and fixed equipment.

In 2015, we find that the marginal profit for Medicare services in hospitals was 9 percent, meaning that the hospitals have an incentive to take additional Medicare patients.

While Medicare margins continue to be low, all payer margins continue to remain at historically high levels, with an aggregate overall total all-payer margin of 6.8 percent in 2015 and the operating margin, which includes revenues and costs from hospital operations, but excludes income from investments and endowments, and that rose to 6.4 percent in 2015, the highest level we have seen over the past 10-plus years.

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. This increase in the operating margin is an indication that hospitals continue to grow their private-sector revenues faster than costs.

Other total hospital financial indicators also stayed strong in 2015, and here, we show it using the EBITDA margin, which is a cash-flow measure.

Next, we turn to our relatively efficient hospitals, where 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 14 percent of hospitals that we had usable data on as having been relatively efficient for three straight years. That's from 2012 to 2014.

We then look at these hospitals' performance in 2015 -- and that's the first column in this table -- and we see that these historically efficient hospitals had 6 percent lower mortality, while keeping costs 9 percent lower than the national median.

Lower costs allow about half of these hospitals to generate positive Medicare margins in 2015, with a median margin around zero.

It is important to remember that when we talk about efficiency, we are talking about quality and cost. These relatively efficient 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 on their quality metrics we analyze.

We project margins for 2017 based on margins in 2015 and policy changes that take place in 2016 and 2017.

We estimate that the overall Medicare margin will decline from minus 7.1 percent in 2015 to about minus 10 percent in 2017.

Although payment rate updates and case-mix growth will increase payments, cost growth is expected to be larger than the payment rate updates.

We expect the margin to decline primarily due to the following three factors: declines in uncompensated care payments due to a drop in the number of uninsured, which the CBO estimated will fall from 13 percent in 2015 to 10 percent in 2017; expiration of payments from the EHR incentive program; and adjustments made to updates to recover past overpayments for documentation and coding improvements.

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 costs of treating Medicare patients.

Relatively efficient providers were able to break even serving Medicare beneficiaries in 2015. However, as we just discussed, there are payment policy changes in 2016 and '17 that reduce payments to hospitals. If current law holds, we would expect negative margins in 2017, even for relatively efficient providers.

Margins are expected to be negative, but hospitals will still have a financial incentive to see Medicare patients due to revenues exceeding the marginal cost of care.

So this next slide shows the estimated update for inpatient/outpatient rates for fiscal year 2018, which would be 1.85 percent if the current estimated market basket for fiscal year 2018 holds at 3.0 percent.

So, moving on, the Chairman's draft recommendation reads as follows: The Congress should update the inpatient and outpatient payments by the amount specified in current law.

As this recommendation would provide current law updates,

there would be no impact of on spending or on beneficiaries or providers.

This draft recommendation is made under the following policy rationale. While Medicare margins are negative for most providers, given beneficiaries' good access to care, providers' access to capital, the update in current law is appropriate. This recommendation balances the need to have payments high enough to maintain access to care and the need to maintain fiscal pressure on hospitals to control their costs.

Zach will now discuss off-campus stand-alone emergency departments to conclude our discussion.

MR. GAUMER: Okay. So, in November, we devoted a full session to the topic of stand-alone emergency departments, and the Commission signaled interest in a recommendation pertaining to data collection. So let's very briefly review the details from that session.

Stand-alone EDs offer a focused set of services and are generally located in higher income urban and suburban areas.

The industry has grown rapidly, and we believe about 400 currently bill Medicare. But we expect this

number to grow rapidly in the years ahead because many are forming joint ventures with hospitals.

We have a concern that because the Medicare program pays more for services provided in EDs than urgent care centers or in the office setting, providers have the incentive to serve patients in emergency departments.

Research on these facilities in Colorado and Maryland suggest the acuity of their patients are more similar to urgent care centers than to hospital EDs, and this suggests that Medicare may be paying more for patients just because they are treated in an ED rather than another setting.

Because stand-alone EDs are exempted from the recent site-neutral law and can be paid higher hospital rates for all the services they provide, we also believe their numbers may increase rapidly.

However, because Medicare claims data from these facilities are not distinguishable from the claims of other hospital EDs, we cannot assess their growth within Medicare or whether Medicare is paying them appropriately.

Okay. Therefore, the Chairman's draft recommendation regarding stand-alone EDs reads: The

Secretary should require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities.

The rationale for this recommendation is that these data would allow CMS and Congress to be informed about the expansion of these facilities and the patients they serve.

This recommendation will not change Medicare program spending. It will also not increase providers' costs and may only minimally increase administrative burden on hospitals. It will not impact patients or their access to emergency department services.

Okay. That concludes our presentation today. We welcome your questions, and up on the slide above you are the two recommendations that the Chairman has put forward.

DR. CROSSON: Thank you, Zach, Craig, and Jeff.

We are now open for clarifying questions. David. Rita.

DR. NERENZ: Yeah. Thank you. Good job.

Just two very quick questions. On Slide 18, what percentage of the total number of freestanding EDs is that 400?

MR. GAUMER: That 400 is about 65 percent of all

the stand-alone EDs, and this comes with a pretty big caveat because -- you know, I think every month, we keep hearing more and more about how the non-affiliated facilities are partnering with hospitals, so that they can enter the Medicare fold. And so we counted about 560 total or so stand-alone EDs, say 350, 400 can bill Medicare. That number, I think, is a conservative estimate of how many are currently billing Medicare, and when I'm saying currently, I am thinking fiscal year 2017.

DR. NERENZ: Billing Medicare as a hospital or part of a hospital.

MR. GAUMER: Yes.

DR. NERENZ: Okay. I just wanted to clarify the recommendation that applies to 65 percent of the total field and that 65 percent may grow. It does not apply to the not-hospital affiliated.

MR. GAUMER: That is correct.

DR. MILLER: Because they can't bill Medicare.

MR. GAUMER: Yeah.

DR. NERENZ: The second question, Slide 13. This is about the margin. In the text, you point out that the three quality-related penalty programs have the net effect

of decreasing aggregate hospital payment about a half a percent. Is that reflected here, or is it not?

MR. GAUMER: Yes.

DR. NERENZ: It is? And do you make any assumptions about a the change as you go from the two time periods here? Are you assuming half percent both time periods?

MR. LISK: So we're reflecting actually increases because we expanded readmissions more, so reflecting the expansion of the readmissions to include the change to pneumonia and the addition of CABG to the readmissions reduction program, for instance, so that is reflected. It's there, yes.

DR. NERENZ: Okay.

DR. CROSSON: Rita.

DR. REDBERG: Thanks for an excellent chapter.

My question is thinking about the right number of hospital beds per capita, which is hard to get it, but I am wondering, do we have any international data, like how we compare to other western countries in terms of hospital beds per population, or could we get some?

DR. STENSLAND: They generally have more beds.

DR. REDBERG: And do we have also any figures on what percentage of our hospital beds are ICU beds?

DR. STENSLAND: We do, but I don't have it here.

DR. REDBERG: Okay. Thanks.

DR. CROSSON: Jack, then Brian and Sue.

DR. HOADLEY: A couple of questions with respect to the uncompensated care payments and the DSH payments, you talk about, on Slide 13, one of the drivers of the change in margins is reduction in these payments, and in the chapter you talk about $12.2 billion in 2014, dropping to $11 billion in 2015.

A couple of questions relative to that. One is, do you have a breakout of how much of that is on the DSH side and how much of that is on the new uncompensated care? And then second, you know, this is obviously assuming current law, and if there are changes in the Medicaid expansions or the other programs that have increased the insurance rate, what effect might any change in law, in general, have on these kinds of payments?

DR. STENSLAND: The first one that -- the decrease in the overall spending that you're talking about, from the $12.2 to $11, that's all just due to the

uncompensated care shrinking, and the way this was set up is the general idea that with part of the DSH -- the purpose of the DSH was to help hospitals with their uncompensated care costs. So then they said, "Well, why don't we directly tie this to the number of uninsured?" And so the way the law currently stands now is when the number of uninsured goes down, these uncompensated care payments go down, but if something happened in the number of uninsured went up, the way the law is situated now is those uncompensated care payments would go back up.

So the only reason we see a decrease here is because the number of recorded uninsured went down. If the under of recorded uninsured went up by that same amount we would see those payments go right back up.

DR. HOADLEY: Thank you.

DR. CROSSON: Brian. Oh, I'm sorry. Bruce. I made a mistake.

MR. PYENSON: Thank you for a terrific report. I think these are questions for Craig. On page 4, there is an increase of 0.4 percent per beneficiary and inpatient, and 2.2 percent for beneficiary for outpatient use. I think this is -- 2015 was the first year of baby boomers

entering Medicare, so the average age has gone -- I think has gone down in this period. So normally we would expect a decrease in these rates, and if -- I'm wondering if I'm thinking about this correctly, and if I am, why is there an increase?

MR. LISK: For one thing, yes, I think there is an increase in the very young, in terms of the 65-year-old beneficiaries, but there is also actually a big increase -- there is also a big increase, about a 1 percent increase in just one year in the number who were 90-plus, for instance, as a share of the beneficiaries, because there's just -- the aging is also going on at the same time too. And so they have higher -- much higher utilization. So there's kind of a couple of different things going on.

DR. CROSSON: So people are living too long. Is that what you're saying?

[Laughter.]

MR. PYENSON: Another question, if I could. On -- I think this is a question for Zach. On page 12, you show an overall Medicare margin of 0 percent for the efficient hospitals. Can you calculate the marginal contribution for Medicare for that subset of hospitals?

I'm sorry. For Jeff.

DR. STENSLAND: What do you mean -- what the marginal profit would be for those relatively efficient hospitals?

MR. PYENSON: Yes.

DR. STENSLAND: It would basically be about that 6 percent more, because, you know, they're -- what's variable and what's fixed isn't that different for them, so maybe more on the order of 15 percent marginal profit.

MR. PYENSON: Okay. Thank you.

DR. CROSSON: Okay. I have Sue and Alice, Kathy.

MS. THOMPSON: Thank you, gentlemen. Great chapter.

On Slide 7, taking a look at the annual percent change in case-mix adjusted cost growth, going back to 2001 to 2008, where it was running along at an average clip of 5.2 percent, dropping down to 1.4 percent. From your analysis of cost reports or whatever, what's driving the reduction in costs for hospitals?

And then a second part to that question goes back to hospital employment increasing by 6.5 percent, because typically I would have assumed the reduction was around

something you can control, like labor. But how much of that hospital employment increase is related to acquisition of physicians? And then a third part is, are we measuring hospital employment on total number of FTEs, or on salary dollars, or how do you measure that?

A three-part question.

MR. LISK: Okay. So the cost growth being lower is a couple of things. As you see, the input price inflation is actually much lower. There's been much lower growth in employee wages as well, and in the past five years plus, hospital employee wages have grown slower than the rest of the economy, where historically they were growing faster than the rest of the economy. And it appears that the hospitals have also just done a better job at controlling their other cost increases and becoming more efficient in terms of those types of things too.

So a combination of things are happening to keep those costs down, but we are seeing what are historically low cost growth, especially if we do it on a case-mix adjusted basis.

MR. GAUMER: Okay. And then in terms of the employment, we're using BLS data for this, and the method

is -- it counts the number of individuals that are employed rather than dollars of their salary or benefits or anything.

What we're seeing underneath that 6.5 percent is that there is some growth in doctors being employed by hospitals, but, you know, that's one piece of this that I'm not sure the BLS is exactly capturing all of them, so I say that with kind of a grain of salt. So there's a little increase in physicians that we see. We also see the growth in employment of RNs and a corresponding decline in LPNs, so lesser-skilled nursing, I guess you could call it. And then there are some reductions, fairly significant ones, in more operational staff, for lack of a better term, things like kitchen staff, grounds, that kind of stuff. So it looks like that's where they may be finding some efficiency in terms of employment, if that's what it is.

DR. DeBUSK: Would outsourcing some of those functions make those employees disappear, or do we have a mechanism for recapturing them as contract services?

MR. GAUMER: I believe that the outsourcing would leave this count that the BLS makes. So we see an increase, despite any outsourcing that might be occurring.

DR. DeBUSK: But it's possible --

MS. THOMPSON: But it's still within the overall cost.

DR. DeBUSK: I was going to say, it's possible. I think Susan's questions were leading to a suspicion that there were greater increases, and I'm wondering if maybe the EVS outsourcing movement, for example, might be offsetting some of that.

MS. THOMPSON: But yet the reduction in overall cost. I mean, that's amazing.

DR. DeBUSK: Yeah.

MR. LISK: And you have to remember, I mean, actually, at least for Medicare we have had updates that have been below market basket as well, so there may be other pressures on there that have kept hospitals -- and just recovering from the economy and stuff too, may have helped put pressure to keep cost growth down.

DR. CROSSON: Okay. Alice.

DR. COOMBS: So several questions I have. Of the 400 EDs, do we know how many of those are recent acquisitions?

MR. GAUMER: We don't. You mean recent joint

ventures or recently built facilities?

DR. COOMBS: Right, whereby a hospital goes out and --

MR. GAUMER: The vast majority of those are recently constructed facilities. So these are hospital systems that have built their own new, free-standing ED, or standalone ED, I should say. You know, like we see a lot of this in HCA hospitals all over the country. And in terms of hospitals that are joint venturing, we hear more anecdotally that there has been a lot of that. We can't put an exact number on what share of the 400 or so are joint ventures. But I would say a large part of the 400 are the result of brand new facilities being built by the hospital itself.

DR. COOMBS: The hospital. Okay. And then the second question I have is, so in the chapter you do an incredible job of reviewing all of the program -- I don't want to call them penalty programs, but could you, hypothetically, say you had a disproportionate share of hospitals, that is probably going to be more susceptible to some of the penalties rather than the rewards with the hospital-required conditions, the reduction program, the

BPV -- all of the programs that could potentially result in penalties. I'm just concerned about the conglomeration of programs that may be in operation for a disproportionate share hospital, whereby they might not have the best performance because of the very nature of the patients that they're taking care of.

So I would like to see what that looks like, the worst-case scenario, if you will.

And then, lastly, I did go over this several times. I would love for you to kind of just briefly talk about the cost-to-charge ratio with the -- especially the graph you put in here regarding radiology costs, the markups, comparing hospital-level versus MS-DRG, and when would you see, in a scenario where that becomes -- the difference becomes very great?

DR. MILLER: Actually, could I get the very end of your question again, because I -- you were -- cost-to-charge ratio, it's within there.

DR. COOMBS: So there's a nice graph, figure, on page -- yeah, see, Figure 5 on page 28, and you get the impression that because there is a variation of the ratio of cost-to-charge for the different entities under one

umbrella -- for instance, radiology has a cost -- a markup of 7.9, the lab is 6.0, and that's under one hospital. And then you allude to another discussion regarding accuracy of MS-DRG level and then accuracy of hospital-level.

MR. LISK: This is going back to the discussion we had last month --

DR. COOMBS: Right.

MR. LISK: -- on the outlier --

DR. COOMBS: Right. It's on the outlier program.

MR. LISK: -- on the outlier program and the changes we were talking about, because you kind of expressed what your desires for changes --

DR. COOMBS: So a critical access hospital wouldn't matter, but a disproportionate-share hospital it might make a different with that as well.

MR. LISK: On the outlier changes, or what?

DR. MILLER: That's where I lost you too.

MR. LISK: I'm just trying to figure out where you're at.

DR. MILLER: Is this related to your disproportionate-share hospital point --

DR. COOMBS: Right.

DR. MILLER: -- or a separate point?

DR. COOMBS: Right. I wanted to know, in relationship to the subset of disproportionate-share hospitals, does -- is there something that falls out as a result of comparing one on the hospital level, versus the MS-DRG versus, you know -- because sometimes -- I mean, there's a discussion here that actually talks about stand-by capacity and all these other things, and cost-to-charge ratio is a function of many other things other than, you know, what we see, so it may not be apparent.

So what I'm trying to find out is, is the cost-to-share ratio in the disproportionate-share hospitals reflective.

DR. MILLER: Okay. All right. Let's do this. It sounds like -- I'm hearing there's a list of measures related to disproportionate hospitals versus others, which you asked about the penalties, and also the cost-to-charge ratios. How does that look in disproportionate-share relative to others? So let us take that as a request and see if we can respond to it.

I was just missing the connection between cost-to-charge ratio, but now I think I've got it.

DR. CROSSON: Kathy.

MS. BUTO: My question is also on the outlier payment section. I'm wondering whether we're going to come back to that in the June report, because we have some pretty specific recommendations, or at least inclinations, and I'm wondering why we didn't go further with it in this chapter. Maybe we're not ready to. And we did have a good discussion last time.

MR. LISK: You had a good discussion and you kind of wanted to not discuss it again -- you thought it was good enough. So what we did was --

MS. BUTO: I wanted to discuss it again.

[Laughter.]

MR. LISK: -- we gave you -- we did it as close to a recommendation without you voting on it, in terms of suggestions of where you thought you were on that, but it's not an official recommendation.

DR. MILLER: Yeah, that's --

MR. LISK: It's kind of where it seemed to be left, so we didn't want to take up time at this meeting --

MS. BUTO: Okay.

MR. LISK: -- to discuss it, but that --

MS. BUTO: I think --

MR. LISK: -- you're up to.

MS. BUTO: -- I think this is a good issue for us to come back to, and I got interested in it again because of LTCHs, to be honest with you, because there are long-staying hospital patients who -- there aren't LTCHs everywhere, and I began to wonder whether outlier payments was an area where, you know, we hadn't fully looked at the intersection between those two. So it's a totally different topic. It's not inpatient care per se, but I started thinking the outlier payments issue is one where, did we delve deeply enough on that kind of question.

DR. MILLER: And in the context of the outlier, or, you know, having that trigger your thought, just to make sure -- for some reason I can't -- I'm not following well today. I think I've got the same hallucinations David has.

Are you saying that you want to --

DR. NERENZ: Who said I wasn't?

[Laughter.]

DR. MILLER: No, I said you were, but you got it right. That's totally different.

DR. CROSSON: He was hallucinating and you

weren't.

DR. MILLER: Well, maybe that was it.

You're saying, you know, there's the outlier policy but you want to think of a short-stay policy. Is that what you're saying?

MS. BUTO: No.

DR. MILLER: No.

MS. BUTO: I just -- let me simplify by just saying I hope we come back to this --

DR. MILLER: To the outlier --

MS. BUTO: -- in a greater length. I think we actually have some very specific thoughts on it. And what triggered my interest in the outlier provision for inpatient was reading the chapter on LTCHs, and the fact that those individuals, unlike the way it's presented here, as a threshold that could be applied to ensure that short-stay cases are not necessarily going to fall into the pool, I began to think about the fact that LTCHs are not distributed evenly around the country, and began to wonder why, or if, in some cases, the outlier policy, high-cost policy, actually covers a number of the patients who are otherwise in an LTCH in another part of the country. So I

just started connecting the dots there. But I'm just saying it would be good to come back to outliers at some point, whether it's for the June report or otherwise.

DR. MILLER: Yeah, and I'm sorry. I crossed up the short-stay thing, and now you've clarified it. I've got it.

DR. CROSSON: On this point, Brian.

DR. DeBUSK: I, too, Kathy, share your concern about the high-cost outlier payment, but to me, if I remember our previous discussion correctly, there was -- one element was using department level cost-to-charge ratios but the other was simply requiring that you have -- do -- I think it was at least a five-day stay to even be eligible.

Could I suggest that we make the recommendation now on the five-day stay component, because that's an immediate -- and I would almost see that as a Band-Aid, whereas the department-level ratios does involve changing the way the calculation is done and things like that. To me, it almost seems like there is a short putt and a long putt here, and I just wonder if the short putt could make it into the recommendations for January.

DR. MILLER: Well, I mean, I'll just say a couple of things, you know, and this is just my mind and these guys are going to have to respond to your question, ultimately. We generally try and have recommendations appear twice, both for Commissioners' comfort of, like, I've seen that, I've thought about it, and I've come back, and also, you know, the public and that type of thing. So that's one thought of whether this is -- and people can react to that.

And also, whether -- if we are going to think about the outlier, whether it does make sense to think of all elements of the changes, you know, at that particular moment. Now my mind just tends to be that way, which is look at everything at once, but I'm not hard over on that, and I'll turn it over to these guys.

DR. CROSSON: Yeah. So, I mean, you make a good point. We've had a pretty good discussion there. Having said that, as Mark says, the process here is sort of one where we come up with recommendations, we present them twice, we vote on them. Now there have been occasions where we will change a recommendation at this meeting, like, you know, it ought to -- it shouldn't be current law;

it should be current law plus one, or minus one, or something like that, or, you know, add an addendum phrase or something to the recommendation.

Taking an issue that we've discussed before and putting it in as a third recommendation, to me it sort of depends on the context. If it follows, you know, naturally from what's up there, and I can think of a couple of occasions where we've done that, then I think it's okay. But if we're taking an idea as valid as that is and inserting it on the fly without, as Mark says, you know, a thorough collaboration of the ramifications of the idea, beyond where we've gone before, then it's difficult to do that because we run the risk of, you know, voting on something, either saying, well, we have a consensus about it now, or taking it to January and voting on it, with, you know, the thorough staff preparation that we normally have.

And so, you know, I guess I'm coming back to some idea similar to what we had in the last discussion, which is it's an important issue, let's bring it forward, but I'm a little concerned about making a recommendation on the fly and voting on it.

MS. BUTO: If I could just add one other point to

that, which is even doing that, which does seem fairly straightforward, would require legislation. And if we're going to, you know, recommend something that requires legislation, I think it's better to have fully thought through the rest of the outlier policy in case there are other pieces; otherwise, it feels like it's too piecemeal.

So, anyway, I would favor waiting, but I hope we don't, as they said, just totally decide not to come back to it. I think it's a good issue to come back to.

DR. CROSSON: Yes, I'm already thinking about a May meeting here. Just kidding.

[Laughter.]

DR. CROSSON: Okay. Clarifying questions?

MR. PYENSON: A question. On page 15, the recommendation -- this is the current law, which is the recommendation. The market basket of 3 percent is an estimate from third quarter 2016, as the asterisk indicates. What is your sense of what's behind that 3 percent? Three percent is, for example, quite a bit higher, I think, than current CPI. And so if we're tying -- are we tying our recommendation to a market basket that we're comfortable with?

MR. LISK: Well, the market basket will be updated, and the historical trend has been that the market basket has gone down. We have actually been -- historically, there has been an over-forecast of the market basket that's gone into current law over the past five years, in fact. The increase is a larger increase in wages, is a compensation for hospital workers. I don't know whether that's going to really happen, but this is what the forecasters are expecting to happen in terms of all the components that go into the input price index.

So this is what we rely on, and it's the best estimate, although they had been consistently overstating the market basket over the past five years.

MR. PYENSON: Thank you.

MR. GAUMER: And I think -- you know, I don't know if you were getting at whether or not we have to use the market basket versus the CPI. Was that your question? Because the market basket is what is in law that has to be used for this update.

MR. LISK: Right, and it reflects hospital input prices, and it's based on national proxies. So, you know, forecasts in other periods have been underestimated, but we

have been in a tendency to thinking the economy is going to be growing more and costs are going to go back up in terms of regular underlying inflation will start rising again. But whether that really is going to happen, I don't know. They keep thinking it's going to happen because they go back to trend lines probably you're familiar with in terms of being an actuary and stuff. I'm not sure. So best estimate.

DR. CROSSON: Okay. I don't see any other hands, and we have moved a little beyond our 50 percent mark in terms of the allocation of time, so let's move ahead. We've got the slide, I think, up there with the two recommendations. For the sake of efficiency -- although it may be risky; I could change my mind -- we'll take both recommendations together. So what I'd like to hear, for those who wish to make a comment, is do you support both recommendations or not. And we'll start -- nowhere, if there's -- Craig.

DR. SAMITT: I support both recommendations as written. No additional comments.

DR. CROSSON: Got him. What was that? What did I say? Okay.

DR. HOADLEY: Yeah, I support both of the recommendations. I could even imagine a case for going beyond the second recommendation from just data collection to addressing some of the issues of where the off-campus -- you know, how the payments are treated for some of these EDs. But, you know, I don't think that's the moment to go beyond that.

I did want to raise questions on two of our older recommendations. I know we referenced the site-of-service recommendations in the chapter, and I wonder if there is value -- and I'm tending to think there would be value -- in actually reprinting those previous recommendations on site of service rather than just sort of summarizing them.

And then I was actually wondering about the status of the uncompensated care definition that we had in last year's recommendation on the S10, whether there's been any response to that recommendation or any changes from CMS; and if not, is that something else that might be worth restating, reprinting in the chapter?

DR. CROSSON: It can be done.

DR. COOMBS: I support both recommendations, and I was thinking along the lines of what Jack said,

especially about the service site neutral, if we were to reiterate that again. Thank you.

MS. BRICKER: I, too, am supportive of both recommendations.

DR. REDBERG: I also support both recommendations, and it did trouble me on page 8 of the mailing materials to see the amount of money Medicare is spending additionally because of the failure to follow our previous site-neutral recommendations, $1.6 billion more because of paying for services that were high-priced at hospital outpatient facilities and $400 million more for beneficiaries' out-of-pocket payments for the same reason. So I hope that action can correct this soon.

MR. PYENSON: Just a comment on the Draft Recommendation 1. I think consideration of no change would seem to be supported by the data, both Rita's comment on the site-neutral as well as the high marginal profit for the efficient hospitals or even the average hospital.

On Draft Recommendation 2, I support it as written.

DR. DeBUSK: I support the recommendations as written.

DR. HALL: I support the recommendations.

DR. CROSSON: Bill? Thumbs up. I saw two thumbs up. Kathy, thumbs up as well. The gladiator makes it -- no, David has got a finger, not a thumb.

[Laughter.]

DR. NERENZ: I support the recommendations, but I'll -- let it go, let it go.

DR. CROSSON: Go ahead. If you can.

[Laughter.]

DR. NERENZ: It won't work. Just to raise a question, actually I'm playing off Bruce's comment. I will certainly support Recommendation 1. I would raise the question, though, whether it's enough just given two things: Slide 13 showing what strikes me as a fairly marked worsening of the situation just across a two-year time period; and then if there's some question about whether the market basket is really going to be as big as we estimated here, and I understand the best available number.

But tempering that is all the other information about access good, capital good, good, good, good, all payer margins looking pretty good. So I'm going to be okay

with the recommendation. But the broader question I just have is: Where do we want these numbers to end up? Meaning as we go through the rest of our two days, we're going to see positive double-digit margins here and there and here and there for all these other sectors in Medicare, and this is distinctly different. When you talk about equity, one of the ways of thinking about equity is the margins in these different sectors should be more alike. They're clearly not. And do we wish them to be more alike? If so, this set of numbers would have to go up more, but it would cost taxpayers a whole bunch of money.

So I'm okay with where we're going, but I just wanted to throw a couple of those caveats out there.

DR. MILLER: Or the other recommendations, the payments come down.

DR. NERENZ: Sorry?

DR. MILLER: Or the other recommendations, the payment rates come down.

DR. NERENZ: That's another way, yes.

DR. CROSSON: And we are going to see some examples of that.

DR. GINSBURG: I support both recommendations. I

also support what Jack suggested as far as a repeating of the site-neutral recommendation from the past.

And I also wanted to make a comment, that I'm a little concerned about what I've heard about the Commission going into the forecasting business. We're all entitled as individuals to disagree with the forecasts used, but I don't think the Commission should be disagreeing, and I think we should use those forecasts.

DR. CROSSON: Okay. Seeing no others, I'm going to assume, since I've heard nothing to the contrary, that we have support for both of these recommendations, and, therefore, in January, these will be brought forward in our expedited presentation and voting process.

Seeing no objection, Zach, Craig, Jeff, thank you so much. Excellent work.

We are now ready for the public comment period, so those of you in the audience who are interested in making a public comment at this time, please come forward to the microphone so we can see who you are and how many there are.

[No response.]

DR. CROSSON: I see no one coming to the

microphone. Therefore, we are adjourned until 1:15. Thank you very much.

[Whereupon, at 11:47 a.m., the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION

[1:15 P.M.]

DR. CROSSON: Okay. Time to get ready. I want to address a couple of remarks to our new audience, but before I do that, I will point out that a couple of Commissioners, in a vain attempt to confuse me, have switched positions at the table.

[Laughter.]

DR. CROSSON: It won't work. It won't work.

DR. DeBUSK: We're going to answer to different names too.

[Laughter.]

DR. CROSSON: Okay.

DR. MILLER: I kind of think it's going to work.

DR. CROSSON: Sorry. For the benefit of our new audience, I just want to make a couple of remarks. Some of you may be veterans here; some of you may not.

The December and January meetings of the Commission traditionally are the point at which we address our recommendations mostly to the Congress, sometimes to the Secretary, for updates for each area, most of the areas, anyway, of Medicare payment. That is something that

we are required by law to do.

So we will be hearing this afternoon four presentations from the staff giving us proposed recommendations, and this is our preliminary discussion. We have, again, traditionally brought these recommendations forward at both meetings, at the December meeting and then again at the January meeting, and the purpose of that is to give adequate time for discussion as well as input from the public, where that is needed.

That said, our experience over the last few years is that it is not uncommon for the Commission members to reach a general consensus here at the December meeting with respect to, generally, support of the recommendation. If that turns out to be the case -- and I will ask towards the end of each discussion to be sure that is the case -- then rather than having the same presentation done again in January, we will have an expedited presentation and voting process in January on those items for which there is consensus reached here at this meeting.

Sometimes in the past, there has been a question with respect to the analysis that we receive and the recommendation we make about the impact of the sequester.

Because I think most of you are familiar with the fact, there is a 2 percent sequester in place which affects the Medicare program, the sequester and its impact is built into the recommendations that we review.

That having been said, we are going to have the first presentation this afternoon, updates to physicians, other health professionals, and then a separate but connected discussion about ambulatory surgery centers. We have four presenters: Kate Bloniarz, Ariel Winter, Dan Zabinski, and Zach Gaumer. And, Kate, you've got that look on your face like you're going to start.

MS. BLONIARZ: Hi. As Jay mentioned, we're going to run through the payment adequacy assessment for physician and other health professional services and ambulatory surgical centers. Thanks to Kevin Hayes, Sydney McClendon, and Brian O'Donnell for their help.

So this slide lays out the payment adequacy framework that we use. I'll note here that we don't report access to capital information for physician and other health professional services, and Medicare does not have cost data for these two sectors. So we use other proxies for Medicare's payments and costs.

Starting with physician and other health professional services, the services are paid under Medicare Part B and occur in all settings. In 2015, Medicare paid $70 billion for these services, or about 15 percent of fee-for-service benefit spending. Services were billed by 582,000 physicians, 183,000 advanced practice registered nurses and physician assistants, and 155,000 therapists and other providers.

The Medicare Access and CHIP Reauthorization Act of 2015, or MACRA, established a set of statutory payments. In 2018, the current law update is 0.5 percent, and two other policies start in 2019, an incentive payment for certain clinicians participating in advanced alternative payment models and a separate payment adjustment for other clinicians.

So starting with access, we have two 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 sources of data and surveys.

Overall, most beneficiaries continue to be able to obtain care when needed at the same or slightly better

rate than for privately insured. A small share of beneficiaries report trouble finding a new provider and are more likely to report finding a primary care clinician than a specialist.

We also looked at some demographic breakdowns. Minority beneficiaries report more trouble obtaining care when needed, and there was minimal difference in reported access between rural and urban beneficiaries.

Finally, one finding in the survey bears particular note. The share of Medicare beneficiaries reporting that they can always obtain regular or routine care when wanted is lower this year than last year, and the last five years show a slight declining trend. This multiyear decline appears for both Medicare and privately insured individuals, and the decline was larger for Medicare.

Our survey is small, and the numbers can bounce around from year to year, but the trend may be of concern. We plan to keep an eye on it and will look at other data sources as they become available.

Moving to other indicators of access, the share of providers who participate in Medicare remains high, and

over 99 percent of claims are paid on assignment. The ratio of providers to beneficiaries is similar to prior years. The ratio of primary care is unchanged, 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.

The Commission has raised concerns about Medicare's current quality program for clinicians. In particular, the program is burdensome. It doesn't allow for a uniform national assessment of quality. Measures are not linked to patient outcomes, and few measures assess low-value care.

In your mailing materials, we discuss three population-based measures. Specifically, low-value care is common in Medicare, and there's a continuing downward trend for most conditions in avoidable hospitalization rates nationally from 2013 to 2014.

I will now turn to Ariel to talk about volume changes.

MR. WINTER: 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.

Volume growth accounts for both changes in the number of services and changes in the intensity or complexity of a service. For example, the substitution of a CT scan for a plain x-ray represents an increase in intensity.

Across all fee schedule services, volume per fee-for-service beneficiary grew by 1.6 percent in 2015. By comparison, average annual volume growth was 0.3 percent between 2010 and 2014.

This chart breaks down volume growth by type of service. Each type of service shown here experienced growth in 2015, and starting from the top line of the chart, it was 1.6 percent for tests in 2015, 1.9 percent for other procedures, 0.5 percent for imaging, 1.7 percent for evaluation and management, and 1.5 percent for major procedures.

Volume changes in the fee schedule are influenced by the ongoing shift of services from freestanding offices

to hospitals. To illustrate this shift, we look at two types of cardiac imaging. In 2015, the number of echocardiograms per beneficiary in hospital outpatient departments rose by 4.7 percent, while the number provided in freestanding offices declined by 3 percent. During same period, the number of nuclear cardiology studies per beneficiary provided in OPDs increased by 0.6 percent, and the number in freestanding offices declined by 5.9 percent.

As the Commission has previously discussed, this change in site of care increases overall program spending and beneficiary cost sharing.

In the context of the fee schedule, volume growth is affected by shifts in setting. 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. So, 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.

This chart shows that fee schedule spending per beneficiary has increased faster than both input prices and payment updates.

From 2000 to 2015, spending per beneficiary grew at a cumulative rate of 71 percent, as shown by the red line at the top of the chart. This is less than the 30 percent cumulative increase in the Medicare Economic Index, which measures changes in input prices, as shown by the white line.

During the same period, payment updates, the yellow line, increased cumulatively by 10 percent. 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 2015 of 0.6 percent. Several factors influenced this change: the 1.6 percent increase in volume in 2015; the small increase in the conversion factor; and payment adjustments outside of the update process, such as the physician quality reporting system payment adjustments.

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 2015. As in prior years, average compensation was much

higher for some specialties than others.

The specialty groups with the highest average compensation were radiology, with an average of $560,000, and the nonsurgical procedural specialties, which consist of cardiology, gastroenterology, dermatology and pulmonary medicine, which had an average of $545,000. By contrast, average compensation for primary care physicians was about $264,000. Previous Commission work showed that such disparities also existed when compensation was observed on an hourly basis.

Validating the RVUs can help correct inaccuracies in the fee schedule and help ensure that certain specialties are not overcompensated. In addition, the Commission has recommended a per-beneficiary payment for primary care that would redistribute some spending from procedural services to primary care.

One way in which CMS has tried to improve payment for primary care has been to create new billing codes for chronic care and transitional care management services. Jay asked about these services at the September meeting.

Although uptake of these new codes has been low, their use has been increasing. In 2015, Medicare began

paying a monthly fee for non-face-to-face chronic care management services. To bill for this service, providers must furnish at least 20 minutes of care management services in a month to beneficiaries with two or more chronic conditions that place them at a significant risk of death, acute exacerbation, or functional decline. Providers must also meet certain billing requirements.

In 2015, almost 300,000 beneficiaries received a CCM service from 7,900 providers. Any specialty is allowed to bill for these services, but primary care providers accounted for 87 percent of the volume. The number of beneficiaries who received a CCM service grew each quarter during 2015, and total payments in 2015 were $41 million, which includes the beneficiary coinsurance of 20 percent.

In response to concerns from providers that the requirements to bill a CCM service are too burdensome and that the service is underpriced, CMS relaxed the billing requirements and added new CCM codes for 2017.

In 2013, CMS began paying providers for transitional care management services for beneficiaries who require moderate or high-complexity decision-making.

TCM services pay for managing care for 30 days

after discharge from an institutional setting, such as an inpatient hospital or skilled nursing facility. The payment covers both face-to-face and non-face-to-face services.

In 2015, 616,000 beneficiaries received a TCM service, up from 267,000 in 2013.

TCM services were furnished by about 51,000 providers in 2015, and 93 percent of these services were billed by primary care providers. In 2015, total payments for TCM were $136 million.

To summarize our analysis, payment adequacy has not changed. Access indicators are stable, as measured by surveys, focus groups, provider participation rates, and the number of providers billing Medicare each year. There was an increase in volume of services, and the ratio of Medicare's payment rates to private PPO rates was stable. Finally, quality was indeterminate.

So the Chairman's draft recommendation reads: The Congress should increase payment rates for physician and other health professional services by the amount specified in current law for calendar year 2018.

As Kate mentioned earlier, the current law update

for 2018 is 0.5 percent.

In terms of implications, there would be no change in spending, and 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 specialty compensation, we will continue to discuss options to better support primary care, such as partial capitation. We will also be exploring options to address the mispricing of services in the fee schedule and looking at ways to group CPT codes into larger families of codes.

Finally, we plan to discuss MACRA and alternative payment models in January.

Now I will hand things over to Dan.

DR. ZABINSKI: Okay. Ambulatory surgical centers. Important facts about ASCs in 2015 include that Medicare payments to ASCs were nearly $4.1 billion. The number of fee-for-service beneficiaries served in ASCs was $3.4 million, and the number of Medicare-certified ASCs was 5,475.

In addition, the ASC payment rates will receive an update of 1.9 percent in 2017, and most ASCs have some degree of physician ownership.

We think it is important to compare ASCs with hospital outpatient departments because OPDs are the setting that is most similar to ASCs, and the ASC payment system is based on the outpatient PPS.

There are some benefits to having surgical services provided in ASCs rather than OPD because ASCs offer efficiencies over OPDs, such as shorter waiting times for patients and greater control over the work environment for physicians.

In addition, ASCs have lower payment rates than OPDs, which can result in lower Medicare payments and lower cost sharing for patients. However, encouraging greater use of ASCs should be considered alongside the issue that most ASCs have some degree of physician ownership, which raises concerns about induced demand.

Finally, relative to OPD patients, ASC patients are less likely to be dual eligible, minority, under age 65, or age 85 or older. There appears to be a number of underlying causes for this, including the fact that ASCs

tend to be in higher income locations.

In our assessment of payment adequacy for ASCs, we use the same measures that Kate discussed earlier on Slide 2. Also, we're not able to use margins or other cost-dependent measures because ASCs don't submit cost data to CMS.

On this table, the values for measures of payment adequacy in the second column indicate a stable situation in 2015. First, the number of fee-for-service beneficiaries served and the volume of services per fee-for-service beneficiary both increased, as did the number of Medicare-certified ASCs and Medicare payments per fee-for-service beneficiary. In fact, the rates of increase in 2015 were higher than the average rates of increase over 2010-through-2014 period.

The 2015 increase in Medicare payment per fee-for-service beneficiary is particularly large at 5.2 percent. This result is a combined effect of an increase in volume per beneficiary of 1.8 percent, an update to the payment rates in 2015 of 1.4 percent, an increase in the average complexity of services of 1.6 percent, and an increase in program spending on separately payable drugs of

0.2 percent.

So, to evaluate ASCs' access to capital, we examined the growth in the number of ASCs because capital is needed for new facilities. A positive growth of 1.4 percent in the number of ASCs in 2015 indicates that access to capital was adequate. In addition, there has been a fair amount of acquisitions of ASCs, physician practices and anesthesia practices by companies that own ASCs. But keep in mind that these companies represent only about 7 percent of all ASCs.

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

Now I turn to Zach who will discuss ASC quality and a draft recommendation.

MR. GAUMER: In 2012, ASCs began submitting their quality data, and in 2014, CMS began reducing payments by 2 percent for ASCs that failed to submit those data.

This year, CMS released the 2013 and 2014 quality data publicly for the first time. It is important to note that CMS has implemented the reporting program

incrementally, and they continue to develop measures, and for 2018 the program will include 12 different measures.

We reviewed the newly released ASCQR data this year, and a general summary of our analysis can be found in our mailing materials. But instead we will focus on our three concerns about the program and some new ideas.

Our first concern is that a significant share of ASCs failed to report their quality data in 2014. For example, 15 percent of ASCs failed to report data on staff flu vaccinations. This reporting gap limits the reliability of the data.

Second, two of the existing process measures reported by ASCs may be topped out. For example, virtually all ASCs reported that they reported administering antibiotics on time. Topped out measures, in general, are of limited value in comparing quality at ASCs.

Third, the list of ASC quality measures lacks claims-based clinical outcome measures that apply to all ASCs. To date, CMS's claims-based outcomes measures only apply to colonoscopy. Others they are developing, similarly, are specific to certain procedures. It might be beneficial to have these types of measures that apply to

all ASCs.

Now, due to our stated concerns, we are exploring an alternative method for assessing ASC quality which assesses the number of Medicare beneficiaries discharged from ASCs who had a subsequent inpatient stay, ED visit, or observation visit within seven days. For 2014, this occurred with approximately 2 percent of all ASC claims, but rates were higher for some types of ASCs and some procedures. In the past, the Commission has also discussed a surgical site infection measure for ASCs.

And, finally, it's important to note that in 2012 the Commission recommended a value-based purchasing program be implemented for the ASCs program.

So to summarize our ASC findings, 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.

At the same time, there were increases in the number of fee-for-service beneficiaries served at ASCs and the volume of ASC services per beneficiary.

There was a particularly strong rate of increase

in Medicare payments to ASCs per beneficiary.

Initial quality data shows some positive results, but gaps in reporting limit the utility of the data overall, and certain areas may require improvement.

We remain concerned that there is no program for ASCs to submit cost data, even though the Commission has recommended that ASCs be required to submit cost data. These cost data could be used to develop an input price index and assess payment adequacy.

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

The Congress should eliminate the update to the payment rates for ambulatory surgery centers for calendar year 2018. The Congress should also require ambulatory surgery centers to submit cost data.

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

The implication of this recommendation for the Medicare program is that it would produce small savings.

The anticipated statutory update for ASC payments is 2 percent, and anything less than that would produce savings.

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

The process of reporting cost data may increase administrative costs for ASCs.

Okay. So that concludes our presentation. We appreciate your time and look forward to hearing your guidance on both recommendations.

DR. CROSSON: Thank you, Kate, Ariel Dan, Zach. Very clear.

So we're going to divide the discussion. These are connected, but they're two separate reports, and so we'll have two Round 1's and two Round 3's in the manner that we usually do. So right now we're on updates to physicians and other health professionals, Round 1, clarifying questions.

DR. CHRISTIANSON: This is a quick one, I think. On Slide 15, the implications on the slide are spending, no change; but in your discussion, you said there would be a

0.5 percent update. Does that mean there's something else that's going down that makes that no change? Are you projecting less volume, or how does spending get to be no change there?

MR. WINTER: As a result of the recommendation, since the Chairman's draft recommendation is to maintain the current law update, relative to current law there would be no change.

DR. CHRISTIANSON: Okay, relative to --

MR. WINTER: As a result of --

DR. CHRISTIANSON: Not relative to --

MR. WINTER: Not relative to -- we're not saying that spending will not go up at all. Other factors are in play, like volume --

DR. CHRISTIANSON: Well, okay, the slide does say spending no change, so it doesn't say no change from current update.

MR. WINTER: Okay. We can clarify that.

DR. HOADLEY: Yeah, on your comparison of commercial rates to the Medicare rates for the physicians, I think you said in the background that it's based on data from one large insurer. Have we done anything to test sort

of the representativeness of that particular insurer's rates compared to others?

MR. WINTER: I personally have not. Is Carlos here? He is indeed. Carlos, would you like to address this question?

DR. MILLER: Well, I think Carlos could -- because I want a line of sight on you, I don't think we've gone through and explored other data sources, okay? So the answer directly is no, we have not done that exploration. There may be some other sources inside that we could look at if you felt it was something that you wanted us to do. Could I get a nod on that second thing? But I don't want to overpromise there because that data set has some different characteristics.

DR. HOADLEY: Yeah, I'm just generally wondering if there were any concerns really maybe the other way to ask the question about -- I mean, obviously there are variations in the commercial market, and I assume that this is a national company. It's not going to be market specific.

DR. MILLER: Yeah, I think your characterization of the data is true, and I'll tell you what. Why don't

Carlos and I talk about this and see how he feels about it? And then we'll either get back to you in January or send you an email along those lines.

DR. HOADLEY: Okay. Thank you.

DR. DeBUSK: You mentioned the physician's fee schedule, and you were talking about the different professions and, you know, their relative incomes. Could you speak a little bit to how "incident to" billing is measured and our ability to discriminate, say, between a cardiologist and their extender when they're billing on an "incident to" basis? Because to me it seems like a blind spot in our ability to differentiate who's actually providing the service.

MR. WINTER: Yeah, there is a blind spot there, but first I wanted to clarify: Are you asking about the physician compensation chart right here? If I can find it.

DR. DeBUSK: Actually, I think you were using that. That was drawn from a different source.

MR. WINTER: Yeah, this is from MGMA data. This is not claims data.

DR. DeBUSK: Yes, MGMA data --

MR. WINTER: Right. This is not showing just

Medicare revenue. So --

DR. DeBUSK: You had mentioned the physician fee schedule itself, though, and the mispricing of physician services --

MR. WINTER: Right.

DR. DeBUSK: -- I think, on a subsequent chart, and that's where I was getting to. Do we really have enough data to understand? I mean, I believe they're mispriced, so I get that part. I just don't know that we -- do we have the underlying data because of this "incident to" billing to be able to really do a top-down approach and understand who's providing -- who's actually providing the service?

MS. BLONIARZ: So it's correct that when a claim is billed "incident to," we don't know that it was billed by someone different from who provided the service, or whether the person that provided the service, you know, had a Medicare billing NPI. Generally, the way it works is services are covered -- "incident to" services are covered for any Medicare billing clinician that has an NPI, so that would be physicians, advance practice registered nurses, PAs. But within the scope of kind of education and

training, other types of providers may be delivering those services, people who wouldn't have a Medicare billing category themselves, such as a, you know, registered nurse.

This is something we've looked at a little bit in the past, and I think our biggest problem is not having data on the claim that the service was provided "incident to."

DR. DeBUSK: So, in your opinion, if we are to dig into the physician fee schedule, let's say, to go to that next level, which I strongly support, are we going to run into this as a road block? Or do you think this is something that at the staff level you could address and sidestep?

MR. WINTER: Yeah, I think we can still bring data to bear on the issue of mispriced services and make suggestions for correcting those values where they are inaccurate, and we have done so over the last decade, at least. So whether it's being provided by the -- whether the service is directly furnished by the practitioner whose NPI is on the claim or by someone else in their practice, we could still -- there are still ways to look at whether the amount of physician work that is assigned to that

service, the amount of clinical staff time, the amount of equipment and supplies that are used, and the cost of those items, we could still look at whether those values are correct or not.

DR. DeBUSK: So we'd largely be constrained to a bottom-up approach, like a RUC-style approach where you're starting with low-level information and building up. We wouldn't have the ability to do, say, a top-down --

MR. WINTER: I apologize I was not clear in my response. So our preferred approach -- you are correct, there is a bottom-up approach and a top-down way of looking at the RVUs, and our preferred mechanism is to go top-down because I think that is a better use of resources. To go bottom-up requires doing something like time and motion studies for each of the 7,000 codes. We don't think that's feasible or a good use of limited dollars.

So we do prefer a top-down approach, and we have sort of piloted this using a contract with the University of Minnesota where they looked at a couple of practices, and they found that, in aggregate, the amount of time that was spent -- the amount of time that was assumed in the fee schedule for certain services compared to the amount of

time that was actually spent by those practitioners, there was a bigger gap for certain specialties like, I think, cardiology than other specialties like primary care.

I think I'd like to talk to Kevin and think some more about the issue of how "incident to" billing would affect that kind of analysis. Off the top of my head, I don't have a great answer for that.

DR. MILLER: And I also think, at least in your last exchange there, there's a difference between, you know, what we can do with claims data and how much there is, you know, any kind of gap. And I, too, would like to sort of say that I agree with the take up here, which is we can probably work around it. But then when you guys got into the bottom-up and top-down, that conversation sort of shifted to, from a policy perspective, how would we think about, you know, setting policy in the future. And you can think of that almost as a different conversation, although there's probably technical ways to look at things top-down and bottom-up.

MR. WINTER: Yeah. And one last point I'll make is that in our comment letter on the physician proposed rule for 2017, we encourage CMS to add a modifier to the

claim to indicate whether a service was provided "incident to," so we would have data on the extent of this phenomenon by type of service, by specialty. They have not done so, but we did make that comment.

DR. CROSSON: Bill, on this point?

MR. GRADISON: No.

DR. CROSSON: Okay.

DR. GINSBURG: Okay. On this issue of comparing Medicare rates with private insurance rates, I was really struck first by the 20 percent decline since 2000 in real terms in Medicare physician payment, which is, you know, the result of lots of very low updates with SGR fixes, and then, you know, I guess starting on the MACRA. And I gather we don't have any information about what the trend has been in private insurance to know whether that's -- or do we?

MR. WINTER: Going back to 2000 or --

DR. GINSBURG: Yeah, just going back for some long -- some period of time.

MR. WINTER: I can talk to Carlos about that and see how far back our data from this large national insurer goes.

DR. GINSBURG: Yeah. Let me get to the next thing. One thing that I've noticed in some of the site visit work I've done is that I think that, you know, the Medicare relative values among different specialties don't exist as much in private insurance as they used to because there's increasingly a pattern that physicians in large practices that have leverage are getting increasingly higher rates in relation to Medicare. Those in small practices have very little leverage.

Primary care physicians rarely have much leverage. They're not in large practices, and even if they are, that doesn't give them as much leverage as if they're in large specialties. So in a sense, the differential in primary care, which is where we're most concerned about possible underpayment, is probably more serious than we may see from aggregate data.

So this, I guess, is a motivator for a lot of our other discussions, but it's just one more fact that the situation could be worse than the aggregate suggests. And I think that's all I have on clarifying.

DR. CROSSON: Okay. Thank you, Paul.

MR. GRADISON: Thank you. I'm concerned about

the question of access to behavioral health services. I appreciate there's a shortage of professionals for the whole country, not just for Medicare. But I'm also aware -- I'm sure all of us are -- of the special problems that the elderly have, the high level of depression, a very serious problem, and also this opiate epidemic has not passed over the elderly or the disabled either.

There are frequent references in here to these issues, but I just want to make sure I got this right. My understanding is that the professions that I'm concerned about as a group, which I would call the behavioral health specialties -- psychiatry, clinical social workers, and clinical psychologists -- are not separated out in your measurements of access and your surveys. I think I'm correct about that, that it's lumped under -- let's stop at that, and then I have a follow-up question. Do you have any data from your sources or others with regard to access to behavioral health services for our beneficiaries as compared with anybody else, other groups?

MS. BLONIARZ: So, Bill, you're right that our survey doesn't break out specialty into subcategories like psychiatry that we might be interested about. We have

asked beneficiaries, when they report having trouble with specialty services, what kind of services are those? We often hear psychiatry as one of them. Dermatology is another. But on a separate project that I'm doing with Dana, we've looked more at access to psychiatric services and the supply of psychiatrists and other mental health professionals. So we're getting data elsewhere on that. But I would say that our experience has been mental health has not been a particular focus in terms of research among the over-65 population. I think it lags somewhat behind other areas.

MR. GRADISON: Thank you. That's my sense of it. My suggestion -- and this is for another day, I'm sure -- is that you consider breaking out behavioral health in your surveys in the future. Thank you.

DR. CROSSON: Well, in addition, Bill, I think I would add to that that, you know, when we use the terms "primary care" and "specialty care," we're often not very exact in terms of what we're talking about. And I think just for myself, with respect to physician shortage issues, when we're talking about primary care, we should be including mental health providers in how we think about

that. And I'm not sure that we've been consistent in doing that.

MS. BUTO: But my question -- and I really appreciate the fact that you flagged, in the survey, the issue of minority beneficiaries reporting more difficulty in accessing care. Realizing that the survey is limited, I wondered if there is any way we were able to tell if there are geographic differences or differences by status, such as dual eligibles versus not, that kind of thing. Because this strikes me as an issue that needs to be addressed, but I'm not sure exactly how to go about doing this, whether we should go back and, like mental health, and try to get more granularity, because this is something that the program should be attending to, it seems to me.

MS. BLONIARZ: And last year we did a little bit more on looking at the reasons that minority beneficiaries report more trouble, because what you say is true. They have -- they are disproportionately likely to be dual, they are disproportionately likely to be lower income than average, and those -- you know, those characteristic are often related with poor access, lower levels of patient experience across all types of measures.

I don't know -- one thing we are struggling with is not having access to the MCBS, the Medicare Current Beneficiary Survey, because that's where we got a lot of data on understanding more about, you know, different characteristics that are associated with poorer access. But it is the fact that there are characteristics of certain demographic groups that make them, you know, more likely to face trouble.

MS. BUTO: Well, is there any way -- even if we can't look at it we ought to consider flagging it for CMS to dive more deeply?

MS. BLONIARZ: Sure. Yeah.

MS. BUTO: Thank you.

DR. CROSSON: Okay. Clarifying questions. We have Pat and then Alice.

MS. WANG: The point that Kathy just raised, I would assume that as we look at, or try to find more data sources to look at those characteristics, residents in health professional shortage area, census-tracked information that links to that, I mean, there is a very big overlap between the characteristics that you described, I suspect, and residents in an area where there is just a

shortage of health professionals to see, which may, you know, suggest different directions from policy recommendations.

DR. CROSSON: Alice.

DR. COOMBS: So a couple of questions I have. One is on this slide. Should there be another curve that actually parallels the onset of the sequester, not as an update but as a reflected -- reflection of what actually happens with the net effect of the sequester, like a green curve, that onsets at the time of the sequester? Just to be more realistic in what actually happened --

MR. WINTER: So a line that says spending after the sequester has been applied --

DR. COOMBS: Right. Right.

MR. WINTER: -- to benefit dollars.

DR. COOMBS: Yeah. Yeah. Yeah. And then -- and on the --

MR. WINTER: One thing is we need to check on whether that red line already reflects the sequester.

DR. CROSSON: Yeah. I would have thought it did. It looks like it does.

MR. WINTER: I'm not sure. I want to check.

That poll is from the Trustee's Report for 2016. I want to check that table and see if it reflects the sequester or not. So we'll check on that and get back to you.

DR. COOMBS: Okay. And then on the curve for the comparative -- the disparities between specialties --

MR. WINTER: Yeah.

DR. COOMBS: -- so that data was obtained from MGMA?

MR. WINTER: That's right.

DR. COOMBS: And so that does the data incorporate hourly work, in terms of -- it's just pure salary, pure compensation, because --

MR. WINTER: It's direct -- yes, total direct compensation for that year. It's not adjusted for hours worked --

DR. COOMBS: Or time, or --

MR. WINTER: But they used to -- back in -- I think the last time they did this was 2007, where they reported data -- they collected data on hours work, and we adjusted compensation for hours worked, and you still saw these significant disparities between primary care and other specialties.

DR. COOMBS: And I have some comments but I will wait until the -- whatever the next round is going to be.

DR. CROSSON: And I will take that as a transitional statement. I think we're done with clarifying questions so now we'll have discussion. Put the slide up, number 15, recommendation. Support the recommendation? Other thoughts? Who would like to begin? Alice.

DR. COOMBS: Thank you very much. First of all, I support the recommendations of the Chairman. A couple of points that I'd like to address. The paper was excellent.

One of the things that I thought was interesting, is I thought the issue around the minority survey results was interesting, but I was also interested in not accessing a doctor for medical problems, and there seemed to be a consistent percentage on both the private side as well as the Medicare side. That seemed to be concerning, and if there's a benchmark for which we say there's an alarm that goes off, this is really serious or this is something we should actually have a certain action plan as a result of seeing that.

And then for the workforce, you know, Brian, you said something that I think is really important, and we

just had some issues within our state about incident to billing, with private insurers saying, "Let's stay at the 85 for no matter what the claim is that comes in." It is very difficult to disaggregate which happens, even in a very robust system whereby you have, you know, an elite academic institution actually have an assignment for quality measures and things of that nature. I think it's very, very difficult to kind of allocate that.

I am interested in what happens with this growing ratio of non-MD clinicians and how do we look at quality going forward, because there's not a way of having attribution in terms of outcomes because of the fact that there's a diversity of clinical setups. For instance, you might have a group of MPs working in isolation. You might have a supervisory role of a physician working in a clinic. I think these are complicated situations that we can't get our arms around for individual practitioners.

So I mentioned the patient access survey, and I think -- it seems to say that access has not been impaired from most of the things, but there's a subset of population for which it has been, the minority patients. But I think, going forward, we have to monitor this because some of the

things that we're implementing may have unintended consequences later on that have to do with delayed care, not that the patient admits that they have a problem with access to care, but they make a decision, a default decision where they won't admit to having an access problem but they will admit that "I'm not going to the physician for X, Y, and Z."

And then the piece about the specialty and the primary care doctors -- I was a primary care doctor once in my life, and as an internist, I think one of the things that I have become acutely aware of, going from there to a specialist, is that the number of hours that are actually put in is far different, and it's very different if you're an employed physician versus non-employed. It's even more different the larger the multispecialty group, because you have a lot more coverage options in a large group. So when you get down to onesie, twosie doctors versus large multispecialties, primary care and specialists, they have a lot more flexibility in terms of hours, and I think this is something that MGMA doesn't do, in terms of looking at hourly and correlating that with wages.

And I looked up some data. A neurosurgeon can

pay anywhere from $90,000 to $200,000 for malpractice insurance alone. Do we get our arms around that? Can anyone understand that? I mean, that's like a lot of cash and a lot of coverage. And then OB/GYN -- and it varies in geography -- a primary care doctor can be as high as $13,000 in some states and as low as $3,000.

So there's some other factors that we haven't considered here, and I think primary care needs to have some kind of robust consideration in terms of supplementing income and actually us evaluating them, but I think on the other side of the pendulum is this whole notion of what do you do for specialty care and the consideration?

For instance, we have a dialysis doctor in our neighborhood who covers three different hospitals. He's needed. I mean, when you get patients with urgent needs of dialysis, and he's a member of multiple ACOs, so that specialist doctor is going to be called on by a whole bunch of primary care doctors. And I'd hate to say that we value one so much less, and they may be covering a lot of primary care doctors. So primary care doctors will call on that doctor and he will say, "Well, I can't help you. I'm inundated."

So I think for our beneficiaries it's really important for us to make sure that there's enough access for both specialists and primary care doctors to really do well, as well as nurse practitioners and PAs.

Recently, with the bundle for hips and knees, I talked to an orthopedic surgeon, just in terms of cultural change, because I wanted to talk about the physician cultural changes with these other things that are going on. An orthopedic surgeon told me, he says, "Well, Alice, you know, 90 percent of our patients are actually going home now, because we have time to really kind of think and be innovative about where the PACs occur."

So I think when you consider some of the things about spend per beneficiary, do consider that there are certain things that are current on another landscape that is shifting decision-making, that is going to result in lower spend per beneficiary. And I was really shocked, and, you know, they utilize a lot more home health, but the fact that they utilize family members as well, to be there to supplement, is an important piece of cost-cutting and efficiency.

So I think I'll stop there.

MR. WINTER: I'm sorry. I looked up the information about the red spending line. It does reflect the sequester.

DR. COOMBS: But the update does not, right? So what I was referring --

MR. WINTER: Yes. The update does not.

DR. COOMBS: -- is a line for -- the line for -- that yellow line --

MR. WINTER: Okay.

DR. COOMBS: -- I was referring to that.

DR. MILLER: I think it does.

DR. CROSSON: Yeah. I mean, the update is an update on the current --

DR. MILLER: Yeah. Well, we'll check it. We'll check it.

Can I actually take you back on your first question? You said people maybe not -- may not say that they have access problems but are delaying care, and the implication of that, for what we've done here, because, again, you know, Kate, I'm not the boss here on this. But our questions are -- well, I don't know it like you -- our questions are about did you get an appointment, did you

delay care.

And so when you said that I was a little unclear on what you were looking for.

DR. COOMBS: So some surveys, a survey we use in our state is were you able to get an appointment within a time frame. We give a time frame. We actually give a time frame. But I don't know how the question is worded. It sounds like, were you able to get care at this time --

DR. MILLER: I see.

DR. COOMBS: -- versus --

DR. MILLER: Right, and we do have some other data sources. We look at that. But now I understand what you're saying. Okay.

MS. BLONIARZ: I think it goes back to why we put wait times in. The first time around, when you've raised this issue before, that generally the survey that we use, some of the other surveys like MIPS ask, can you get an appointment when you need one, that's kind of dependent on how people view the severity of their need, or, you know, they may be willing to defer care.

So, yeah, we understand the point you're making.

DR. CROSSON: Craig.

DR. SAMITT: So I support the Chairman's recommendation here. I know you've referenced the fact that we'll do future work. I just -- I'm still troubled and concerned about primary care, in particular. It's a singular data point but the concerns about accessibility to primary care, with 2016 showing erosion from the prior years, I just worry if that is a leading indicator.

And as we've discussed in prior meetings, what I'm worried about, if there is an ongoing imbalance of reimbursement in primary care, is as much about the pipeline of future primary care, and I don't know whether we track and measure that to any degree, but a single eroding data point this year could be worse next year, and then you've got several years to try to fix and remedy physicians that may actually choose not to select primary care versus other disciplines.

So I'm worried that there is -- it's a canary in the coal mine to see that data point, and whether we should be more worried about this, and I know we won't make changes in this recommendation, but I think it's something that we need to study further when we evaluate primary care early next year.

DR. CROSSON: And Craig, I agree with that, and I actually think that the pipeline effect is more than a few years. It's -- I mean, depending on specialty it's many years, so determinations on the part of physicians are made sometime in the middle of medical school, and in some cases before that, based upon economic prospects, among other things.

Is it conceivable -- we have anecdotally talked about, over the last number of years, about the pipeline, the impact on primary care, and I would say primary care plus. Is there a thought that we could actually -- is there a way to get this from AAMC or ACGME, to take a look at trends?

MR. WINTER: We can look into that.

DR. CROSSON: Okay. Yeah, Rita.

DR. REDBERG: I also support the Chairman's recommendation, and in addition to the concerns about primary care I would like to mention concerns about low-value care, because, you know, clearly Medicare has spent -- this is a very, as you noted in the mailing materials, very conservatives estimates, because we don't have clinical data and there are a lot of downstream checks and

procedures that occur from low-value care, like imaging for low back pain and PSA screening, and the high spendings, like PCI for a stable coronary disease.

These are things that are not just costing a lot of money but are harmful for beneficiaries, so it seems like it's a lose/lose, because we are doing things that are making people worse off than if we hadn't spent all this money. They lose time and they lose quality of life, and sometimes worse than that. And so I think it has to be a high priority.

DR. CROSSON: I agree, and as you well know, better than anybody probably, you know, one of the issues in the Medicare program from the very beginning has been a limited number of tools to deal with appropriateness. And, you know, we have tried to deal with that in a number of ways and we need to continue to do that.

DR. REDBERG: There are things like the quality measures. We could put a lot more overuse into quality measures. I know there was an attempt that CMS is re-looking at, about PSA measures, but when the Preventive Services Task Force gives PSA testing a Grade D, meaning it's not recommended, that's pretty -- that seems like a

clearer path, and some are easier than others.

DR. CROSSON: Jack.

DR. HOADLEY: I support the draft recommendation, and I guess I wanted to, like Craig, just sort of talk about the importance of some of the future work on primary care, I think to the fact that we've got an existing recommendation on the per-beneficiary payment that seems to not have led to any action, at least to date, and, you know, we've obviously had discussions of other ways, other alternatives to go there. And I think it's worth just restating, for the record, that those are important efforts and should continue to be a priority.

DR. CROSSON: Agreed.

DR. MILLER: And just to -- I think you said this, but we're expecting to come back to that in the spring, right?

MR. WINTER: January.

DR. MILLER: Oh, in January.

DR. CROSSON: January.

DR. MILLER: Well, early spring and --

MR. WINTER: The early spring.

[Laughter.]

DR. CROSSON: Early spring.

DR. MILLER: Yeah. So you should start to hear about that in relatively short order. But yes, it will be also said in the chapter.

DR. CROSSON: Okay. So once again --

DR. MILLER: Paul.

DR. CROSSON: I'm sorry. Paul, I didn't see you. Sorry.

DR. GINSBURG: I also support the recommendation, the Chairman's recommendation, with the frustration of, you know, really wanting to do something to address the primary care issue that we've all been talking about. It's just very important to me that it is on our agenda, and I look forward to that.

DR. CROSSON: Okay. Once again I think I see a broad consensus here on this issue. We haven't dealt with ASCs yet, but on the issue of physician and other health professional payment. We will, without objection, take that forward in the expedited voting process in January.

Okay. So now we're going to come to Round 1 questions with respect to ASC update. Bill.

MR. GRADISON: On page 21, there is reference to

a proposed requirement of 1,000 units of service to provide some assurance that the ASC knows what they're doing.

My understanding of this is when you say 1,000 -- and it's mentioned here a couple of different -- the wording is slightly different in a couple of different places -- that you would mean 1,000 colonoscopies or 1,000 cataract surgeries, not --

MR. WINTER: Yes.

MR. GRADISON: Okay. Question: those numbers actually sound kind of high to me. I'm not suggesting they are but they sound that way to me, and I wonder whether this 1,000 requirement for a specific service would, in any dramatic way, affect what these organizations do. In other words, would it cause some of them to become more specialized and to shift some of their volume in ways to make sure they hit the 1,000?

I'm just thinking, what if you have an active ASC that does half a dozen different things, and -- this is hypothetical, but they're doing 750 of each of them. They wouldn't qualify under this, and I just wonder if you can measure this against the real world, because I'm just speculating in my question.

DR. ZABINSKI: I guess I have to clarify some things in this section.

The 1,000 units, it's not per ASC. It's for all ASCs. The idea is identify a service, a particular service, where the total volume across all ASCs is at least 1,000. It's just to provide some degree of assurance that they're being done in ASCs, just for the reason it would seem at least somewhat safe and that they're doing them safely in ASCs.

DR. CROSSON: Okay. Jack.

DR. HOADLEY: On that same discussion that Bill was just alluding to, you referred to sort of what we did previously. Was that as a formal recommendation, or is that just more general discussion?

DR. ZABINSKI: No. That was a general discussion in the June 2013 report.

DR. HOADLEY: Thank you.

DR. CROSSON: Amy and then Alice and then Mr. B.

MS. BRICKER: I was fascinated by the statistics around the subsequent hospital visits. So I don't know if it's appropriate for us to maybe follow up with some additional conversation around that or as part of our

actual recommendation to ensure that we're looking at the right metrics when assessing the quality. I think that's really interesting that cardiology was listed, that percent that end up back in the hospital in seven days, low number of cases.

That's all.

MR. GAUMER: That's something that we're kind of looking at here initially for the first time, so it's something that we plan on thinking more about. These rates right here are not risk-adjusted, and that's really critical for a measure like this. I appreciate you saying that, though.

DR. CROSSON: I actually have a question here myself just for a second. I'm trying to remember how many years that I've been here that we've had a similar recommendation with respect to ASCs and the reporting, and there's resistance from the industry.

I apologize if you don't know this, but what has been the track record, say, for the last five years of what the actual updates to ASCs has been? Have there, in fact, been zero updates, or have they been, in fact, getting robust updates anyway?

DR. ZABINSKI: Well, the actual updates, they have always been the CPIU, less some multifactor productivity. It's somewhere, anywhere from -- I know a year or two ago, it was like as low as .3, projected for a couple years now, up to 2.0 percent, so generally less than, say, what the hospitals get, but something positive.

DR. CROSSON: Well, okay. So "robust" is probably not the right term, at least in some people's context, but it would still seem that one could draw conclusions from that, and that is if the updates were not adequate. In fact, this part of the industry had reason to believe that they should be getting higher updates. Then there would be less resistance to cost reports. That, in fact, that case could be proven, or am I being overly simplistic? Anyway, that's a rhetorical question.

Alice.

DR. COOMBS: I understand the ASC does not submit claims data, as we know now, but is it possible that you could actually look at re-ops? So a surgical site infection measure is great, but what about someone who doesn't necessarily go to the hospital, but they may go right back to the ambulatory surgical center and have

another surgery and never interface with being admitted to a hospital?

MR. GAUMER: That wouldn't be included in the measure that we spec out here, but that's something that we could consider looking at as a part of the episode. We didn't do that this year, but I don't think you guys have done that in the past.

DR. COOMBS: That's something that we do as a part of a quality measure for us because it's very easy to get at. Another thing was done. You have a code for it. It's being billed for. Got it. Bingo.

DR. CROSSON: Okay. Bruce.

MR. PYENSON: Thanks, Jay.

Terrific report. A question for Zach. On page 10, there's a description of risk scores, comparing HOPD to ASCs, and I'm assuming there, you used the HCC risk score for the patients.

DR. ZABINSKI: Correct.

MR. PYENSON: Of course, HCC probably is the risk score in the prior year, based on the prior years' experience.

DR. ZABINSKI: Yeah, that's right.

MR. PYENSON: It's the prospective risk score.

DR. ZABINSKI: Prospective.

MR. PYENSON: And that perhaps is almost more of a -- perhaps better at episodes than events as an indicator. In effect, the 12-month episode is what the risk scores is based on.

You say that for some of the high-volume procedures, the risk score was higher for hospital outpatient. For others, it was lower. Do you think that there really is a difference, or is it more -- a difference with respect to the importance of the patients, and the fact of having surgery or not having surgery when you wrap that all up, do you think the patients are really different, or is that just a phenomenon of better coding or something else like that?

DR. ZABINSKI: I don't think it's better coding.

MR. WINTER: Daniel?

DR. ZABINSKI: Yes. Be my guest.

MR. WINTER: So I did the analysis originally, and in talking to physicians, surgeons who work at ASCs, they will tell you that there are some patients where they're just too sick. They have too many comorbidities to

safely operate on them in an ASC. So they will take them to a hospital instead.

So we were trying to find a proxy that we could identify for all beneficiaries or a large sample of beneficiaries, a proxy for patients' health severity or comorbidities, and so the fairly easy one to get access to is the risk scores, beneficiary risk scores.

We never said it's a perfect proxy for disease severity or the impact of disease severity on an ASC's cost or the cost of doing a procedure in one facility versus another, but we think it's a reasonable proxy, and we've used it for several years. But if you have other ideas for other clinical information we could use that's either available on claims or administrative data, we'd be open to that.

MR. PYENSON: The question, of course, there is this dramatic difference in cost between HOPD and ASC, and the HCCs weren't really designed for this, but how big were the differences? I don't think that was in the report, say they're statistically significant.

MR. WINTER: Oh, the actual numbers?

MR. PYENSON: Yes.

DR. ZABINSKI: Let's see.

MR. PYENSON: Maybe they are in the report.

DR. ZABINSKI: Yeah. That's an average in here.

MR. WINTER: The average.

DR. ZABINSKI: Yeah. 1.57 in OPDs and 1.13 in ASCs on average.

MR. PYENSON: And we don't really have an opinion if that affects the actual cost of having the operation?

DR. ZABINSKI: Bi,

MR. WINTER: The actions of cost data --

DR. ZABINSKI: Yeah.

MR. WINTER: -- we can't make that calculation, but in looking at the literature and talking to physicians, there seems to be something of a correlation between the cost of a procedure or the time it takes to do a procedure and the number of comorbidities and the severity of those comorbidities for a patient. So, if they require extra attention while they're undergoing anesthesia, for example, that could require additional time, additional resources.

MR. PYENSON: But within the context of an HOPD, you can evaluate the RVUs for anesthesia and see of those are correlated, for example, with HCC. So, within the HOPD

environment, you could do that, I suppose.

MR. WINTER: To look at anesthesia time, yes.

MR. PYENSON: Thank you.

And you could probably do it with some of the other things that happen on the same day, whether there's more, perhaps, imaging or other things going on.

DR. MILLER: I missed the antecedent. Let's say you find something like that. Where in your thinking does that take you? And maybe I missed your opening.

MR. PYENSON: Well, that's a great question.

[Laughter.]

DR. COOMBS: Can I add something to this? Only because when you look at anesthesia time, it has very little correlation with a number of things that I think is implied here in terms of what the patient looks like, whether or not the time is correlated with intensity of treatment or anything like that.

I mean, one thing alone by itself is that in HOPDs, you might have more trainees. Trainees add to the time of a procedure in and of itself. I'm reluctant to use anesthesia time as a proxy for measuring anything.

MR. PYENSON: Well, it might be correlated with

recovery room time, which is a -- I mean, the anesthesiologist gets paid through Part B, so that's not the issue. So I'm looking for things like that.

But I had another question. On page 33, you suggest a methodology or ASCs submitting information, for submitting cost information, and as I mentioned at previous meetings, I think the Medicare cost reports that are established in other sectors are not a good model. What I'm seeing here is some terms like "total charges," as though we're encouraging ASCs to develop a charge master. I know the term "charges" can mean many different things. I wonder if you'd consider using a standard RVU kind of approach or look at the entire output from the standpoint of repricing everything according to the Medicare fee schedule as a basis for developing a cost accounting approach for ASCs. So my question is what direction were you thinking of this, because this is pretty high level.

DR. ZABINSKI: Well, I think in the general sense, the idea was to go in the direction of your typical cost report, but we're not totally wedded to that idea. We could go with an alternative, such as your RVUs. Off the cuff, I'm not going to give any elaborate answer on that,

but it's something to think about.

MR. PYENSON: Okay.

DR. MILLER: And at least I think part of our initial motivation would be comparability to the OPD, which is, I think, some of our thinking, not all of it, and it doesn't close the door on your other idea. But I think wake somebody up in the middle of the night, I think that was part of the thinking too.

MR. WINTER: And the other reason we made the recommendation and made it for several years is so we can have -- so CMS can have accurate data to develop a more accurate market basket for ASCs because they've been using the CPIU for decades, and there's evidence that it's not great proxy for the cost of operating an ASC.

So we looked at whether the physician practice expense, the MEI -- that's a proxy that includes practice expense for physician practices -- whether that would be a better proxy for ASCs, and we were looking at some fairly old cost data that were collected by GAO from a survey in 2004 and found that the cost structure of ASCs is pretty different from a physician practice, and so I would be concerned about using the physician RVUs as a proxy for ASC

relative cost.

I don't know if that's what you're suggesting, but that's how I understood it.

MR. PYENSON: Well, I think, first off, I just have a real distaste for the Medicare cost report kind of structure.

DR. MILLER: You've been clear on that.

[Laughter.]

MR. PYENSON: So we have an opportunity in a relatively small segment of Medicare spending to prove that something else can work, and for lack of something -- I'll use the term "RVUs," but, in effect, repricing all of the services of the ASC according to the Medicare fee schedule could be that proxy, and you avoid the issue of charges entirely.

DR. ZABINSKI: I got your point that you weren't necessarily talking about physician RVUs, so we're on the same page on that. But, yeah, it's something to think about. It's complicated.

DR. MILLER: Yeah. And the other thing is there was a point -- and now this is really ancient history. There was kind of a junior varsity cost reporting effort on

ASCs.

DR. ZABINSKI: Yeah.

MR. WINTER: They did at least two surveys, and the last one they did was, I think, in '98, '99, 2000, that range, and they were not -- CMS was not satisfied with the quality of the data that they collected. It was a survey. It wasn't a cost report kind of thing for all foster care. It was about 1,000 or so facilities that they sampled.

DR. MILLER: And my only point in making this was -- and, again, it still may not meet your interest or your concerns -- it wasn't exactly replicated the cost reports on the hospital side.

MR. WINTER: No. No.

DR. MILLER: And so we see your point.

MR. WINTER: And one thing they tried to do with that survey, as I recall, was to create relative values, an RVU kind of concept, and it didn't work out. And I forgot exactly why, but they were thinking along those lines.

MR. PYENSON: Thank you.

DR. CROSSON: Okay. I saw Paul. Clarifying questions?

DR. GINSBURG: I was just getting into this

discussion about cost reports. I don't think we want to go into it this deeply, but there's a real debate, tradeoffs about the objectives. Is the main objective to be able to compare to the hospital outpatient departments, which might limit you? Instead of getting a 21st century approach to cost measurements, you'd have to resign yourself to a 1960s approach to get that comparison, or is getting a better indicator for trends more important than that? So not something we want to resolve today.

DR. CROSSON: Helpful points.

I see no further questions. We're on ASC update. The recommendation is up on the screen. Comments on the recommendation or other related ideas?

Kathy.

MS. BUTO: I support the recommendation.

A concern I have, generally, as compared to probably the general view of the Commissioners is I'm worried about too broad an extension of site-neutral payment, particularly in an area where we don't know very much about costs or even capacity. So I just raise some questions for future thinking, which are, are we confident that ASCs are distributed widely enough around the country?

So that if we were going to pay ASC rates -- and I know this is not part of our recommendation -- to OPDs, that we wouldn't be actually reducing access for some of the beneficiaries that you've identified as being underserved by ASCs, like Medicaid duals, minority, particularly African American patients, et cetera.

So I'm a little worried about playing with all the criteria for how we apply site-neutral and using ASC rates in hospital outpatient departments without knowing more about whether there will be access, who we're affecting, what services we're talking about, and whether we're really undermining the ability of hospitals to provide broad services to the population.

So I'd be just concerned about that going forward, but I support this recommendation. I hope we'll look more deeply into this before we decide what we're doing in this arena.

DR. CROSSON: Yeah. I mean, I think in general -- and we've tried to be careful about this -- any site-neutral recommendation we make needs to be characterized by comparability in all the areas that you described.

Okay. Other -- Amy, yes.

MS. BRICKER: I am supportive of the draft recommendations.

DR. CROSSON: Okay. Thank you.

Alice?

DR. COOMBS: I'm supportive of the recommendation, and I just wanted to address something that Kathy said. So ASC would be probably the higher priority for site-neutral compared to the other things that we've kind of proposed, mainly because the sicker patients are already in the hospital. But I would do something to kind of adjust for the hospital taking care of its burden of sicker patients, especially for disproportionate share hospital. But my concern would be like yours, but I think the stage is already set for that. Maybe there's some shifting that might occur in the future.

MS. BUTO: You mean you don't -- you're comfortable with applying ASC rates to hospitals? That's what I think we're talking about. At least that's the way I read the text box.

DR. COOMBS: So I would say that in this one situation, the opposite is what I want to say, is that the hospitals have shown due diligence to take care of the

burden of sicker patients -- that's what I really want to say -- than with the ASCs.

DR. CROSSON: I thought what I was hearing was something quite -- a little different from -- let's make sure we're apples and apples. But I thought what Alice was saying was something like they're not apples or apples, or where they're not apples to apples, it would be an adjustment factor.

DR. COOMBS: Right [off microphone].

DR. CROSSON: Is that what I was hearing?

MS. BUTO: Right. So I think we're basically on the same page. And I'd also worry about capacity, not just, you know, apples to apples but, in fact, are there ASCs available? Before you start applying ASC rates to hospitals, are there ASCs available as an alternative?

DR. REDBERG: I support the Chairman's draft recommendation, and I also wanted to mention, on the theme of low-value services, that if you look at the list of the most frequently provided ASC services, there's a lot that are of questionable value. A lot of them are spinal injections, which were on the list of low-value services that we just talked about. And there's also a lot of upper

and lower GI endoscopy, which we don't know the value of. Certainly, though, getting to the things that are easy to measure, you know, the recommendation for colonoscopy for cancer screening is every ten years, yet we know the data shows that Medicare is paying for it at a more frequent rate than that, like every three to seven years. And I suspect some of that's going on at the ASCs, particularly with the data that was shown that increased volume of services is associated with physician ownership of ASCs, and those are usually physician referral services. So I think, you know, before we start talking about the payment rates, the first important thing is were patients better off having got any service or were they unindicated services in ASCs?

MR. PYENSON: I support the Chairman's recommendation, though I would question the inclusion of the last bullet item, that it would cost -- reporting would increase administrative costs. I'm not sure that we know that or if that's -- or the significance of that. I hate to sound like, you know, the standard line on the Paperwork Reduction Act that, you know, this form takes five minutes to fill out or something. But I think the reality is that

ambulatory surgery centers are significant businesses. They have accounting capabilities. Often they file taxes. They have significant income. And this sort of reporting out to be easily automated, so it may not, in fact, incur significant cost. I just don't know, and I'm not sure if that's been investigated. So I wonder if we could either strike it or say "may incur some administrative cost."

DR. MILLER: I don't think that's a problem. I'm looking at Zach and thinking that more what we were trying to be sensitive to is industry saying, "Oh, my God, you have no idea, it's going to cost us so much money." And we're at least acknowledging that we had heard that. We appreciate your view on it and will reflect it.

DR. CROSSON: Wait, so I'm confused. So are you saying you want the last sentence removed?

DR. MILLER: No. I think he's talking about the last sentence of the implications.

DR. CROSSON: Oh, implications. Okay. I'm sorry.

DR. MILLER: So we'll tone that down to "could," "may."

DR. CROSSON: Okay. All right.

DR. MILLER: That's what you were looking for.

MR. PYENSON: Yes.

DR. CROSSON: Not the body of the recommendation but the implications.

DR. MILLER: Yeah. We did not go in and do an estimate of how much time it took to do this, you are correct.

MS. WANG: I'm supportive of the recommendation. I wonder why we wouldn't also add that Congress should require the submission of quality data. I realize that there's a penalty that apparently doesn't seem to bother the centers because so many of them are willing to take a 2 percent cut, which does suggest that the payment update recommendation is well founded. But it bothers me somewhat that Medicare cannot ask for or demand as a condition of payment all of the information.

MR. GAUMER: One little bit of feedback or fact-filling-in here: There is a low number of ASCs that actually receive the 2 percent penalty. I think in my script there I said, you know, for example, 15 percent of ASCs didn't report this measure or that measure. It varies by measure. Fifteen percent of ASCs did not receive the 2

percent penalty, and that's because in part CMS allowed some of the, you know, hospital -- or, excuse me, ASCs to suppress their data from reporting publicly. So they did report it -- most of them did do the reporting, but the information was suppressed when it was publicly released. Does that make sense.

DR. REDBERG: It doesn't make sense -- [off microphone].

MR. GAUMER: No. Right, right.

DR. ZABINSKI: No. I mean, just as a fact of numbers, in the first couple years of the data reporting, about 2 percent of ASCs chose not to report the data at all. That total number, that's about 115, something like that. So that's what --

DR. MILLER: You guys --

DR. CROSSON: Well, go, you finish

DR. MILLER: So it sounded to us, I think, like you were saying a lot of people aren't reporting. I think they're saying -- tell me if I'm following this -- we think most people are reporting, but then the data we get to see what's going on, some of it is suppressed. So we might not necessarily have an accurate number of how many people are

reporting, and it could be that very many of them are.

DR. ZABINSKI: That's correct.

DR. REDBERG: Do the regulations state public reporting or just suppressed reporting?

[Laughter.]

DR. ZABINSKI: Another point on the suppressed reporting, so far CMS has only allowed it for two years, '13 and '14, and also on a limited set of the data measures. As far as I know, CMS has not extended that allowance to suppress the data. I haven't heard about them doing so. So in the future, hopefully, it will not occur anymore.

DR. MILLER: To either of you, do you recall a motivation when this was talked about? Because I'm not up to speed on this.

DR. ZABINSKI: No, there wasn't a real strong like, you know, because of this. It was most like this is what's going to happen.

MR. WINTER: And this did not appear in rulemaking. This was in a memo that they put on their website and sent around to folks on their listserv. So we just happened to notice it, but it wasn't -- I don't think

it's ever appeared in a rule. Is that correct?

DR. ZABINSKI: No, it has not appeared in a rule.

MS. BUTO: So back to Pat's point, though. We could add Congress should also require ASCs to submit cost and quality data, if we wanted to.

MR. WINTER: Yeah. It is in statute that they have to submit quality data or take a 2 percent --

MS. BUTO: Or take -- okay. So maybe we ought to consider 2 percent being too low.

DR. CROSSON: Okay.

DR. MILLER: But, again, most of them could be reporting, and once the data is no longer suppressed -- and no, I don't know how the hell that happened, Brian. You know, it might be that this is a very small problem.

DR. CROSSON: Okay. We've got several ideas on that, so let's get more.

DR. NERENZ: This is just an amendment to the current idea. I don't think I'd push hard for reporting of the current quality data, because it doesn't look very good to me. No, you said two measures are topped out. I looked in Table 4. Other measures by the same mathematics are even more topped out. You've got three left. One of them,

my own judgment, doesn't speak very much to quality at all. At least I don't see the clear evidence. So rather than push hard to report what probably is not informative or does not differentiate the facilities from each other, I'd wait until there are a good set of measures, then require reporting.

DR. HOADLEY: Just following on this point, it may be that it's going to become a moot point, but I don't recall any other sector where institutions have been allowed to have data reported suppressed, and it just seems like a strange policy. And maybe that's worth just a sentence somewhere to comment on it. It sounds like it doesn't at this point raise to recommendation status, but --

DR. CROSSON: So let me try this: So I think what I'm hearing here is discomfort with the current quality reporting, both in terms of the way it's done and the fact that some entities -- and we don't know how many -- are reporting and having it suppressed. Or am I wrong about that, we do know but we don't -- how many are having the data suppressed? But that's time limited, anyway. I'm sorry.

DR. ZABINSKI: Well, the answer to that is we don't know exactly how many are having it suppressed either. We can get, you know, a range perhaps, but exactly, we don't know.

DR. CROSSON: So we could do -- it seems to me we could do a couple of things. We could ask for additions to the text around this set of concerns and essentially calling on the Secretary in this case to review the whole quality measurement process and reporting and its relationship to payments. We could, on the other hand, since this is, to my mind -- it is material to this. It's not a separate idea, really. We could add another recommendation, or we could add -- well, I don't think -- submitting quality data is already there, but what we could add, if we wanted to, we could add -- and I'm doing the opposite of what I said before; I understand that -- something very simple asking the Secretary to review the current assessment of quality in ambulatory surgical centers, and maybe a couple of other words. Is that -- so how do people feel about one versus the other? Satisfied with augmentation of the text? Or do you want to add another recommendation? Because if we're going to add it,

we have to draft it and add it now so that we can vote on it again in January.

MS. WANG: I'm comfortable with your formulation, but I would maybe augment that with developing looking at the quality measure set, ensuring that it is meaningful, and ensuring that it is publicly available.

DR. CROSSON: Yes, okay. In the text.

MS. WANG: Yeah.

DR. CROSSON: Yeah, okay.

DR. NERENZ: I guess I'd also support it in the text, in part, I think, because our focus here is on the payment updates, unless there's an explicit link between payment and the quality metrics, I think it's in a somewhat separate territory. I'd be happy to have it just show up in the text.

DR. CROSSON: So you're arguing for Chairmanship consistency on my part?

DR. NERENZ: That's generally a good idea, yeah.

[Laughter.]

DR. CROSSON: Thank you for that. I was seeing the same thing in Brian's eyes as well.

DR. HOADLEY: I agree that the text makes sense -

- doing it in the text makes sense, and, you know, given the sort of squishiness of what the history is here, you know, that's a good way -- another good reason to sort of not try to formalize it in recommendation terms.

DR. CHRISTIANSON: Is the intent then that the group will come back with some better quality measures for us to discuss? Is that what we're looking for eventually? Because just saying we think there should be better quality measures, if we know what better quality measures are, could come up with some that would be helpful.

DR. MILLER: Okay. So this is what I'm taking away from it. First of all, all of what I'm going to say is in the text, and I agree with that, too. I would rather try and deal with it there where I have a lot more flexibility, and if somebody doesn't like a work or we don't get it right, we're not into the bolded recommendation range. But, of course, we can do it any way.

I think it would have two things, Jon. One is the public availability of the data, which I think is pretty clear. You know, you may have been suppressing it, we are assuming, and we want you to stop doing that, you

know, as soon as -- or immediately.

Then the second thing I would see is we have some concerns about how the quality measures are falling out. Maybe some of this stuff that David said we would like another look at this. And then what I would do -- and I don't have this to tell you right now -- is maybe -- and I know Zach has been thinking about this in the background. Some of our own ideas that we would say you might want to look here and here. And I know he has a few of those things in his head, and we'll get that all excavated and put on a piece of paper for you. You good with that?

MR. WINTER: Yes [off microphone].

DR. MILLER: All right.

DR. CROSSON: Okay. So that having been said, again, I see, without objection, general consensus to support the recommendation as drafted. We will, therefore, in January have this brought forward as part of the expedited review process.

Okay. Thank you, Kate, Ariel, Dan, Zach. Nice job.

[Pause.]

DR. CROSSON: We have Carol Carter with us here,

and we are going to talk about the payment update for skilled nursing facility services.

DR. CARTER: Great.

Before I get started, I wanted to thank Sydney McClendon for her work in helping to get this chapter together.

I'll begin by providing an overview of the SNF industry and then present information related to the update and end with a summary of the Medicaid trends that we are required to report.

Here's a sketch of the industry in 2016. There were about 15,000 providers, and about 1.7 million beneficiaries, or about 4.4 percent of fee-for-service beneficiaries use SNF services. Medicare spending was just under $30 billion, and Medicare makes up 11 percent of SNF business, but 21 percent of revenues.

I'll be using our update framework to assess the adequacy of Medicare's payments. I'll go through this material quickly, but there's more detail in the chapter.

Access to SNF services is adequate and stable. Supply was steady between 2015 and 2016. In 2015, 88 percent of beneficiaries live in a county with at least

three SNFs, and less than 1 percent of beneficiaries live in a county without a SNF or swing-bed facility. Occupancy rates were down slightly but remained relatively high, at 86 percent. However, about one quarter of facilities have occupancy rates below 75 percent, indicating some capacity for additional volume.

Between 2014 and 2015, covered admissions increased, consistent with the increase in inpatient hospital stays, which is required for Medicare coverage, but stays were shorter, so total days declined.

The mix of days reflect the biases in the PPS design. Since the SNF PPS was implemented, there's been a steady increase in the share of days classified into the intensive therapy case-mix groups.

In 2015, 82 percent of days were assigned to these groups. Even though the number case-mix groups for medically complex patients was expanded in 2010, their share of days remains low.

The growth in the amount of therapy furnished is not related to the patient characteristics but instead reflects two design features of the payment system. First, the amount of therapy and not patient characteristics drive

payments. Second, as more therapy is furnished, providers' costs increase, the payments increase even faster. MedPAC and the OIG have both found that furnishing more therapy is more profitable than furnishing less therapy.

In 2016, the Department of Justice settled lawsuits related to the therapy practices of three companies. In addition to the therapy side, the PPS poorly targets payments for non-therapy ancillary services, such as drugs, so patients with these care needs can be hard to place at discharge from the hospital. The Commission first recommended changes to the PPS in 2008.

Turning to quality measures, the performance was mixed. We track three groups of risk-adjusted measures: discharge to the community; potentially avoidable readmissions, both during the stay and during a period after the stay; and changes in function.

The average facility rates of discharge back to the community and readmission rates improved between 2014 and '15, but the function measures were essentially the same. The chapter shows the variation in rates and indicate there is plenty of room for improvement.

Turning to access to capital, industry analysts that I spoke with report that capital is generally available and expected to remain so in 2017, but is getting tighter. Lending wariness reflects two broad trends. First, SNF use may decline as bundled payments, ACOs, and enrollment in MA plans expands and their utilization is lower; and second, the Department of Justice investigations into therapy practices may have a chilling effect on some providers' therapy practices. The reluctance by some lenders does not reflect the adequacy of Medicare's payments. Medicare continues to be a payer of choice.

In 2015, the average margin for freestanding facilities was 12.6 percent, and that was the 16th year in a row that the average was above 10 percent.

Across facilities, margins vary substantially. One quarter of SNFs had margins of 2.4 percent or lower, and one quarter had margins of at least 21 percent. There continues to be large differences between for-profit and nonprofit facilities, in part, due to differences in their mix of patients and therapy practices, but also because on average, nonprofit facilities are smaller. They have higher costs per day and in recent years have had higher

cost growth compared to for-profit facilities. The marginal profit was 20 percent, indicating that facilities with free beds would have an incentive to admit Medicare patients.

To understand the differences in performance, we look at the industry in a couple of different ways. One way is to compare the characteristics of high- and low-margin SNFs, and we define those as those in the top and bottom quartiles of the distribution of Medicare margins. And we find that differences in payments and costs drive the disparities in margins.

On the cost side, compared to lower-margin SNFs, high-margin facilities had considerably lower costs per day after adjusting for differences in case mix and wages. They have lower routine and ancillary costs per day, and they have higher average daily census and longer stays that yield greater economies of scale.

On the revenue side, high-margin SNFs had higher revenues in day in part because they provide more intensive therapy and have fewer medically complex days.

Another way to look at the differences in performance is to identify a group of efficient providers

and compare them to other SNFs. Efficient providers are those that perform well on both cost and quality metrics three years in a row, and in this sector, the metrics we use are standardized cost per day, the readmission rate, and discharge to community. We do not prescribe how many SNFs should meet the definition. Rather, we set the definition and identify the providers that meet it.

In 2015, over 1,000 SNFs, or about 9 percent of the industry -- or actually the SNFs that we included in the analysis were relatively efficient. They are more likely to be urban and for-profit and can be found in 44 States, and they include three in frontier locations.

Compared to other SNFs, they had community discharge rates that were 27 percent higher, readmission rates that were 15 percent lower, and because they, on average, are larger and had higher daily census, they achieve greater economies of scale. Their standardized costs were 8 percent lower, and on the revenue side, their revenues were 10 percent higher. The combination of their lower costs and higher revenues per day result in an average Medicare margin of over 19 percent.

In assessing the level of fee-for-service

payments, we also look at the payment rates that some MA managed care plans pay for SNF care. In the four publicly traded firms, fee-for-service payment rates averaged 23 percent higher than MA managed care payment rates, yet the characteristics of SNF users enrolled in MA and fee-for-service are not that different. It would not explain these differences in payments. The publicly traded firms also report seeking managed care business, suggesting that the rates are attractive.

To estimate the average 2017 margin, we assumed that costs grow at the market basket between 2015 and 2017. For 2017, we also factored in CMS's estimate of the first-year costs to comply with revised nursing home regulations that CMS finalized this year.

To estimate payments, we updated the payments by the market basket updates, net of productivity. For 2016, there is also a forecast error correction that lowered that year's update. The estimated average Medicare margin for freestanding SNFs in 2017 is 10.6 percent.

In considering how payments should change for 2018, the broad circumstances of the SNF industry have not changed significantly from last year. The PPS continues to

favor therapy over medically complex care and still needs to be revised. The level of Medicare's payments remains high. The wide variation in Medicare margins reflects differences in patient selection, the mix and amount of therapy services furnished, and cost control.

The continued trends support the Chairman's draft recommendation that reads: The Congress should eliminate the market basket for 2018 and 2019 and direct the Secretary to revise the prospective payment system for skilled nursing facilities. In 2020, 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 and costs.

This recommendation would shift payments within the industry, decreasing payments for intensive therapy care and increasing payments for medically complex patients. Based on a facility's mix of cases and therapy practices, payments would shift from free-standing to hospital-based SNFs and from for-profit to nonprofit SNFs and from essentially the highest-margin providers to lower margin providers. Payments would also increase for rural facilities. By freezing rates for two years, the

recommendation also brings payments in closer alignment with providers' costs.

In terms of implications, the recommendation would lower spending relative to current law. For beneficiaries, we do not expect an adverse impact on them. Access for medically complex patients, we would expect to increase.

For providers, given the level of Medicare margins, we expect providers to continue to be willing and able to care for beneficiaries. The impact on individual providers will vary based on their mix of cases and current practices. The recommendation would reduce the disparities in Medicare margins across providers.

As required by PPACA, we also report on Medicaid trends in spending, utilization, and financial performance for nursing homes. Just under 15,000 providers participated in Medicaid, and that was a small decrease from 2015. Medicaid spending is estimated to be $46 billion in 2016, and that's a small increase from 2015. And spending is projected to increase again in 2017. The non-Medicare margin for 2015 was negative 2 percent, and the total margin remained positive at 1.6 percent.

And with that, I will put up the Chairman's draft recommendation, and I look forward to your discussion.

DR. CROSSON: Thank you, Carol.

Clarifying questions? Pat.

MS. WANG: It's just this is a -- in the draft recommendation, is it assumed -- so, if there's a concern about the PPS not adequately paying for medically complex patients, is it assumed in this recommendation that the PPS is updated to shift payments to those conditions coincident with the recommendation on the update factor?

My concern is that the update factor is eliminated, that the PPS is not updated in time to rebalance payments among these different kinds of conditions, and so the SNFs that have the lower margins, because they are treating medical conflicts, et cetera, get sort of a double hit. This is just a question about sort of timing, I guess, and recommendations.

DR. CARTER: Timing, yeah.

So the recommendation -- let me put it up. I'm sorry. I thought it was the last slide, but it wasn't.

So this timing does assume that during the two years of no updates that the payment system would be

revised, and then given that, then the Secretary would evaluate sort of whether further adjustments was needed.

Of course, we revisit our recommendations every year. So, if we have a sense that the new PPS design isn't in play and ready for implementation, then we could revisit this recommendation, but yes, it does think about the time needed to implement the new payment system and then moving forward.

DR. MILLER: I'm also going to say what she said, just a little bit differently. I'm also looking at Kathy because of things she said earlier.

This doesn't say wait to do the -- okay. Just so you're clear.

DR. CARTER: Yeah. And we've had a previous recommendation that had timing that was different, and we were concerned that there was no action being taken, so we changed our recommendation.

DR. MILLER: I just want to make sure you understood how this is --

DR. CARTER: Yeah. There's a long history here. Yeah.

DR. CROSSON: Jack, is your hand up?

DR. HOADLEY: No . I was just thinking about making a further question/comment. I mean, it seems like the implication of that conversation is that we're making the judgment in this recommendation that having no update in 2018 and 2019 is appropriate, regardless of sort of what else happens on the revision, and the revision, we also believe should happen. And then as of 2020, the picture may look different. Is that a fair --

DR. CROSSON: But I think, as Carol said, from the window of today.

DR. HOADLEY: Right.

DR. CROSSON: The window next to your looking out could be different.

DR. HOADLEY: It could look different. But, as of today, we're making the judgment that it's appropriate to have no update for the next couple of years, that we could almost have stopped there, except that we also believe the other things are true as well.

DR. MILLER: I would agree to that. There are degrees of ways you could say things, and this might be more for the public than for the Commissioners. I mean, the Commissioners have always been concerned that there are

disparities in financial performance here, and that's why we think the PPS revision is so important and that in a world where you're trying to bring the rates down, there should be some shuffling of dollars, but there's also extremely and consistently high margins. And we had a couple rounds of conversation that in order to kind of force the conversation along, maybe we should begin to proceed, and the thought process in the two steps is we're not being overly aggressive. We're starting to titrate, to use Brian's word, titrate down and begin to put pressure. If you don't like this, you need to get this PPS reform thing in place. And that, I believe, captures a couple of conversations that you've implicated.

DR. CROSSON: Kathy.

MS. BUTO: Yeah. I like this direction a lot, but I almost feel like it's just a little bit of a baby step beyond where we were last year. I know we're being careful.

I'm wondering whether we -- we could go with this now, but I wonder if we could go to the step of saying, going forward, something like start with the issue the Secretary should be directed to revise the PPS system. In

particular, mention therapy services, if we need to do that, and then to say Congress should eliminate the market basket update for 2018. And if by 2019, the PPS system changes are not under way -- and here is where it gets messy, because it would be hard to do this in the time frame that we have for this update -- I would like to see something like that for 2019, SNFs that have a proportion of therapy services in their costs or some measure of inappropriate use of therapy services to generate their revenue, that there actually be a negative update. And I know we're looking at that for other providers, but I'm just saying not penalize, to Pat's point, all SNFs -- in fact, the SNFs that are trying to do the right thing are the ones that get hurt in a scenario like this -- but really try to be more targeted that there ought to be some effort to actually look at the SNFs that are exhibiting this behavior.

So I would just like to see it go another step further but also try to target it a bit better.

DR. CROSSON: Let me just point out we're still on questions.

MS. BUTO: Right. So this is not a question.

DR. CROSSON: It didn't sound like it, but --

[Laughter.]

DR. CROSSON: So I just want to -- we'll come back to this point, because I think you have a very substantive point here. But I want to finish with the questions. Is that all right?

DR. MILLER: I shouldn't have --

MS. BUTO: My question --

DR. MILLER: -- she drew me in.

[Laughter.]

MS. BUTO: You started this, and my question actually was going to start with, did we consider --

[Laughter.]

MS. BUTO: -- something like a negative update, but we can talk about that --

DR. CROSSON: Did we consider that I have an entirely different idea?

[Laughter.]

DR. DeBUSK: I think I'm responsible for this.

DR. REDBERG: I'm learning the trick. You have to direct the question at Carol.

[Laughter.]

DR. REDBERG: So Carol, I'm asking you -- no. Is there evidence, and is there credible evidence that the over-provision of these therapy services may actually be hurting patients? And Rita, I apologize if I've hijacked your issue.

[Laughter.]

DR. DeBUSK: I feel like I've stolen something from you. I apologize.

[Laughter.]

DR. DeBUSK: But when I was going through the reading, I mean, that was -- the one -- there was sort of this overarching theme of is there -- is it possible that this over-provision is actually hurting patients?

MS. CARTER: So we don't have information on that, and I would say, in general, sort of -- Rita, I'm going to channel you right now -- I don't think there is good information on the value of therapy. I will say that over the years, as we've looked at sort of the functional improvement of patients, we're not seeing that, at least in the measures that we use. And so at least in terms of patients getting more therapy, but is there functional improvement? Do we see larger improvements in functional

status, and we're not seeing that, which is different than what you're asking, which is do people get harmed. I'm looking at the benefit side.

DR. DeBUSK: But are we certain that there's no harm?

MS. CARTER: We don't have information on that.

DR. CROSSON: Okay. Questions. Paul.

DR. GINSBURG: I learned a lot about SNFs from reading your paper. It was really helpful. And I kept having a question in my mind about, to what degree are hospitals able to steer patients that are being discharged to particular SNFs that they might feel would be good for the patients, or is this strictly they can suggest something but it's up to the patients?

MS. CARTER: So what we hear is that, of course, beneficiaries always have freedom of choice, but there is sort of what I would call some soft steering that goes on, where hospitals -- and particularly with the readmission penalty, hospitals, I think, have really narrowed down the number of different SNFs that they refer to. And I hear that when I talk to capital -- the financial analysts, but also just in the trade press, about SNFs are being demanded

to show to hospitals their quality measures, including readmission rates and other things, because they want to be in the network of a hospital's referral, the choice provider.

So I think -- and, of course, beneficiaries will have things like, is the SNF close to my home, which is an important consideration. But I think there is some soft steering, and I think it's increased over time as provider -- on the hospital side, they're very focused on the readmission rates.

Is that helpful?

DR. GINSBURG: Very.

DR. CROSSON: Bruce.

MR. PYENSON: Thank you, Carol. It's a terrific report.

Yeah, on page 22, you talk about the SNF volume, the expectation that SNF volume will decline with bundled payments and CJR and so forth. Do you have a view of how much that would be and whether that would change the mix of patients who actually need therapy -- diminish the portion of patients in that category?

MS. CARTER: We don't have information on that,

although I do think that you're seeing that a little bit in the days, the reduction in days. I think we are hearing, anecdotally, that some ACOs are bypassing SNFs entirely and sending patients from the hospital directly home with either home health care or outpatient. So we are seeing a little bit of decline in just even SNF admissions relative to that. I know admissions, overall, were up. And we did see, in the data, overall, that -- and Craig and I were just looking at these numbers yesterday -- that the referrals from hospitals to SNFs actually went up last year. But that doesn't mean that for particular alternative models they're using SNFs less.

DR. CROSSON: Clarifying questions.

So seeing none, Let's move to a discussion of the recommendation, and I think, Kathy, I'd like to go back to you, because I think what we have on the table -- and I'd kind of ask you to reformulate it again -- is a proposal -- and I'll just say, grossly -- to construct a more aggressive recommendation. So go ahead.

MS. BUTO: Yeah, and this was, in part, driven by -- I read ahead to the IRF recommendations, and the reason I did that was I was trying to understand, because we have

similar -- there are some similar issues and they also share some patients, and we've had issues between the two kinds of facilities, so I wanted to get a sense of where we were going there. And I saw, you know, without getting too far into it, a different kind of recommendation, and wondered if we had considered a more aggressive recommendation here, because I think we've noted the last two years that I've been here that, you know, not much progress going on with that PPS reform in this area.

So is there something that we could actually recommend that would say, and if no progress is made, at a minimum we would like to see some adjustment made, really, at sort of a gross level, to recognize those facilities that are taking advantage of the current system, and potentially having a lower update for those kinds of facilities going forward, not in '18 but maybe '19?

So that was my thinking.

DR. CROSSON: Yeah. I think what I'd like to do at this point is ask -- people can provide any perspective they want on anything here relative to the recommendation, but on this point I would like to focus on that and get a sense from the other Commissioners for moving in that

direction, that is, a more aggressive, more pointed kind of recommendation, or not.

While we are doing that, Kathy, what I would ask you to do is actually draft a substitute recommendation. Do you feel like you could do that?

MS. BUTO: Sure. Yeah.

DR. CROSSON: So we'll continue the discussion and then depending upon the nature of the discussion, we could put up, you know, both for consideration.

DR. MILLER: But can I just say one thing about that, and asking Kathy to do it is actually a great innovation and work load.

[Laughter.]

DR. MILLER: I strongly support that kind of action before I say what I'm about to say, which is I think, you know -- and I know you want to put this conversation to develop -- you know, my reaction to Kathy was going to be, I think if everybody wants to consider that, we can consider it, but the metric would be a little bit hard for me to fill out and write in right now. And that's -- so I'm wondering what Kathy would write there. But because that's what -- I would really want to spend

some time with Carol in kind of going in, because we don't want to just say "I don't think, profitable, unprofitable," we want to look at a particular behavior and feel like we're targeting those places that we think are off -- you know, off track a bit.

MS. BUTO: You're totally right about that, which is why I wasn't going to try to write this until Jay asked me to.

DR. CROSSON: Okay. All right. All right.

MS. BUTO: But -- no, because I actually think the staff has a much better feel for where those boundaries would be, and we may not want to get specific but describe the characteristics.

DR. MILLER: It's more complicated than red hair --

MS. BUTO: It's more complicated than just writing up new words.

DR. MILLER: There you go.

DR. CROSSON: So, right. But let me go after this again.

So a third way of doing this is to come back with a different recommendation in January, following the

considerations that we've described. Now, how -- just help me -- how have we done that in the past? Are we close enough here that we could consider the recommendation, having been read twice?

DR. MILLER: So my best shot at this -- and this would be messy, and I think it means that we would probably have to come back and have a whole session on this --

DR. CROSSON: Yes.

DR. MILLER: -- and I think, as a staff person, what I would try and do is I'd come back with this, and then I'd come back with an alternative that said "you did agree" -- and this assumes that everybody agrees, and we haven't even had that part of the conversation yet. But if everybody wanted to go in this direction, I'd have an alternative, try and be able to explain as best as possible what that targeting is, and then, in that session, you would say, "I don't like this" and we would retreat, or you say, "I love it. Kathy drafted the perfect recommendation," and we go that way.

But it probably really couldn't be litigated until the next meeting --

DR. CROSSON: Right.

DR. MILLER: -- would be the way I see it.

DR. CROSSON: So that's another alternative, and probably a better one.

So I saw Jack and then Alice and then Pat and Paul. Jack, Alice, Pat, and Paul.

So, but let's -- while people may have other issues, let's try to adjudicate this one first. Are people in favor of the direction Kathy has proposed, without the specifics, and the notion that we would come back in January with this idea, but an additional idea, and then we could determine which one -- which direction we want to go?

MS. BUTO: Well, Jay, I would just humbly suggest someone might have a better idea about -- along these lines, so maybe before --

DR. CROSSON: Right. I'm saying you have a general direction, but I want to hear from everybody else. So I'd -- now I lost it. Jack, Alice, Pat, and Paul.

DR. HOADLEY: So I do like the notion of, you know, having -- I mean, our stance, as stated here, is still a good one, that if both parts of a sentence were done, we would have a revised PPS and we would have a path and a timing to get there. So it's not even necessarily

like we have to completely abandon this approach to be more aggressive, because this is an aggressive approach.

It seems to me there might be one other alternative, which is to use the text around this to say something like "and if this recommendation is not pursued, our intent next year would be to," or, you know, because we're really talking about a 2019 recommendation, and this continued sort of thing, and we could state -- therefore, it could be the softer, non-bolded language as we talked about in the last conversation, to say "our intent would be to come forward with an approach," and then we could describe it a little more squishy terms, about the goals we were trying to accomplish. And if we have by then, by the time we're writing this in a few weeks, in January, we have a sense of what that -- you know, some suggestions of how that would work, obviously we could say those.

But the notion would be to sort of give the fallback position in the text, and use that as part of the message, to say, you know, this really does capture the preferred route over the next three-year period, but if that is not done, we have another notion of where we will go, and that gives people sort of the same fair warning.

The other thing I was going to suggest, before this came up, I mean, we also have one other track going, because we spent all of last year on the revised overall PPS, and I was sort of struck by the absence of any reference to that, and my suggestion was simply going to be put a text box, that might even appear in each of the PAC chapters, since a lot of people read our reports chapter by chapter, not the whole report, that would just quickly explain -- and it could be very brief, but quickly explaining all of what we talked about last year and then reference people to that.

But in this context it would also -- I mean, there's a point at which this becomes a moot discussion if that other process goes forward. I know the time frame is a lot longer there. And so, again, the text can be used to sort of mention that. But we've also said, in that report, some thought about how to move forward more quickly if there was a will to do so. So it seems like bringing that in gives us another way of sort of saying, you know, "Here's a series of options. This is the one we're recommending, because it addresses the problem quickly and efficiently, but if you guys don't go there, we have this

other thing," that's sort of the Kathy line, "and, furthermore, we have a longer-term thing which could be accelerated as we discussed last year," reference all that report.

DR. CROSSON: Okay. So Jack has a third proposal --

DR. HOADLEY: Not to complicate things.

DR. CROSSON: -- a third proposal, which is the text solution. So that's on the table as well.

Did you have a -- on this point?

DR. DeBUSK: I had a comment. First of all, Jack, I completely agree with you on this idea of the unified PACs model, but what strikes me is, knowing that we've got 2019, could we use the inputs that were already -- that we've already vetted, or in the process of vetting for the united PACs models, as the inputs for the prospective SNF PPS? If anything, it would help us validate the PACs model, because it would get us used to using, for example, those functional and cognitive measures and things that we needed in that model.

So this could really be a stepping stone to impact and would avoid duplicative work.

DR. CROSSON: Okay. I'm going to -- just hold for a second, because I've got another idea to put on the table.

DR. MILLER: I'd let it run.

DR. CROSSON: You want to go further, and then give the other idea.

DR. MILLER: Right. Let's do that.

DR. COOMBS: So first of all, I would divide that into two, because it might be a little bit more palatable, so separating the two concepts.

But, Jack, you went right into the bedroom I was going to go into --

[Laughter.]

DR. COOMBS: -- because we spent that time -- Carol Carter got her ribbon last year for bringing the PAC PPS. The thing that I would be more concerned with, Kathy, is that if you gave a negative update to one in tandem with the other ones that we need to discuss going forward, what does that do, if you don't give the rest of them the same kind of -- degree of update, whether it's negative or whether it's zero or whatever, because it would shift things. And what we said, via consensus, is that we agree

that it is the resources required for treatment, the modeling that you did was really excellent, and I would like to stick with that piece and this as an entity going forward, because I think that PAC PPS will move the meter in terms of getting the same care, at different places, with the same resource utilization, and also a similar type of cost correlated with that.

MS. BUTO: Yeah, but where I was going, a little bit, was, just to respond to that point, was I remember raising the question Carol, with the PAC PPS, whether we really needed to do anything on SNF PPS. Why not just go directly in the direction of the PAC PPS? And I thought you said that it would be helpful to have this series of changes made in order to sort of -- as a glide path into the PAC PPS.

So I'm thinking if we wait until 2019 -- I'd forgotten what -- our report is 2020, for the final recommendation for the structure of the thing -- that's waiting a bit long. So that's really what motivated me to think of, is there an interim measure that would accelerate getting into that glide path -- and maybe there isn't. Maybe we just go --

DR. COOMBS: I'm just saying that you have three entities for which there are choices that hospitals make about where to send patients, and if you adversely affect one more significantly in a different fashion than you do the other, then your paternalistic choices are going to be made based on that, what you decide to assign to SNFs versus IRFs versus LTCHs.

DR. CROSSON: Pat.

MS. WANG: I don't want to make this more complicated.

[Laughter.]

MS. WANG: My concern -- and the conversation is all really relevant -- my concern is that SNFs that are providing higher shares of medically complex and special care not be hurt while all this other good stuff is going on, because the zero percent update recommendation is based on high margins in the aggregate that seem to be driven by sort of following the incentives of the current reimbursement system, which is not in the special care area.

So I wonder whether it would be simpler simply to say -- this is why I asked the question before about the

timing, because even a year of a zero update for a facility whose Medicare margins are low, because they are providing all of this very complex care, could be very harmful, is to say that, you know, unless PAC or the PPS or something is implemented by 2018, that the zero update factor will be comprised of a positive update factor to facilities that provide whatever the median share of medically complex special care cases, whatever the right metric is, and a negative update for all others, so that the zero update -- because this is in the context of how much additional money should be put into the system, and I think that the assessment here is that there is enough money in the system.

My concern is that facilities that are kind of doing the right thing not be hurt in the interim, that there be -- so that's another way. Instead of trying to come up with a, you know, definition of how much therapy is too much therapy, who is a good guy, who is a bad guy, is to focus instead on what it is we're trying to support, which is care for medically complex patients.

DR. MILLER: And I want to -- but I do want to give you one piece of information on this, and for you guys

to think about, and it has to do with hurt. Now I want to be clear -- there's always a distribution, and there are high margins, just in the abstract way. If somebody has really high costs, they're just inefficient, and everybody's, you know, not doing their job, you know, we don't want to reward that, that type of thing.

And, Carol, SNFs that are low therapy, high medical, their margins are in the six to eight range?

MS. CARTER: I'm not sure. Well, I could look it up. That sounds about right.

DR. MILLER: Yeah, and I want to say, you know, page 31.

MS. CARTER: Yeah, exactly. So low therapy, seven; medically complex, high shares, eight.

I wondered whether you were going to be going, just to point out that the revisions to the PPS redirect money to medically complex, low therapy providers, in substantial ways, and part of the thinking behind the timing of this recommendation was to actually put some pressure to change the payment system, because we have been recommending that the PPS get changed since 2008, and that's a long time.

So I think we were hoping that the -- because we had a different timing for a couple of years, and we shifted trying to put some pressure on change. And so it's true that there's a distribution, and Mark's right. There are providers that, even with the redistribution that's going to happen with the revised payment system, that doesn't fix if they have a high cost structure. Right? The PPS doesn't do -- doesn't address that. And so there would still be a distribution.

DR. MILLER: And what I wanted you to have in your head -- and, you know, you still end up wherever you want to be. There is something there of a margin for the actors that I think most of you are referring to, that even if there were some limit -- a limit or, you know, no updates for a few years, I don't think it drives them into the reg immediately. So if you thought they were operating out at zero, I don't think they're quite there.

DR. CROSSON: And if we were going to make a recommendation to essentially revise the PPS in this way, revise the payment to SNFs in this way, the way you describe, the Secretary would still have to do that and would still take an implementation time; whereas, this

recommendation is simply saying to revise it, and as Carol said, we have a good indication of how that's going to be revised, which is the way you say.

DR. GINSBURG: What I've been thinking about, and it keeps getting augmented as people make comments, is, to the degree that we could actually use our update recommendations to move in a crude way in the direction of a better PPS system, so that perhaps we can say that therapy should have a negative update, and the addition for complex patients should have a positive update. And what this reminds me of is actually the way that we got to the physician fee schedule back in the 1980s, that there was initially in 1988 recommendations by the Physician Payment Review Commission to reduce the payment rates for selected services that the Commission believed there was strong evidence were paid too much. And the next year, there was a proposal for a full-blown resource-based relative value scale fee schedule. And I was just thinking that, to the degree we could, do have the ability to make separate update recommendations for different parts of the package in the SNFs now, it could perhaps foster the industry to get behind a revised PPS, because we're heading that way in

a crude way anyway.

DR. CROSSON: Right, I'm getting a little confused by a chicken and egg here because essentially you're proposing a version of a revised payment system, and we're asking for the Secretary to revise the payment system.

DR. GINSBURG: I'm talking about some very crude steps with our update recommendations in the direction of where we know a revised payment system would come out. And it just would be, you know, just one year's changes, and you know, we'll hope that the Secretary produces the full-blown revamped PPS system so that we don't have to do this.

DR. CROSSON: Okay. So I -- Kathy.

MS. BUTO: I totally know where Paul is going with this, which is the impetus for doing the PPS has to come from the industry. They have to want to do it. And if they want to do it, then the agency will want to do it. And so the question of how to make the alternative, which is the status quo, less attractive is kind of the challenge here. And, you know, there are a number of ways to do that.

What I want to just put in the mix here is if --

let's say nothing happens and 2019 comes along, isn't that too late, really, to be implementing a PPS system before -- if we assume that PAC is going to -- potentially could be rolled out two years later or so? What do you think? I mean, I'd just be interested in knowing, because maybe this is really the best we can do and 2019 is going to be too late anyway [off microphone] just because.

DR. CARTER: I think CMS has spent a lot of time and made really good progress one designing this new PPS, so I think they're further along in that than the PAC PPS.

I think that what it would encourage from the provider standpoint are the same in the sense that both -- you know, the SNF PPS design is -- that was foundational work for the PAC PPS work. They are using patient characteristics rather than services to set payment, and so I think last year when you -- in June or May, when we were talking about whether one was a good glide path to the other, I said I thought so because they would be encouraging providers to do the same things. So then it really does become an issue of timing and whether they could get -- CMS could get to this sooner than a PAC PPS, and I said I would think so, yes.

DR. CROSSON: So let me add one other idea and then see if we can't figure out what we're going to do here. So, Kathy, as I was reading the PAC papers, I was coming to, I think, a same -- maybe just simply the same level of concern or even worse than you were as well, which is that we've been making, not just in this area but in other areas, recommendations repeatedly based on what are high margins, which are costing the Medicare program money as well as beneficiaries, and that in many cases we have not had responsiveness to that, and that perhaps one thing we might do this year would be to put a front piece or a mini paper ahead of the PAC reports which could contain a number of things. Jack, it could contain your text box on the PAC PPS. But we could also take a look, either prospectively or retrospectively, or both, you know, at the consequences of our recommendations across the PAC areas, the consequences to the program and to beneficiaries of the fact that those recommendations had not been implemented. And I think, you know, adding it all up, particularly if we did it both retrospectively and prospectively, it would be a very large sum of money and, you know, move the Commission to a more aggressive stance in general about the

collection of these PAC areas. And I guess what I'd like to say is I think we should do that.

So assuming that we're going to do that, then we have, you know, kind of on the table -- because I've heard both sides a little bit here. Let's just go ahead with this for now or let's come back in January with this and specific to this update recommendation, in addition to the kind of global -- little global chapter I was talking about, let's come back with a choice so that we can pick one or the other for this update recommendation. I think those are the -- that's what we have on the table.

So I think I'm going to ask for some hands here, because I can't eyeball this too easily. One notion would be that we would take this on more aggressively across the areas of post-acute care, which have extraordinarily high margins and for which there has been no activity that we can discern, and then this would be the recommendation. That's Choice 1.

Choice 2 would be the little chapter I described, plus coming back in January with this recommendation, plus another one, which, Kathy, help work on with the staff.

MS. BUTO: By the way, I'm very comfortable with

the approach that you laid out where we lay out the mini chapter. I would also add to that some sense of the timeline --

DR. CROSSON: Yes.

MS. BUTO: -- the flow from whatever PPS into PAC, and then going with this recommendation, rather than trying to come up with another recommendation in that time frame.

DR. CROSSON: Okay.

MS. BUTO: I think that might work better. And since we don't have the specificity, I'm not sure how we do that in the time we have.

DR. CROSSON: Okay. So Kathy has put that one choice on the table. The second choice was, to a large degree, a consequence of the position she brought forward. She's now said she's comfortable with the one alternative that I described, which is the small chapter laying out in rather stark terms the consequences to the program and to beneficiaries of not having moved aggressively or not moving aggressively in the future, or both. And this is then our recommendation that we would bring forward in January. Do I have support for that position? Without

objection, okay. Then that's what we'll do.

Thank you, Carol. Appreciate it.

[Pause.]

DR. CROSSON: Oh, by the way, for the Commissioners, I haven't really mentioned this, but in terms of the mailing for January, we've made note of a number of changes to the text, for example. So you will be getting these chapters again in its revised version, with a notice to what's new and what's not new, as well as other issues we're going to be taking on in January. So plan on checking your luggage on your January trip.

Okay. Dana is here, and we're going to talk about updates for inpatient rehabilitation facility services. Dana?

MS. KELLEY: Okay. Good afternoon.

After illness, injury, or surgery, many patients need intensive rehabilitation care, including physical, occupational, or speech therapy. Sometimes these services are provided in inpatient rehabilitation facilities.

In 2015, Medicare spent $7.4 billion on care provided in 1,180 IRFs nationwide. There were about 381,000 IRF stays in 2015, and on average, Medicare paid

more than $19,000 per case. Per-case payments to IRFs vary depending on patient's condition, level of impairment, age, and comorbidity. Medicare accounted for about 60 percent of IRFs' discharges in 2015.

To qualify as an IRF, a facility first must meet Medicare's conditions of participation for acute care hospitals. In addition, IRFs must have a medical director of rehabilitation and a preadmission screening process to determine that each patient is likely to benefit significantly from an intensive rehab program.

An IRF also must demonstrate that it is 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 1 of 13 conditions, specified by CMS, such as stroke, hip fracture, and brain injury. 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 they must need at least two types of therapy, one of which needs to be physical therapy.

Last year, we presented the results of analyses that showed that high-margin IRFs have a different mix of cases than other IRFs do. We also found evidence to suggest that patient assessment may not be uniform across IRFs. These findings raised concerns that patient selection and coding may contribute to disparities in IRF profitability. I will briefly review our findings.

As you will recall, in our analysis, we ranked IRFs by their Medicare margins and sorted them into five equal-sized groups. Quintile 1 had the lowest margins; and Quintile 5, the highest. As you can see, high-margin IRFs have a different mix of cases than low-margin IRFs. Looking at the red bars, IRFs with the highest margins, Quintile 5, have a smaller share of stroke cases, and they have a much larger share of cases with neurological conditions, shown here in green. Neurological conditions include multiple sclerosis and neuromuscular disorders like ALS and muscular dystrophy.

We also found differences across IRFs in the types of stroke and neurological cases admitted. IRFs with

the highest margins have many more stroke cases with no paralysis. They also have many more neurological cases with neuromuscular disorders, as opposed to multiple sclerosis or Parkinson's disease.

We've also noticed some interesting patterns of coding in IRFs. We matched IRF claims and assessment data with data from patients' preceding acute care hospital stays. Then we looked at the relationship between patients' conditions in the acute care hospital versus that in the IRF. We found that patients in high-margin IRFs were less severely ill during their preceding hospital stay, compared with patients in low-margin IRFs. High-margin IRFs cared for patients who had a 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 changed, with patients in high-margin IRFs appearing to be more impaired, on average.

Patients in high-margin IRFs had lower motor and cognition scores, indicating greater functional impairment. These lower scores generally increase payment. This pattern was evident across case types.

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 illustrates the kinds of differences in coding we see. Here, we are looking at average motor scores at IRF admission for patients with two types of stroke -- stroke with paralysis and stroke with no paralysis. We would expect stroke patients without paralysis to have better motor function than patients with paralysis, and if we look down the columns, that is exactly what we see here.

If you look in the middle column, which I have highlighted in yellow, for the lowest-margin IRFs, you can see that patients with paralysis have, on average, a lower motor score, 29.2, than patients without paralysis, who have an average motor score of 35.3. The lower motor score indicates a lower level of motor function and generally increases payment.

We see the same in the right-hand column for the highest-margin IRFs. Stroke patients with paralysis have a lower motor score, 24.6, than patients without paralysis. In part, because of this lower level of motor function, overall, stroke patients with paralysis have IRF stays that are more than two days longer on average than stroke patients without paralysis.

But we also see something very unexpected in this chart. In the highest-margin IRFs, the average motor score for stroke patients without paralysis is 29.0. This is almost exactly the same as the average motor score for patients with paralysis in the lowest-margin IRFs. All else equal, the payment for these two cases, with a motor score of 29, would be the same. This raises questions about the inter-rater reliability and the assessment process, and that's a problem for any payment system.

Medicare's payments should be aligned with patients' costs, with higher payments made for patients with greater resource needs. For that to happen, patient assessment needs to be reasonably consistent across providers, but our work suggests it may not be.

Our findings led Commissioners to make two

recommendations in March 2016. First, MedPAC recommended that CMS ensure payment accuracy through focused medical record review, and we encouraged the Secretary to reassess inter-rater reliability across IRFs.

Second, MedPAC recommended that CMS reduce potential misalignments between IRF payments and costs by redistributing payments through the high-cost outlier pool. Expanding the outlier pool would increase outlier payments for the most costly cases. This would ease the financial burden for IRFs that have a relatively high share of these cases. This was intended to be a short-term solution to patient selection and coding issues, but it's only a kind of rough justice. CMS needs to ensure that the IRF case-mix groups adequately capture differences in patient acuity and cost across cases and providers.

I will turn now to our review of payment adequacy for IRFs. We have used our established framework that you have seen in earlier presentations today. We will start by considering access to care.

We first look at the supply of IRFs. In 2015, there were about 1,180 IRFs nationwide, with more than 36,000 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 22 percent were freestanding facilities. However, because they tend to be larger and have more beds, they accounted for almost half of Medicare discharges from IRFs in 2015. The number of freestanding IRFs has been growing, and the pace of that growth picked up in 2014 and 2015.

Overall, 30 percent of IRFs were for-profit entities. These accounted for half of all cases in 2015. The number of for-profit IRFs grew, on average, 4.6 percent per year between 2013 and 2015.

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. This drop was expected. Tighter enforcement of the 60 percent rule was intended to help ensure that beneficiaries who used IRFs really needed that level of care. As a result, fewer lower-severity cases, such as knee replacements, were admitted to IRFs. But since 2008, you can see that use of IRF services has

been very stable. The number of cases per fee-for-service beneficiary increased 1.7 percent in 2015.

To assess the quality of care furnished in IRFs, we worked with a contractor to develop use six risk-adjusted measures. Overall, we found that the measures have been stable or improved since 2011. On average, IRFs' patients gain almost 24 points in motor function during the IRF stay and about 4 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.

We found that the risk-adjusted rate of potentially avoidable readmissions during the IRF stay was 2.4 percent in 2015 and was 4.2 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 are themselves 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 this morning, hospitals maintained good access to capital markets in 2015 and 2016 due to hospitals' high level of profitability and continued low interest rates.

As for freestanding IRFs, about half are independent or local chains with a small number of facilities. The extent to which these providers can access capital is unclear. One large chain dominates the freestanding IRF market, accounting for 46 percent of all freestanding facilities in 2015.

Expansion of capacity through construction of new IRFs reflects good access to capital for this chain. The chain also acquired one of the nation's largest providers of home health care in late 2014. This is part of a vertical integration strategy that we are seeing in several large post-acute care companies. The companies believe that providing a continuum of post-acute services will allow them to respond to reimbursement pressures and make them desirable participants in coordinated care delivery models and bundled payment arrangements.

In 2015, the Medicare margin increased more than one point to 13.9 percent. As you can see, financial performance varied across IRFs. The aggregate margin for freestanding IRFs was 26.7 percent. Hospital-based IRFs had an aggregate margin of 2 percent. There was a similar spread between for-profit and nonprofit IRFs. Of course, these two categories are highly correlated. Most freestanding IRFs are for-profit. It's not shown on this chart, but only 14 percent of freestanding IRFs are not-for-profit. In 2015, the aggregate margin for these freestanding nonprofit IRFs was 14 percent.

Why do we see such a disparity between hospital-based and freestanding facilities? There a number of factors at play; first, economies of scale. Hospital-based IRFs tend to be much smaller than freestanding IRFs, and they have fewer total cases. Their occupancy rates are also somewhat lower.

Hospital-based IRFs are also far more likely than freestanding IRFs to be nonprofit. So they may be less focused on reducing costs to maximize returns to investors.

Recently, CMS began collecting data from IRFs on the amount and type of therapy provided to patients. Our

preliminary analysis suggests that hospital-based IRFs may provide more therapy to patients and use higher-cost modalities, which could help explain their higher costs. This is something we plan to look into further as more data are available.

We also can't rule out unmeasured differences in case complexity. We have noted differences in the mix of cases in freestanding and hospital-based IRFs. Hospital-based IRFs also have many more high-cost outlier cases, which could in part reflect unmeasured case complexity.

Despite the comparatively low margins, Medicare payments to hospital-based IRFs exceeded marginal costs by a substantial amount, 20.5 percent in 2015. This compares to a marginal profit of over 41 percent in freestanding IRFs.

One last thing to note, IRF units may be beneficial to their host hospitals. Our analysis has found that acute care hospitals with IRFs have higher margins than acute care hospitals without them.

Unlike most of the other providers MedPAC analyzes, margins for IRFs increased in 2015, and we project that they will continue to grow, albeit at a slower

pace. We project an aggregate Medicare margin of 14.3 percent for 2017. 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 2016 and 2017. 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.

So, to summarize, we observe capacity that appears to be adequate to meet demand. Our risk-adjusted outcome measures are stable or improved since 2011. Access to capital appears adequate. We estimate that the margin was 13.9 percent in 2015, while marginal profit was 20.5 percent for hospital-based IRFs and 41.5 percent for freestanding IRFs. We project a margin of 14.3 percent in 2017.

The Commission has recommended that the update to IRF payments be eliminated for every year since fiscal year 2009. However, in the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase; thus, payments have continued to rise. But growth in costs per case has been low.

As you can see here, from 2009 to 2015, the cumulative increase in payments per case was 14.2 percent. Costs per case have grown just 8.3 percent. The gap between payment and cost growth has been particularly wide for freestanding IRFs.

In 2015, margins for freestanding IRFs reached an all-time high of 26.7 percent. The aggregate margin for IRFs in 2015 of almost 14 percent indicates that Medicare payments substantially exceed the costs of caring for beneficiaries.

So the Chairman's draft recommendation reads as follows: For fiscal year 2018, the Congress should reduce the Medicare payment rate for inpatient rehabilitation facilities by 5 percent.

We don't expect this recommendation to have an adverse effect on Medicare beneficiaries' access to care or out-of-pocket spending. Even with a 5 percent reduction in the payment rate, we project that the aggregate margin for IRFs will remain above 8 percent. This recommendation may increase the financial pressure on some low-margin providers, but this effect would be eased by our recommendation from 2016 that the high-cost outlier pool be

expanded.

You will recall that expanding the high-cost outlier pool would reduce potential misalignments between IRF payments and costs, so it would redistribute payments within the IRF PPS. Currently, the outlier pool is set at 3 percent of total IRF payments. Expanding the outlier pool to 5 percent would increase outlier payments for the most costly cases. The expanded outlier pool would be funded by an offset to the national base payment amount.

Reducing the payment rate for IRFs by 5 percent and expanding the outlier pool from 3 percent to 5 percent would decrease total payments to IRFs by 5 percent. Because of the expanded outlier pool, the impact would be smaller for hospital-based IRFs, nonprofit IRFs, and IRFs with low margins.

And that concludes my presentation, and I'm happy to take any questions.

DR. CROSSON: Thank you, Dana.

We have time for clarifying questions. I have one myself, just a consequence of my own ignorance. So, if you could turn to the slide -- and I have it in the packet as No. 8 -- which has the motor score by paralysis -- that

one, yeah. So, in the paper, as I read it, these ratings are based on a 91-point scale; is that correct?

MS. KELLEY: Well, these are motor scores.

DR. CROSSON: Right.

MS. KELLEY: Yes. Yes, it is.

DR. CROSSON: Right. So I think the question to me -- and maybe, Bill, you could give some help here -- to what degree are these differences clinically meaningful, A and B? Are we -- irrespective of that, do we, in fact, have a different kind of rehabilitation directed at the patients without paralysis that might be inherently less expensive than the types of rehab that are directed towards patients with paralysis?

MS. KELLEY: So I'm not sure I understand your question, but these are scores that are given based on motor function deficits.

DR. CROSSON: Right.

MS. KELLEY: So they're not -- I'm not sure I --

DR. CROSSON: So on a 91-point scale -- I guess my question is a clinical one -- how much difference is there between 24.6 and 29?

MS. KELLEY: Ah. That depends on the case mix

group or the case type. Within each case type -- stroke, brain injury, neurological conditions -- are several case mix groups that are differentiated primarily on function scores, although also sometimes age and comorbidity also impacts that.

The difference between case mix groups within each case type, it varies. So there's not necessarily -- having a 29.0 functional score in a stroke patient does not necessarily -- although the level of functional impairment is similar, the costs of dealing with that within a stroke patient may be different from --

DR. CROSSON: Thank you, and that's what I was getting at. Just thinking about it, as a former clinician, one would imagine different -- Bill, do you want to help me? -- different types of rehab directed at the stroke patient with paralysis than at the stroke patient without paralysis. Right?

MS. KELLEY: Well, yes, and that's a slightly different question, I think, or maybe has a slightly different answer. So a stroke patient without paralysis may need far -- may need a different kind of care. They may need, for example, gait training; they may need more

cognitive therapy. These indicate the motor scores, but the real deficit for a patient without paralysis may be one of cognition, in which case their therapy would be focused more on that.

DR. CROSSON: Right, okay. But you can't make any kind of global thought about the relative cost of the two.

MS. KELLEY: No. I think you need to have more than just the functional score information. It's also relevant, the type of condition that they have and the comorbidities they have as well.

DR. CROSSON: All right. Thank you. Bill, do you want to comment on that?

DR. HALL: Yeah, I had trouble with --

MS. KELLEY: Can I interrupt for one second? I'm sorry.

DR. HALL: Sure.

MS. KELLEY: I just want to clarify. But for this particular example, these are all patients with stroke.

DR. CROSSON: Yes.

MS. KELLEY: So one would assume that these

patients -- the 29.2 indicates a similar level of impairment, and all the patients without paralysis -- obviously, people differ, but the standard of care one would assume would be relatively similar.

DR. CROSSON: Okay. I think I understand. I'm not sure.

DR. HALL: I had some of the same concerns about Slide 8. I guess the reason that we're taking stroke is that it's a -- we all feel we have an understanding of what stroke is and that some had paralysis and some did not. But there might be some impact of whether you were in a low- or a high-margin institution. Do I have this right so far?

MS. KELLEY: What this slide shows is that patients in low-margin IRFs who have paralysis get a similar functional score on average as a patient in a high-margin IRF without paralysis.

DR. HALL: Right.

MS. KELLEY: We know that a patient without paralysis typically has better function than a patient with paralysis. So for them to get the same functional score does seem unusual. Everything else equal about these

patients -- comorbidities, age -- the payment for these two patients would be the same, even though patients without paralysis have a length of stay that's two days shorter than patients with paralysis.

DR. HALL: Okay.

MS. KELLEY: So on average, we're paying the same for these two patients even though what we know about patients with and without paralysis and what we know about their conditions in general and the comorbidities, et cetera, would suggest that their payment should not be the same.

DR. HALL: So the only point I would make on this is that if, in fact, the diagnosis was stroke and some did not have paralysis, we don't have much granularity here. For example, if I'm right-handed and I have a stroke and it turns out to be on my left side, I will get better with motor function very quickly or not have any at all, but my ability to phonate, to express myself, and lots of other things will be considerably impaired. So I guess what I worry about this is this is kind of a -- if someone wanted to attack us, they might say, well, this is really a question not understanding the clinical implications of a

stroke that produces dominant motor features and one that doesn't. So I'd be a little worried about it. That's all I would say. And maybe I could think about this a little bit more.

DR. MILLER: Can I add something here? When you went through this last year, you looked at a couple other conditions, too.

MS. KELLEY: Sure. We've looked at all the top conditions, including neurological conditions. We looked at lower extremity fractures as well.

DR. MILLER: And my second point was what I would ask -- and, you know, there were patterns that you were seeing that were similar. It was more was -- why are we seeing this pattern consistently different between a high-margin and a low-margin SNF? So even if for some reason here selecting this example clinically, we weren't on top of it as much as we might have needed to be, there was a whole set of other things that she -- right, okay.

DR. HALL: There's ample evidence, right.

DR. REDBERG: With due respect, I don't think it's likely that the difference in margins, there were also differences in sides of strokes and dominance, and that's

pretty dramatic differences on a motor score. And I assume the motor score, you told us what score was used. It's computed by the facility or someone at the facility?

MS. KELLEY: The assessment is done by the facility, yes.

DR. REDBERG: Yeah.

DR. CROSSON: Okay. Other clarifying -- better clarifying questions?

MR. PYENSON: Thank you very much for your report [off microphone]. We saw for both IRF and nursing home that hospital ownership is associated with higher cost, and I'm wondering if that is a cost allocation issue or if you can tell the difference between how costs are allocated versus something else. And, in particular, the issue of the therapy involved -- and this is my ignorance. It's not -- is therapy a cost driver?

MS. KELLEY: So taking your first question, I don't know what the case is in SNFs. Carol would have to address that. And in IRFs, we don't see the allocation issues as being that large here. The major difference between hospital-based and freestanding IRFs is in their direct care costs. And, yes, therapy is a large driver of

the cost.

MR. PYENSON: So just a question on that therapy. Of course, outpatient physical therapy is a relatively low cost service. But in an inpatient setting, it's a different therapy, so it's a different cost?

MS. KELLEY: In the inpatient setting, a major driver of the costs are the therapy. There's not -- you know, the other direct -- you know, there's nursing, obviously, but it is a lower-cost service on an outpatient basis, that is true. These patients usually, typically receive up to about three hours a day of therapy.

MR. PYENSON: So a cost an hour of therapy I'm thinking in the outpatient side might be -- Medicare might pay $100 or something in that order for that?

MS. KELLEY: Offhand I don't know.

MR. PYENSON: Okay.

DR. CHRISTIANSON: Other clarification questions?

[No response.]

DR. CHRISTIANSON: Everybody is clear. So we should move on to the Chairman's recommendation and get some feedback on that. Anybody want to comment specifically on that? Obviously, it's a more aggressive

recommendation than the one we just talked about.

DR. NERENZ: I am probably going to be willing to support this, although you already pick up the hesitation in the comment. You know, the updates are always a blunt instrument, and they just have to be because they apply across the board, and that's just what it is. And so I'm sort of willing to support it in the spirit of that's what's in front of us. And given everything that we see, this seems reasonable.

But I guess if we could flip back to Slide 5, I'm wondering then somewhere in our near future work agenda, this seems really important to me, because we see it here, this difference in case mix expressed across these different quintiles of margin. But it seems like you see it woven through the issue of the hospital-based/freestanding; you see it for-profit/not-for-profit. It just keeps showing up over and over again. And I'm wondering if -- well, I'll just express it, rather than the blunt instrument, is there a less blunt instrument that, say, the problem is really in the prospective payment system. The problem is that we're paying too much for the green bars and we're not paying enough for the orange bars.

Or maybe the two don't imply each other.

Now, that's not the issue in front of us, and I understand that's not what we're being asked to debate. But is that a direction we can talk about in the future? Or are we already going down that path with our talks about not only PPS here but the whole PAC system in general?

MS. KELLEY: So last year in your recommendations to Congress, there was a discussion about the need to look into variation in profitability across case types, so that would address that very problem.

DR. NERENZ: Okay. So we've got that out there already.

MS. KELLEY: It's something we've already talked about, we've raised as an issue in the past, year.

DR. NERENZ: Okay.

DR. MILLER: But your instincts are right on target. The other part of the --

DR. NERENZ: I'm not hallucinating?

[Laughter.]

DR. MILLER: The only good thing that's happened today is we can now assign work to Commissioners, and what I like about it is surprising them in public with it.

Your instincts are right. In addition to what she said, there's also, don't forget, the outlier pool is out there to do rough justice. But a reasonable question might be: Why aren't we more in a granular way going inside the payment system and analyzing where the PPS is misfiring, like we did in SNF and like we did in home health? And the problem is the granularity in the classification here doesn't give us the same opportunity. Is that a fair comment?

And so we are kind of stuck more with these blunt instrument tools, but your instinct, exactly the same as ours, and then as we got in there, it doesn't quite afford you the same tools to get in and fix it.

And then, you know, like in other settings -- this is the last thing I'll say -- you know, you go into the PPS, you realign what you're paying, then the dollars flow in the directions that you're talking about to these types of providers and not those types of providers, that type.

DR. CHRISTIANSON: So, David, remind me, when you started out, did you say you supported or not supported?

DR. NERENZ: Yes, I will, recognizing that it's

the blunt instrument that's in front of us, yea or nay, and I just extended the thought.

DR. HOADLEY: Yeah, I do support this recommendation, and I had, you know, even just reading the chapter, before we saw the recommendations, definitely had the thought that a negative recommendation -- a negative update, you know, could make some sense. But I think, again -- and you really just made this point -- last year's two recommendations are going to be reprinted in this chapter. They showed up. And we talked in the last conversation about this introductory chapter, or whatever you're going to call it, that will put it in the context of the broader PAC system, broader strategy across these different PAC elements. And I think that's part of what creates the context for this to sit here, you know, this isn't working, we have this -- you know, we have some patchwork fixes, we have an update, but we also have a vision for a larger change down the road that, you know, we hope by design will work better.

DR. CHRISTIANSON: Yeah, I would agree with that. Is that something, Mark, that you were contemplating?

DR. MILLER: Absolutely true [off microphone].

MS. BUTO: I would support the recommendation, particularly in light of the fact that all of our payment recommendations have basically not happened over the years. At a bare minimum, this seems reasonable.

The other thing I would try to mention, because I'm assuming this is going to fall under that umbrella preamble that Jay was talking about, is we had a very good discussion -- I think it was the year before last -- about the interaction between SNFs and IRFs, and I think it was a pretty granular discussion because there was a lot of talk about whether, in fact, there was a subset of patients who could, you know, easily be taken care of by SNFs or not and how that might affect the IRF benefit.

I think a little bit of that has to be in there, because we're going to be talking about all of these entities together, and I still have some concern about making sure that we aren't undermining really necessary services that IRFs are providing at the same time that we think there are some patients who could be adequately treated in SNFs and paid more appropriately.

So all of this is woven together with revising SNF PPS and eventually getting to a PAC PPS. But I hope

the overview will take care of that.

DR. GINSBURG: Yeah, I support the recommendation as well and just have an observation that it's almost the theme of the day that so many segments we've looked at in the aggregate, their margins appear to be excessive. But because of shortcomings in the payment system for the distinct services, distinct types of patients, we're hesitant because we're likely to drive margins too low for some subsegments. That just reinforces the need to overhaul our payment systems. But I think it's useful to, you know, have some aggregate constraints almost to force it.

DR. CROSSON: And as I mentioned before, I think it would be eye-opening, hopefully for us and others, to actually look at the amount of money in play here over a multi-year period of time.

DR. REDBERG: I was just going to support the recommendation as well, and also I wasn't sure with your last comment whether you were suggesting -- but if you were, I would support it -- to include in the text in this chapter also an estimate of how many billions of dollars have been spent because of the failure to heed previous

MedPAC's recommendations on the payment updates for IRFs.

DR. CROSSON: So just to be clear, what I was proposing, that we actually have a mini chapter before the PAC chapters that brings it all together.

DR. REDBERG: Okay.

DR. CROSSON: But it's up to the staff as to how to do this, but essentially, you know, could present an overall view of how much extra money is being spent across the post-acute-care segments, both by the program and by beneficiaries, at least as a consequence of, you know, failure to implement the recommendations that we've had on the table over a significant period of time. So it would be part of that.

DR. REDBERG: And the other point perhaps is because there seemed to be clear differences in the margins between freestanding and hospital-based IRFs, whether we would want to have a more negative update or some other kind of corrective action.

DR. CROSSON: Right. If I understand what you're saying -- and I agree with that -- it is that as Paul was saying, when the payment system is revised, it's revised in such a way that takes account of that.

DR. REDBERG: When it is revised [off microphone].

DR. CROSSON: Yeah.

DR. CHRISTIANSON: But I think to Bruce's point, I'm not sure we know how much of that difference is a result of differing allocations of fixed costs in hospital-based IRFs versus freestanding. So that complicates, I think, what you just said.

DR. MILLER: I took her point and your response differently, but I may have missed it, so I took that exchange as if you had a unified assessment instrument that allowed you to then in turn create a unified payment system, you would be moving to this rebalancing across the PPS. You would have a new PPS system, next paragraph and next thought, by the way, that moves dollars around between freestanding and hospital-based and not-for-profit and for-profit and that type of thing, as opposed to, well, I'm going inside each of those entities and figuring out their fixed and variable costs. That's the way I took their exchange.

DR. CROSSON: Okay. So while I -- yes, David.

DR. NERENZ: Just one more point to add to that,

because we see it over and over again, this issue of the cost allocation. We've already seen it a couple times. We're going to see it again in home health, this issue of the hospital-based. Sometime or other it would be nice if we could actually see examples of that, and I'm not quite sure how you get at it. Maybe it's site visits, maybe it's case examples. But, you know, we talk about it as a plausible thing. We have indirect evidence of it. I guess I'd like to see it directly somehow, if we could. I'd like to see an example of somebody's cost report or something that says here's a freestanding and here's the administrative cost, tunk, tunk, tunk, tunk, tunk. Here's hospital-based or hospital-owned, same size, same similarity. Here are the administrative costs allocated, tunk, tunk, tunk, tunk, tunk. Much bigger number, much longer list. I want to see what the difference is. Is there any way we could do that? Because this -- every year we see this. It doesn't go away.

DR. MILLER: Yeah, and remember, some of it is -- just like the exchange we had here, some of it is which types of patients they take and what the PPS we're doing. And then I think what you're saying is beyond that, what

would the cost structure look like?

So what my recollection is is that a number of years ago -- yeah, okay.

DR. CARTER: Right. So we didn't find -- we've looked at this issue, and there are not cost allocation issues for both SNF and IRF, and at least in the SNF sector, they have -- hospital-based have higher costs per day, and it's higher costs across the whole variety of cost categories. And it includes things like rounding on patients and not stopping orders on ancillary tests and labs and drugs and therapy and you name it. So it's really a higher cost. And, you know, they have -- they pay their nurses more typically, at least in the SNF setting. So it's higher costs kind of across the board, and it's not a cost allocation issue.

DR. NERENZ: Okay. Although -- again, I'd have to go flip to the chapter -- I think it's at least maybe mentioned in passing. Maybe it's in the home health that we see it more clearly. It just seems like even in past years it has come up fairly frequently.

But even what you just said is actually quite helpful, and I think to the extent any of those examples

could just be popped into the chapter, that would help, because then people could see much more clearly where it is or is not happening, both ways.

DR. CROSSON: Okay. Thank you. So, again, while I missed some of this, I did get the sense when I came back -- I got a lot of different impressions when I came back in. But one of them was that there was general agreement here in support for this, and so we will put it into the category of facilitated, expedited presentation and vote in January.

Thank you, Dana.

Our last discussion for today is home health care services, payment update. It's going to be presented by Evan Christman, who used to be named Zach, as I remember, but that was a while ago.

Evan, you have the floor.

MR. CHRISTMAN: Good afternoon. Now we will review the framework as it relates to home health.

Just a brief summary here. This presentation is going to have three parts. I'm going to do a brief overview of the benefit, a brief review of the recent issues the Commission has noted with home health, and then

we'll proceed to the payment adequacy framework.

As an overview, Medicare spent $18.1 billion on home health services in 2015. There were over 12,300 agencies. The program provided about 6.6 million episodes to 3.5 million beneficiaries.

Here are some of the issues that we flagged in prior years. First I would note that home health is an effective service when appropriately targeted, and can be an important service for serving frail, community-dwelling Medicare beneficiaries. However, eligibility for the benefit is poorly defined and does not encourage efficient use. As I will note in a minute, there has been rapid growth in episode volume, which raises particular concerns in the current fee-for-service environment that rewards providers for additional service.

The benefit also has an unfortunate trend of program integrity problems. There has been significant recent activity on this front, including a moratorium on new provider enrollment and some areas and efforts to implement a pre-claims review process. The Secretary and the Attorney General have made a number of efforts to address fraud in this benefit, but many patterns of unusual

utilization suggestive of fraud remain.

We have also noted significant geographic variation and utilization, which program integrity and the poor definition likely contribute to.

In terms of the payment system the Commission has noted two problems. First are issues with the incentives in the current system. The 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 ever year under the PPS. This trend, and the fact that more profitable HHAs tend to favor therapy episodes, raised 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 in 2000. The fact that home health can be a high-value service does not justify the excessive overpayments. As discussed in the paper, Medicare margins have averaged better then 16 percent in the 2001 to 2014

period. These overpayments do not benefit the beneficiary or the taxpayer.

As a reminder, rebasing is a payment reduction for home health in PPACA designed to bring payments more in line with costs. 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 $81 an episode, or 2.8 percent. However, this decrease will be offset each year by a payment update of about 2.1 percent that will add back much of what is cut. Across the years, the net payment reduction for the 60-day episode will be about 3 percent. As I will report in a few slides, margins have remained substantial in 2014 and 2015, despite these reductions. And I would note that these are only cuts to the base rate. Agencies have historically been able to offset payment cuts like these by keeping cost growth low and increasing average payment by focusing on more profitable therapy services.

As a reminder here is our framework. It is the same one other sectors have followed in earlier presentations.

We begin with supply. As in previous years, the supply of providers and the access to home health appears to be adequate. Ninety-nine percent of beneficiaries live in an area served by one home health agency, and percent live in an area served by five or more.

Turning from access to supply, the number of agencies was over 12,300 by the end of 2015. There was a net decline of 115 agencies in 2015, but we're still near the all-time high of providers, hit in 2013. And the decline is concentrated in a few areas, such as Texas, Florida, and Michigan that have been the target of efforts to reduce fraud. These areas that experienced rapid higher utilization in growth and supply in previous years.

Overall, the supply of agencies in 2015 was 63 percent higher than 2004.

Next we look at volume. Episode volume in 2015 increased slightly. The small increase in 2015 reverses the trend of modest declines we have seen observed since 2011. The number of users and the share of fee-for-service beneficiaries using the benefit increased slightly, while the number of episodes per user decreased slight, and total payments increased by 2.3 percent to $18.1 billion.

This figure gives you a sense as to how utilization has changed since 2002. Turning first to the yellow line, the national average, you can see that utilization increased through 2011, and has declined slightly in subsequent years, with a small uptick in 2015. The other two lines split the 50 states into two groups for this period. The top line shows the trend for the five states with the biggest decline in utilization since 2011. As you can see, these states grew substantially faster than the rest of the nation prior to 2011.

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 growth has been more incremental.

Overall this graph suggests that the decline in volume since 2011 has been concentrated in areas that previously had experienced high growth, and home health utilization in most of the county has increased since 2011.

The paper includes a more detailed discussion of utilization changes in 2011 through 2015, and I can speak to that on question.

Our next indicator is quality. The first rows

show the risk-adjusted rates of functional improvement. Across the years, you can see that the rates of functional improvement for transferring and walking have increased on an annual basis. In contrast, hospitalization rates have been flat in 2004 through 2014, but for the first time show a decline in 2015.

I would note two key cautions about these data, first that they represent self-reported information from agencies and may reflect variation in agency assessment practices, and second, functional data is only collected for the subset of patients that are not hospitalized, and this may bias the functional improvement measures.

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. In general, financial analysts have concluded that the publicly traded agencies have adequate access to capital, and we have seen a recent uptick in acquisition activity. For example, Almost Family bought Community Health, LHC Group expanded its supply of providers, and the big action this year was that Kindred bought the second-largest home health company in the

country, Gentiva. All of these activities suggest that companies have adequate access to capital for entry or expansion.

Before we turn to margins, I want to frame the issue and remind commissioners about recent trends in costs and payments. The average payment per episode has increased in 2015, and it is higher than the level prior to rebasing in 2013. Despite the cuts to the market basket, the average payments have increased because agencies are billing for a higher level of case-mix. A major contributor to this phenomenon of higher-billed case-mix is a problem with the PPS I mentioned earlier. Agencies can raise their payments by providing more therapy visits in an episode. In effect, under the current payment system, agencies can offset cuts to the base rate by providing more therapy visits to push up payments.

The story with costs has also been favorable. In general, cost growth varies from year to year, with some variability, but on average it has been low, with a 5-year trend of -0.1 percent. The ability to increase payments while keeping costs has been a cornerstone of the high margins we have observed.

Turning to 2015, we can see that margins were 15.6 percent for free-standing providers. The trend by type of provider is similar to prior years, with for-profits having better margins than nonprofits, and urbans having higher margins than rurals, but the differences are relatively small.

The marginal profit for home health agencies was 18.1 percent in 2015. I would also note that these data rely upon the home health cost report. CMS audited a sample of 2011 cost reports and found that costs were overstated by 8 percent. If reported margins were adjusted for this error, our home health Medicare margins for 2011 would have exceeded 20 percent. While it is speculative to apply the 8 percent to other years, the results suggest that the margins we report for home health could be higher.

Data for 2014 and 2015 allow us to assess the financial impact of the first two years of rebasing. Recall that the Commission has been concerned that PPACA rebasing would not adequately address overpayments, and the margin results for 2014 and 2015 bear this out. Margins in 2015, the second year of rebasing, are almost three percentage points higher than 2013, the year before the

rebasing reductions went into effect. The double-digit margins we report for these two years contrast with an earlier estimate of the policy's impact produced by the home health industry. In 2013, an industry analysis projected that the first two years of rebasing would look significantly worse than the actual reported financial performance. The analysis projected that margins for 2014 would be 5 percent and margins for 2015 would be a half-percent, and this obviously contrasts with the actual results for these years.

This year we also examined the performance of relatively efficient home health agencies. Recall that we define relatively efficient providers as those that are in the lowest third of providers of cost, or the best performing third of providers for quality, without having extremely low performance on either measure. About 15 percent of agencies met this standard.

Relatively efficient providers had a median cost per visit that was 12 percent lower then other agencies, and Medicare margins that were 11.8 percentage points higher. Relatively efficient providers were typically larger in size, with the median efficient provider about 28

percent larger then the median for other agencies. Relatively efficient providers had lower hospitalization rates, they provided about the same mix of nursing, therapy and aide services to their patients, and they also delivered similar numbers of outlier and low-use episodes. However, efficient providers tended to serve a more urban mix of patients compared to the mix of patients served by other providers.

We estimate margins of 11.1 percent in 2017. 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. The base payments will decrease slightly to reflect rebasing required under PPACA. There will also be an adjustment for case-mix growth.

We assumed cost-growth of one-tenth of one percent in 2016 and 2017, and also assumed nominal average payment growth of 1 percent a year. These are close to recent trends, but assume that payment growth will be a little lower than observed in 2015, and cost growth will be a little higher than the five-year average.

Turning back to our framework, his a summary of our indicators. Beneficiaries have good access to care.

The number of agencies has reached 12,300. The number of episodes and users increased slightly in 2016 -- excuse me, in 2015. Quality measures have improved in 2015, access to capital is adequate, and the margins for 2015 are 15.6 percent, agencies had a margin profit of 18.1 percent, and the estimated margins for 2017 are 11.1 percent. And again, these are average margins, and our review of the quality and financial performance for efficient providers suggests that better-performing agencies can achieve better outcomes with profit margins that are significantly higher then other agencies.

This brings us to the draft recommendation for 2018. This recommendation has two parts. First, we're going to bring the level of payments down, and end the use of therapy as a payment factor, which would be budget-neutral but redistributive.

The recommendation reads that Congress should reduce payments by 5 percent in 2018, and implement a two-year rebasing of the payment system, beginning in 2019. The Congress should direct the secretary to revise the PPS to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

The impact of this change would be to lower spending relative to current law. The impact to beneficiaries should be limited, and it should not affect most providers' willingness to serve beneficiaries. Eliminating therapy as a payment factor would be budget-neutral in aggregate, but redistributive among providers. Nonprofit agencies would see their aggregate payments increase, while for-profits would see a decrease.

This completes my presentation. I look forward to your questions.

DR. CROSSON: Thank you, Evan. So we are open for clarifying questions. Kathy.

MS. BUTO: So, Evan, the -- in terms of rebasing and eliminating use of therapy visits, so what we would do or what we would recommend they do is take some kind of average of therapy visits that's provided and build that right into the episode payment? I mean, how would you --

MR. CHRISTMAN: I guess the --

MS. BUTO: -- how would you go about doing that, exactly?

MR. CHRISTMAN: I mean, I guess it's -- the easiest way I could explain this is right now the case-mix

system uses your -- sets your payment using your clinical and functional characteristics and the number of visits, and we would simply eliminate the part that uses the number of visits and set payment for all -- right. So we're going to a sort of a fully perspective system.

DR. CROSSON: Jack.

DR. HOADLEY: You talked briefly about this rural add-on, and I saw in the chapter you talk about it expiring and in a sense this has more targeted approaches to limit rural add-on payments to areas with access problems should be pursued. Is that something that we're exploring more, or is it more in the context of if there's a problem with rural then something different than the expiring approach would be the way to go?

MR. CHRISTMAN: I think the -- our basic point has been that if you think there's an access problem you should come up with a more targeted policy, you know, as the paper goes through. You know, it's basically a volume-based add-on, so higher-volume areas do better and low-volume areas do much worse, and obviously more targeted policy would seek to flip that. We've talked about it in other settings.

I think, you know, from our perspective, 99 percent of beneficiaries live in a ZIP served by home health. Generally we think access is pretty high. Again, if people can identify specific locales they want to target, then that's, I think, what we're implying, is that's what the policy should focus on.

DR. HOADLEY: But otherwise we're not really identifying a particular access problem in rural areas. So, okay. Good.

DR. CROSSON: Questions?

Seeing none, we will move ahead with the discussion of the recommendation. Could we have the recommendation slide, Evan?

The recommendation is before you. It has several pieces.

Discussion. Craig.

DR. SAMITT: So I support the Chairman's recommendation, although I have to admit, I don't know about the rest of you, I'm having déjà vu as we have this discussion. So I guess I ask, you know, we've made these recommendations, it feels like it's the fifth year in a row, but they don't get adopted. So I'm just wondering if

we're missing something that we should be discussing that we're not discussing.

DR. CROSSON: Well, I don't know that we're missing anything --

DR. SAMITT: It's a rhetorical question.

DR. CROSSON: -- in terms of the thoroughness of the analysis or the rightness of the recommendations. I think what's missing is pressure outside to implement the recommendations and save money for the program and for beneficiaries. That's one of the reasons I agree with you, not just here, but having sat and read through all of these, one who has been on the Commission for a while, as you have, comes to the conclusion that, well, maybe we need to step up the volume or something, which is in part why we're proposing to create this additional pre-chapter, which draws together the impact of our recommendations, what they could have been, what they could be in the future, and it kind of sums it all up in terms of the impact on the Federal Treasury and the impact on beneficiaries over time.

Having said that, we still exist in a political process, and with respect to CMS, the situation where I

think, in many ways, they struggle with all the priorities that they've been given and the time and resources that they have available to do the work. But our notion so far here is to just be a little louder than we've been.

MR. CHRISTMAN: I guess the one point I would just say, Craig, sometimes it is a game of inches. I guess the point I would just make is the latter part about eliminating the therapy visits. We've been recommending that for five years, and the good news is that literally this week, CMS released a draft payment system for review that in fact does that, and while it's not always encouraging to bring the same recommendation back every year, they're in a better position to implement this recommendation than they've ever been, so that's some progress.

DR. CROSSON: Rita.

DR. REDBERG: I just would note, as you showed on Slide 15, CMS obviously gets impact from industry on all of these recommendations, and industry's projections were wildly off, as compared to ours, which were not, but I'm sure that's part of the pressure on CMS, recommendations from industry which clearly has financial interest in their

own projections on the impact of rebasing. But they were really off.

DR. CROSSON: Yeah. We have noticed over the years some occasional difference of opinion between various parts of the industry and the Commission in terms of both facts and policy.

Pat.

MS. WANG: I'm good with the recommendation. Just a small thing with the awareness, this is a deja vu scenario, so maybe it doesn't make that much difference. I liked the specificity and the way that this recommendation was worded about the timing and would encourage us to think about doing something similar for the SNF recommendation about the timing of implementing PPS, whether or not people listen. But I liked that this was very specific that rebasing should start in 2019, et cetera.

DR. CROSSON: Jack.

DR. HOADLEY: I support the recommendation, and I just wanted to reemphasize one point you made in talking about the mini chapter, pre-chapter, or whatever. Each time you've said it, I think you've been very careful to say there's potential lack of savings or uncaptured savings

for the program, the taxpayer, as well as the beneficiaries. Now, it's not as relevant in this particular sector as the others, but I do think that's an important point that doesn't always get heard in these discussions. It feels like this is all about the program versus the providers, but there's a beneficiary piece to it too.

DR. CROSSON: David.

DR. NERENZ: I guess I'm going to express the same concerns I had just the last time about this as a blunt instrument, the recommendation. I will support it, but I feel much more comfortable as it applies to the freestandings than I do as it applies to the hospital-based.

In the chapter, although I don't think you had it in one of the slides, we have margins right now of negative 15 percent for the hospital-based home health agencies, and the text goes on to say, well, that's because they have higher costs, and it's because the hospitals allocate costs. So all the questions I had last time, I think, really apply here in spades.

I'd really like to see that laid out because the

implication is, well, the hospital home health agencies are perhaps wasteful, they're inefficient, they're just a way of allocating cost, so they don't show up someplace else. But I'm not sure I really believe that or I'm comfortable with that, and particularly, what we saw last time about the case mix, I'd at least like to see the case made in more detail that these folks are really doing the same work, but they're not doing it as well, and so it's okay to hit them with a 5 percent cut as well. I really do worry about that because I think we saw some signals in the prior section that maybe they're not doing the same work. Maybe they're not taking care of the same patients, and maybe this cost allocation thing is not as clear an explanation for the difference.

So if we're going to hit everybody with 5 percent, I really, really would like to make sure that we're not hitting the hospital-based programs too hard because I'm afraid we are.

DR. MILLER: So it's been a while since I've thought about it. The change in PPS does move money in direction of the hospital-based. So I would amend -- not that you would want me to, but I would amend your comment.

I think there are two things always going on. We do think there is some difference in the patients, and if they would undertake the PPS, that would move dollars in the direction of the hospital-based, and when you look at the cost structure, the cost structure is higher there. And we can try and drill down on that and be more precise about it.

DR. NERENZ: And I do appreciate that because also we've seen this in a couple other places, where this is one thing, but then there are a couple of things that are not in the recommendation, like about a rebasing or about a shift of PPS that has the effect of countering an adverse effect I'm concerned about. And I think as long as that's articulated very clearly in the report and maybe just go on to say yes, this 5 percent cut really is going to hit these hospital-based programs where they're already negative, but this other help is coming in this form or this form. I'd like that a little better.

DR. MILLER: Okay. And we do mention the PPS thing in the recommendation, right? Should direct the Secretary to --

MR. CHRISTMAN: Right. It's the second clause.

Yep.

DR. MILLER: Yeah.

MR. CHRISTMAN: I think we can outline a little bit more explicitly, the shift in payments that occurs under some of the revised PPSs. The shift of dollars to the facility-based providers is quite significant.

DR. NERENZ: And maybe it's just the fine point connection that that's a fairly generic wording, but to say if this was actually done as recommended, it would have this effect of shifting some dollars to the hospital programs.

DR. CROSSON: We can make that clearer.

DR. NERENZ: That's the connection.

DR. MILLER: Absolutely.

DR. CROSSON: Pat.

MS. WANG: This is related to David's comment, and maybe it's for the mini chapter. I don't really see this as just about saving the program money. I think that the other very important thing that's being discussed here is ensuring that payment is targeted appropriately and is providing proper incentives particularly for people to take care of folks who are more complex, because that is a theme

that has run throughout, whether it's the IRF or the SNF or home health, that there is some confluence of I'm a type of provider or I'm whatever that is taking care of a more complex patient, and my payments are somehow not matching costs.

So I would just urge us in the mini chapter to stress that it's not just about saving green dollars, but it's also the recommendations are intended to really ensure that the proper incentives are in place to take care of people who really have needs.

DR. CROSSON: That's a good point, Pat. Somehow we're focusing on payment, and so we tend to spend a lot of time on that. You have done this before, each time correctly, which is to remind us that there is more at stake here. And to the extent that the payment system is having an unintended negative effect on quality for beneficiaries, that's at least as important.

DR. MILLER: And to the comments that Craig was making, like why doesn't it happen -- and this comment has no rational endpoint -- I've always been frustrated by the fact that why that portion of the industry that would, in fact, benefit from these changes and are taking these

patients doesn't peel off from their associations and say why isn't this happening, but that was worth all you paid for it, so I'll stop.

DR. CROSSON: Okay. Seeing no further comments, again, I'm assuming that we have support for the recommendation. Therefore, in January, we'll come forward with an expedited presentation and vote.

Thank you to Commissioners for what has been a 9-hour activity here. Everybody has done a fabulous job from my perspective of staying on point and helping us get to where we need to get to.

Now, before we leave, we have time for the public comment session. If there are those of you in the audience who would like to make a public comment, please come to the microphone now, so we can see who you are, how many there are.

[No response.]

DR. CROSSON: Seeing none, thank you. We are adjourned until 8:30 tomorrow morning.

[Whereupon, at 4:57 p.m., the meeting was adjourned, to reconvene at 8:30 a.m., Friday, December 9, 2016.]

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 9, 2016
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair
JON B. CHRISTIANSON, PhD, Vice Chair
AMY BRICKER, RPh
KATHY BUTO, MPA
ALICE COOMBS, MD
BRIAN DeBUSK, PhD
PAUL GINSBURG, PhD
WILLIS D. GRADISON, JR., MBA, DCS
WILLIAM J. HALL, MD, MACP
JACK HOADLEY, PhD
DAVID NERENZ, PhD
BRUCE PYENSON, FSA, MAAA
RITA REDBERG, MD, MSc
CRAIG SAMITT, MD, MBA
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AGENDA PAGE

P R O C E E D I N G S

[8:30 a.m.]

DR. CROSSON: Okay. We're going to begin on time this morning. Welcome, everyone. We're going to resume our discussion of payment updates this morning. We'll have three presentations.

For our guests from the public, I just want to make a couple of comments. Many of you I can see are veterans. Some of you are not. By law, once a year -- in this case in December and January -- the Commission makes payment recommendations, generally to the Congress, for areas in which Medicare is the payer. We do that two months in a row, make the recommendations, submit the recommendations for discussion in December and then again in January. That's to give the Commission time for due consideration as well as information for the public so that they're aware of what we're doing and provide feedback as appropriate.

It has been the custom over the last few years -- I think the recognition has been that in some cases the discussion may lead the Commission to a general consensus here at this meeting in December -- that's not uncommon,

has not been uncommon so far in this meeting -- in which case we will not repeat the whole presentation, the whole discussion prior to the vote in January, but we'll have an expedited presentation and an expedited vote in January if at the end of the discussion it is evident that the Commission is in agreement with the recommendation that comes at the end of the presentation.

So the other point I'd like to make, because sometimes questions come up, is with respect to the recommendations in what way do we consider the sequester which is currently in place, and the sequester, for your information, is already under consideration and is built into the recommendations that you will see.

So, with that, we will begin the first presentation. We're going to be discussing payment updates for outpatient dialysis services, Nancy Ray and Andrew Johnson. Who is going begin? Nancy, take it away.

MS. RAY: Good morning. Outpatient dialysis services are used to treat most patients with end-stage renal disease. In 2015, there were about 388,000 Medicare fee-for-service dialysis beneficiaries treated at roughly 6,500 facilities. Total Medicare spending was about $11.2

billion for dialysis services.

During today's session, we will be providing you information about the adequacy of Medicare's payments for outpatient dialysis services. To examine payment adequacy, we use a common framework across all sectors. When data are available, we look at the factors listed on this slide, which include examining beneficiaries' access to care, changes in the quality of care, providers' access to capital, and an analysis of Medicare's payments and providers' costs.

We look at beneficiaries' access to care in this sector by examining industry's capacity to furnish care as measured by the growth in dialysis treatment stations. Between 2014 and 2015, growth in dialysis treatment stations grew slightly faster than beneficiary growth. Between 2014 and 2015, more facilities opened than closed; there was a net increase of roughly 150 facilities. This net increase included for-profit facilities, freestanding, as well as facilities located in rural and urban areas. Few facilities closed. The roughly 70 facilities -- about 1 percent -- that closed were more likely to be hospital-based and nonprofit compared to all other facilities. Few

patients -- less than 1 percent -- were affected by these closures. There is no indication that affected patients were unable to obtain care elsewhere.

Another indicator of access to care is the growth in the volume of services. We track volume growth by assessing trends in the number of dialysis fee-for-service treatments and dialysis beneficiaries. Between 2014 and 2015, the total number of dialysis beneficiaries grew by 1 percent while total treatments grew by 0.4 percent. Between 2014 and 2015, we do see a slight decline in the non-annualized number of treatments per beneficiary. However, the number treatments per beneficiary steadily increased between 2009 through 2014, and the rate in 2015 is greater than the rate in earlier years -- between 2009 through 2011. We will reexamine this measure in next year's analysis to see how it trends. And as I'll show you in a moment, quality indicators for 2015 are trending in the positive direction.

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, erythropoietin stimulating agents -- has changed. ESAs are the leading dialysis drug class in terms of utilization. Before implementing the dialysis PPS in 2011, there were both clinical reasons and financial ones for their overuse. As anticipated, after the PPS, ESA use went down significantly. Between 2010 and 2014, use of ESAs declined by 45 percent per treatment. This outcome was expected and desired and has occurred according to researchers with some positive changes to beneficiaries' health status. Most of the decline occurred during the initial years -- 2011 and 2012 -- of the PPS. Between 2014 and 2015, ESA use declined. In addition, in recent years we are seeing a shift in beneficiaries being switched to lower-cost products.

Next, we look at quality by examining changes between 2011, the first year of the PPS, and 2015. Mortality, admissions, and readmissions are trending down. The percent of dialysis beneficiaries using home dialysis, which is associated with improved quality of life and patient satisfaction, has modestly increased from a monthly

average of 9 percent in 2011 to nearly 11 percent in 2015.

However, the rate of growth between 2014 and 2015 has slowed. Your mailing materials discuss a shortage that began in the fall of 2014 and continued through 2015 of the solutions necessary to perform one type of home dialysis. One indicator that measures how well the dialysis treatment removes waste from the blood -- dialysis adequacy -- remains high.

Regarding access to capital, indicators suggest it is adequate. An increasing number of facilities are for-profit and freestanding. Private capital appears to be available to the large and smaller-sized chains. In 2016, a mid-sized chain went public. Since 2011, the two largest dialysis organizations have had sufficient capital to each purchase a mid-sized dialysis organization as well as physician services organizations.

So moving to our analysis of Medicare payments and costs, in 2015 the Medicare margin is 0.4 percent. The biggest difference across freestanding facilities is the difference between rural and urban facilities. The aggregate Medicare margin for rural facilities, which account for about 20 percent of facilities, is negative 5.1

percent. The lower Medicare margin for rural facilities is related to their capacity and treatment volume. Rural facilities are on average smaller than urban ones and have fewer stations and provide fewer treatments. And smaller facilities have substantially higher cost per treatment than larger facilities, particularly overhead and capital costs.

The 2015 margin does not take into account the revised low-volume payment adjuster and the new adjuster for all rural facilities that CMS implemented in 2016. We think that the revised low-volume adjuster is a step in the right direction although last year we discussed approaches to better target the adjustment.

For this year's analysis, we also calculated the rate of marginal profit -- that is, the rate at which Medicare payments exceed providers' marginal cost. It is calculated by subtracting out capital costs from each providers' total cost per treatment. In 2015, the marginal profit is nearly 16.6 percent, suggesting facilities with available capacity have an incentive to treat Medicare beneficiaries. This is a positive indicator of patient access.

So the 2017 projected Medicare margin is negative 1 percent, a decrease compared to the 2015 margin. This decrease is net of payment and cost factors. So, first, let's review the payment factors that the projection accounts for.

The first factor that the projection takes into account is the rebasing of the base payment rate. The Congress rebased the base payment rate to account for the reduced drug utilization -- particularly use of ESAs -- that I showed you on Slide 6. Rebasing has been implemented between 2014 and 2018 in two phases. In the first phase, in 2014, rebasing reduced the base payment rate by roughly 3 percent. In 2015 through 2018, rebasing has been carried out by decreasing the update to the base rate.

For 2016 and 2017, this rebasing adjustment decreases the update by 1.25 percentage points.

Now, in addition to the rebasing adjustment, this projection also accounts for a small positive regulatory change that CMS made in 2017 and a small estimated reduction in total payments due to the ESRD Quality Incentive Program in both years.

So now let's discuss cost factors affecting the 2017 projection.

The first is a regulatory change that began in 2016. For 2016, the limit on the medical director compensation that facilities can report on their cost reports was removed. Prior to 2016, Medicare imposed a limit on the amount of compensation that could be reported on facilities' cost reports. So essentially there has been a change in the definition of facilities' cost reports.

Keep in mind that medical directors also bill Medicare fee-for-service under the Part B fee schedule for services provided as clinicians. For example, in 2015, Medicare and beneficiary payments to clinicians to manage their dialysis care was $920 million. Also, some medical directors can enter into joint ventures with dialysis organizations. Commissioners may want to discuss how the 2017 projection should treat this change. By recognizing all of the cost, some facilities may not face sufficient pressure to be judicious in the amount they pay medical directors. If the projected 2017 margin used the old cost definition -- which included a limit on medical director compensation -- then the 2015 margin and the 2017

projection would be roughly the same.

The second cost factor affecting the projection is how costs are reported by providers, which we have had longstanding concerns about. We see, for example, a different cost structure among the larger chains particularly in the reporting of overhead costs. Based on the Commission's recommendation, the Congress directed CMS to audit dialysis facility cost reports, and this audit is currently in progress. Prior ESRD audits -- the last audit was conducted more than 10 years ago -- 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' willingness to increase payments would be based on faulty data. The use of unaudited cost report data in the margin calculation is another reason to be judicious about recognizing all reported costs.

Policy changes to occur in 2018 include the statutory update of the base payment rate which is reduced by the productivity adjustment less 1 percentage point, which is the last of the rebasing adjustments. There is also an estimated small reduction in total payments due to

the ESRD Quality Incentive Program.

So here is a quick summary of the payment adequacy findings. Access to care indicators are generally favorable. Quality is improving for key measures. The nearly 16.6 percent marginal profit suggests that facilities with available capacity have an incentive to treat Medicare beneficiaries. The 2016 projected Medicare margin is negative 1 percent.

So the Chairman's draft recommendation is: The Congress should increase the outpatient dialysis PPS base payment rate by the update specified in current law for calendar year 2018. Under current estimates of the market basket index and productivity adjustment, this would result in an update of 0.7 percent.

In terms of spending implications, this draft recommendation has no effect on spending relative to the statutory update.

This recommendation should sufficiently cover providers' cost increases and thus not adversely affect providers' ability to furnish care. Given this sector's large marginal profit, this recommendation is not expected to have an adverse effect on beneficiaries' ability to

obtain care.

DR. CROSSON: Thank you very much, Nancy.

We're now open for clarifying questions.

MS. BUTO: Nancy, back to Slide 6, if we could. Can you give us a sense of how much of the decline in the use of ESAs in particular is due to changes in price versus changes in utilization? I know the dollars are both, but I just wondered --

MS. RAY: No, in this slide, the dollars are all based on 2016 average sales price. So I've held price constant in this slide.

MS. BUTO: Okay. So it's really just utilization that's gone down.

MS. RAY: Yes.

MS. BUTO: Okay. That's very helpful.

The other thing is --

DR. MILLER: Price has moved around, but the purpose of this --

MS. BUTO: I would expect it to have dropped, but I --

MS. RAY: Right.

DR. MILLER: Yeah, that drop is to show you --

MS. BUTO: Just the utilization.

DR. MILLER: -- the clean utilization.

MS. RAY: Right, right.

MS. BUTO: Okay.

DR. MILLER: Is that -- you're okay with that?

MS. RAY: Right, right, particularly because, to be clear, since 2011, Medicare does not pay separately for these products.

MS. BUTO: Right, right. So they are not actually figuring out what the price differences are.

MS. RAY: Exactly.

MS. BUTO: The other thing is that physicians used to get -- this is ancient memory, but used to get a monthly capitation payment for taking care of ESRD patients, and I remember your slides having to do with the compensation for medical directors. Is it medical directors who typically get the monthly capitation payment? And are you talking about a different payment than that when you talk about their compensation?

MS. RAY: So medical -- a clinician managing the patient, the dialysis patient, on a monthly basis is paid the monthly capitated payment. That could be the medical

director, or it could be just another physician.

MS. BUTO: Okay.

MS. RAY: Now, in addition to the dollars that the medical director can bill under the Part B fee-for-service payment system, they are also paid by the dialysis facility to act as the medical director. There's one medical director per facility.

MS. BUTO: Okay. So we don't know how much overlap there is between -- because that's additional compensation that the medical director is getting, is kind of what I'm getting at here.

MS. RAY: That's correct. Yeah, so on the cost report, they do report who the medical director is. I have not compared --

MS. BUTO: Yeah, those two. There's probably some degree of overlap there.

MS. RAY: Yeah.

MS. BUTO: And then the last question is: I notice that there has been a reduction of payments related to the Quality Improvement Program. Can you give us an insight as to what's behind that reduction in payments for -- are there quality metrics that aren't being met?

MS. RAY: Right, so the ESRD Quality Incentive Program, as mandated by the statute -- so it's not a budget-neutral program. So it can pull out dollars, and it can reduce payment by up to 2 percent per facility.

MS. BUTO: Right. And what's the reason behind -- do we have a sense -- because it sounds like there is a reduction related to that that you were factoring into margins, right? And so the question is: What aren't they doing, why are they not getting --

MS. RAY: Well --

MS. BUTO: If it's a net loss or a net reduction.

MS. RAY: Right. So a few number of facilities are experiencing a small decrease due to the QIP, the Quality Incentive --

MS. BUTO: Because they're just not meeting the adequacy requirements?

MS. RAY: Well, it's based on both clinical measures as well as reporting measures. And I can come back to you at the January --

MS. BUTO: Just a sense of that, I think it's helpful to know.

MS. RAY: Sure.

MS. BUTO: Because, you know, if we're talking about whether you stay with the statutory update or not, one question I would have is: Would that contribute to further decline in quality? Unless we think the quality measures that they're not meeting are really more processing than outcome measures.

DR. CHRISTIANSON: [Presiding.] Jack, you're next.

DR. HOADLEY: So in the chapter you had some additional detail on the ESAs and shifts among some of the different ESAs in the most recent year, and I think you said in your comments that price was a factor. Is price pretty much the primary factor in that, or were there some clinical decisions being made as well, or do we know?

MS. RAY: I don't know.

DR. HOADLEY: Okay.

MS. RAY: But there is a new ESA on the market, and it was -- began being marketed in 2015.

DR. HOADLEY: And was that -- do you know if that ESA was coming out at a lower price point than some of the older ones, or --

MS. RAY: by my estimates it looks like it, but

those are just my estimates.

DR. HOADLEY: Yeah. And with the potential for biosimilars for some of these products, is there any sense of incentives within the system to -- that might slow down a shift to biosimilars, or has there been any -- have you looked into that at all?

MS. RAY: So I believe that FDA is currently reviewing one application for an ESA biosimilar. You know, one way to anticipate, you know, when that's approved that it would increase competition among the ESAs.

DR. HOADLEY: And that would be -- the default assumption would be that it would create some price competition under the incentives in this system --

MS. RAY: Yes.

DR. HOADLEY: -- and I guess my only question is, is there anything else going on in there that might mitigate against that, but just maybe something to look at --

MS. RAY: Okay.

DR. HOADLEY: -- once that happen. Obviously that's into the future, yeah, and whether there's potential for rebasing, if that's a -- if that makes a substantial

impact on total costs.

DR. MILLER: There's no automatic rebasing, like if there were a big drop, if that's what you're asking. You have the pressure of a bundled payment. If they got a big price decrease and had some head room, I think somebody would actively have to go and --

DR. HOADLEY: Right, and that's presuming -- that's what happened, you know, as a result of this trend, and I'm just --

DR. MILLER: [Speaking off microphone.] -- mostly utilization.

DR. HOADLEY: Right.

DR. MILLER: That might be a price effect, but yeah, somebody actively --

DR. HOADLEY: Actively.

DR. MILLER: Yeah. Somebody being in the Congress actively went and made an adjustment here.

DR. HOADLEY: So just something to look at. If we see that kind of pattern down the road, that could be something to talk --

DR. CROSSON: [Presiding.] Rita, I think you're next on the list.

DR. REDBERG: Thanks. Thanks for an excellent report.

I was gratified to see the increase in home dialysis because, as you noted, it's associated with a better quality of life for the beneficiaries, and that was despite the problems with Dialysite [phonetic] that occurred in 2014, which was unfortunate.

Do you have any insights into what was responsible for the increase in home dialysis, and how we could encourage it -- so the increase from 2011 to 2015 --

MS. RAY: Right, and --

DR. REDBERG: -- what was driving that?

MS. RAY: The increase in home dialysis? I think that PPS was driving it. I think the bundled payment has encouraged the use of -- I think the PPS is partly a reason for the increased use of home dialysis. It was trending up even before the implementation, before 2011.

DR. MILLER: Yeah, and the thing I hate to ask when I'm not quite sure, there's also a payment that goes along to educate and train the beneficiary as well --

MS. RAY: Yes.

DR. MILLER: -- that was created as part of the

PPS, or adjusted in some significant way as part of the PPS. Am I remembering this right?

MS. RAY: Yes. Medicare does make a separate payment for the dialysis training sessions.

DR. REDBERG: And my other question was actually on -- do you happen to know, in the cost reports, do the medical directors include how many hours a week the medical directorship takes and the salary range that you see in cost reports?

MS. RAY: So under the cost reporting rules, the medical director's time can be billed up to 25 percent. So they basically take their estimated compensation and then you can multiply up to 25 percent of that to get what that allowable cost is entered into the cost report.

With respect to the -- what the medical directors are making, the cost report information is kind of -- what do I want to say? -- a little bit squirrely on that. To give you a sense, though, however, MGMA average compensation for a nephrologist was roughly $360,000 in 2015.

DR. REDBERG: And my last question was -- I have one more question.

DR. CROSSON: Sorry, Rita. Go ahead.

DR. REDBERG: It's on the increased use of the dialysis drugs that are outside the bundle, the calcimimetics and the phosphate binders, because, you know, obviously we learned from ESA, I think very painfully, that we were spending billions of dollars on drugs that were not, you know, given way higher doses than were good for the dialysis, and it's nice to see the trends otherwise. But I notice now that these drugs outside the bundle have increased 22 percent per year, and that the intent of the -- was to include all the drugs in the bundle but the achieving of better life experience delayed including those drugs in the bundle, and I'm wondering if you have any insight, again, why they were taken out. It certainly seems like it may not be in our beneficiaries' interests to see this increase and that it's related to being outside the bundle. Any further information?

MS. RAY: So when CMS implemented the bundle in 2011, the agency proposed to include the Part D drugs but decided to delay it until 2014, just so they could iron out the, you know, exactly how to put them in, and to, you know, and how to set the base rate accordingly.

After the CMS delay, Congress then stepped in and, you know, and through various -- three times delayed the inclusion of the Part D drugs into the oral -- into the bundle.

DR. CROSSON: I've got David, Bruce, Craig, and Alice. David is -- and Brian.

Let me just as one --

DR. CHRISTIANSON: Paul.

DR. CROSSON: Sorry, Paul. Let me just ask one question myself, because I thought I understood the medical director thing and now I'm not so sure.

So previously -- tell me where I'm wrong here, immediately -- previously the medical director salary, if that's the right term, was -- there was a cap on that, and then you -- then they accounted 25 percent of that towards their cost. The change -- is the change that the entire salary is now accounted for, or that the cap has no limit? Which of those two things?

MS. RAY: So before 2016, facilities could report up to 25 percent of the -- what they called the reasonable compensation equivalent, and that was roughly $196,000. That $196,000 has been lifted.

DR. CROSSON: But it's still 25 percent.

MS. RAY: Yes. It's still 25 percent --

DR. CROSSON: Okay.

MS. RAY: -- up to 25 percent.

DR. CROSSON: Right.

MS. RAY: If you bill more than 25 percent you have to justify that.

DR. CROSSON: Thank you. I understand. Sorry.

Bruce.

MR. PYENSON: Nancy, thank you very much for a great report.

In other reports we looked at yesterday we were able to compare patients covered under Medicare Advantage to the fee-for-service program, and that's perhaps difficult to do, given the coverage rules. But there are a significant number of patients in ACOs who have end-stage renal disease and are covered under that program, perhaps due to the attribution methodology.

If we were going to compare patients and outcomes, how would -- do you think that would be a useful -- that that analysis would provide useful information?

MS. RAY: Yeah, I think it would. The ESRD ESCO

program, which is the -- what I would say the equivalent of ACOs for ESRD organizations, that began in 2015. So 2016 is the -- we don't really have data for that yet. But I think in the future that would be one promising area to look at.

DR. JOHNSON: Bruce, can you say a little bit more about which outcomes in particular that you're thinking of taking a look at?

MR. PYENSON: It's, of course, hard to compare cost outcomes because of the way payment is made, so other outcomes might be the other Part A and Part B costs associated with patients.

DR. CROSSON: Craig.

DR. SAMITT: So back to Slide 11, I have a couple of questions about the cost factor.

Just to clarify the medical director cap shift, are you saying that the total compensation per full-time medical director could be as much as $196,000, and the cost report could include 25 percent of that number, which means that if the new threshold is somewhat higher, because that's the market demand for that role, it would then be 25 percent of that higher number? Okay.

MS. RAY: That is correct, and to be clear, in 2016 and beyond, there is no threshold. It's whatever the market --

DR. SAMITT: Whatever the market will bear.

MS. RAY: Yes.

DR. SAMITT: So my question is about the materiality of that. So do we have a sense of what the potential impact will be on the marginal profit as a result of that, plus what we think the materiality would be about the cost report audit? You talked about, it sounded like anywhere between a 4 to 8 percent potential impact. So I'm just wondering, in terms of marginal profit, what would we estimate those two factors would have on the dialysis centers?

DR. MILLER: So, Nancy, for -- projecting forward to 2017, we did make an assumption about the effect of the change in the threshold?

MS. RAY: Yes.

DR. MILLER: So here's what I'm going to say. Okay? Ready? You've got about a 2 percent -- let's just call it, in round numbers, 1-1/2 to 2 percentage adjustment in your margin from 2015 to 2017. All other things equal,

the marginal profit goes down two points too, but you can see the tentativeness and the guessing in my voice, Craig. Is that kind of what you were asking?

DR. SAMITT: For just the medical director piece, or both parts?

DR. MILLER: Well, whatever -- no. You're right. The total effect, factors between '15 and '17, is the 2 percent. I don't know that we could quantify, or whether we have specifically quantified the medical director component of that.

DR. CROSSON: Wait, wait. Let me see if I understand this. So let's assume, for the moment, that the salaries -- the market is not, in the short term, going to push the salaries up.

DR. MILLER: Yeah, but just before you go on --

DR. CROSSON: Yeah.

DR. MILLER: -- Nancy, immediately a higher cost enters the --

DR. CROSSON: I know that, but what I'm saying is -- the way I'm thinking about this is that this is primarily an accounting change, right, because the dialysis center has been paying the medical director the amount.

The accounting for what -- based on the cap changing, what the 25 percent would amount to in terms of the cost report changes, but the actual money out the door for the dialysis center to the medical director hasn't changed. And so the -- so, in other words, the margin will appear artificially lower --

DR. MILLER: Yes. Correct.

DR. CROSSON: -- as a result of this.

DR. MILLER: Yeah, and in our methodology -- all I was trying to say, in our methodology, you know, both the average and the marginal profit would be affected by this change, because we're getting the information from the cost report.

DR. CROSSON: Right, but that's different from --

DR. MILLER: What's really --

DR. CROSSON: -- what's really happening.

DR. DeBUSK: [Speaking off microphone.]

DR. CROSSON: Right. No comments about that.

Alice.

DR. COOMBS: Thank you, Nancy. I look forward to your report every year.

I want to talk a little bit about something that

I've asked before, and this is the packaged dialysis patient, in terms of the total cost, including the $900 million. MA has patients that develop renal failure while they are MA patients. Do we have any information about what the total cost is, either from the MA population or Kaiser, a closed system, like Kaiser, or some system like that, where you can actually attribute it -- you have the whole cost calculated and then you have attribution of cost within the bundle or within the global cost of care of the patient?

DR. JOHNSON: We haven't started to dig into the cost side of that as much, but the MA payments are based off a fee-for-service population and their total costs. So at least the cost to the Medicare program is roughly equivalent on both sides. I know that isn't quite your question.

DR. COOMBS: Right, because I've heard quotes from the ASN about the total cost of the end-stage dialysis patient requiring standard dialysis is X number of dollars. And so how do we carry that out to the next level of substantiating it within that packet? I'm really curious because every time I go to one of these presentations

there's a quote, and I'm figuring out how they get to that quote.

DR. JOHNSON: That's a good question. That's something we'll be sure to look into for next year.

DR. COOMBS: Because going forward with -- especially with the ESCO, it would be a very important piece of that.

And then, secondly, about the kidney -- I was very interested in the education piece and when it's implemented. And it seemed like it was implemented already when you're CKD 4 instead of when you're earlier. And were there any plans to kind of implement that earlier, because if you can avert the onset of Stage 4, I mean, that's where money savings is.

MS. RAY: Right. So the Chronic Kidney Education Initiative that is included in your mailing materials is for Stage 4, chronic kidney.

DR. COOMBS: Right.

MS. RAY: That's correct.

DR. COOMBS: Right.

MS. RAY: You know, let me get back to you in January to just review Medicare's other education

initiative before I -- so I can better answer your question.

DR. COOMBS: And lastly, the whole notion of transplant -- and I looked at the wonderful chart that you had -- very good stuff, in terms of reflecting how transplant -- African Americans, Asian Americans are less likely to receive kidney transplants. I was curious as to if you were to project if someone gets a kidney, how much savings that is as a result of the transplantation. It might be something worthwhile looking into, because long-term, I've taken care of patients in the ICU who have had transplants, and it's an amazing turnaround for their life, and, in addition, you know, costs and comorbid conditions, management, everything becomes so much easier to manage, and the global cost goes down as a consequence of quality of life improves dramatically.

MS. RAY: Right, and for the next version of this paper we can include the total cost from the USRDS, and they itemize out spending for patients who have gotten a kidney transplant versus dialysis patients. So we can put that in there for you.

DR. CROSSON: Okay. I have Brian and Paul, and

then we're going to move -- and Kathy -- and then we're going to move on to the discussion here.

Brian.

DR. DeBUSK: If we could go back to Chart 6, please.

That is obviously a very impressive trend in utilization of those drugs, presumably through the introduction of the prospective payment, or the bundled payment. Do we track, or have we tracked the unit prices of those drugs over time an compared their unit prices, say, to drugs overall?

MS. RAY: I do track the ASPs for the drugs that are in the bundle.

DR. DeBUSK: Have they mirrored the price increases that we've seen of other drugs?

MS. RAY: I'd have to get back to you on that. What I can tell you is that within the Vitamin D group, for a couple of years there was some price competition going on between those two products after the implementation of the PPS.

DR. DeBUSK: There is something -- when we had our Part B drug discussion, I remember Kathy pointing

something out about not necessarily bundling codes, combining codes, but maybe combining the code with the procedure, you know, more of a bundled approach. And to me this seems like that would be an interesting test to see how drug companies responded to the bundling. Did their unit price for that basket of drugs, when sold to a dialysis clinic, did that basket track the overall prices of drugs in general? Or did they respond differently with the change in their unit price?

DR. CROSSON: That's a good point. I just think one of the complexities is what do you compare it to, because there's going to be so many things moving around. But there might be a cohort of pharmaceuticals that would represent a comparator. I'm not sure.

DR. DeBUSK: And could we find the ones that were sold specifically to dialysis clinics? Can we tease that apart?

DR. REDBERG: Compare it to the Part D dialysis drugs outside the bundle.

DR. MILLER: Okay. So a few things here, and then some of the drug folks, I'm going to say something, so pay attention.

One thing to keep in mind is the other thing that happened here -- now, I still think that the large effect you saw here is PPS, but also remember there was an FDA black box that came out at the same time. So there was a clinical indication here that also changed. But, still, when you watch the data -- and I'm doing this by memory, Nancy -- there was sort of a black box effect, and then there was a PPS effect. And, you know, we thought a lot of that utilization was affected by PPS. So your point stands, Brian, is what I'm trying to get at.

Then I have one other thing to say about his point, but you seem to want to say something right now -- okay. Well, the other thing I was going to say is that I could imagine this being fairly complex depending on whether the drug can be used in other channels and for other purposes about what the price effect would be. So if you put it in a bundle -- and this is pretty much your dominant population, your dominant payer -- you could be really affecting, you know, prices, utilization very strongly. But if those drugs can travel to other types of patients and other types of channels -- I'm trying to use a drug term to sound like I know what I'm doing over there,

Amy -- you know, does that mean that the price effect might not be quite the same thing? So this is not no, but it may be more complex than --

DR. DeBUSK: As a corollary, could we pull invoices, say, to dialysis clinics versus where those drugs are sold in other settings and just look and see if there's a difference?

DR. MILLER: I'm not sure we have that granularity. I think what we have is, you know, cost report data and then ASP information in other sources, and we'd be trying walk some -- I'm not sure we know the unit price that the dialysis facilities are purchasing at, right?

MS. RAY: Right. So the way it's reported on -- so the way that dialysis drugs costs are reported on the cost reports, you have a category for the ESAs, and then you have a category for the other Part B drugs that are included in the bundle. So you really can't tease out, for example, under the Vitamin D's, you can't tease out Zemplar versus Hectorol, the two dominant Vitamin D agents.

MS. BRICKER: Brian, are you trying to understand if the pricing from the manufacturer is different because

of the doctors that are affiliated with ESRD versus someone that's buying the same drug not in relation to dialysis? Is that what you're trying to determine?

DR. DeBUSK: I'm trying to see the impact that the bundled payment would have on the overall ASP of the drugs that follow to the dialysis center to see how the manufacturers would respond. Would they price under business as usual policies and just accept the fact that fewer drugs are going to be used? Which is what that chart shows. Or would there be a reduction in the price of those drugs as well, presumably to compete? Because essentially what this has created -- what I'm seeing here is a shrinking market, because the market has -- utilization has decreased more quickly than the number of ESRD patients has.

MS. BUTO: I think ESRD is so peculiarly Medicare that a better bundle to look at might be the cancer oncology bundle that CMS is now trying to put in a demonstration, because cancer drugs can be used in populations outside of Medicare. But ESRD is so strongly Medicare, and the other uses of ESAs for cancer and other things wouldn't be comparable. So I'm not sure it's a good

case example, but I think probably the behavior you're talking about did happen.

MS. BRICKER: To finish my thought, it would be more or less -- I don't know if there's a different class of trade, so class of trade going to drive really pricing around product, and there's not a different class of trade associated with purchasers for ESRD versus non, and so I don't know that -- and you're not going to buy direct from a manufacturer, right? So I don't know that -- we should definitely consider it, but I don't know that you're going to really see manufacturers acting differently because of bundled payment, because the class of trade associated with you as a purchaser isn't going to be different if you're associated with dialysis procedure versus some other physician service. I don't know if that makes sense.

DR. CROSSON: Okay. Jack, on this point?

DR. HOADLEY: I was just going to say that my question earlier about the multiple products within the ESA class sort of goes to -- you know, there's three -- there was a shift from two of the products to a third one particularly, or it's a little more complicated than that, and I guess part of the problem is we don't see the sort of

price points that are going on in the centers amongst those. And so whether there's any maneuvering within the class because they're in this context, but if we could get into that, that would also be potentially interesting to see what's going on, how they're responding, when there are multiple choices within that particular class.

DR. CROSSON: Okay. I've got Paul and then Kathy, and then we do need to move forward.

DR. GINSBURG: Yeah, just a question on the quality measurements, and what I started thinking about is that, of course, these quality measures are influenced by the service in question, but also other things. And I was wondering if there was less of a relationship between the services in question and quality here than we're running into in many of the other areas. Or I'm just kind of probing, and there may not be anything there. But I just wanted to raise it.

I don't think I've been clear. I'm just thinking about these patients have other medical conditions not related to their ESRD, and also the physician payment is not part of this facility payment to the dialysis facility. That's probably very important in, you know, whether there

are admissions or readmissions, not just the quality of the dialysis they receive. So that's what I was getting at.

MS. RAY: Right. So I'm not a clinician, but, yes, these patients have a lot of comorbidities -- congestive heart failure, diabetes, hypertension. That being said, you know, there are -- I think that the treatment dialysis facilities furnish these patients does play a big role in their outcomes. And I guess I could use a little bit of clinical help here.

DR. COOMBS: I just want to say something. The point that he's making is a good point, but you're assuming that the prevalence of comorbid disease is fairly constant within this population. What might be more interesting is the number of patients that are admitted from dialysis who are either extremely dehydrated, meaning you overdialyzed them or you haven't done the job to get them to the point where their volume status is adequate and they may have congestive heart failure. So that might be more interesting, is how many patients are admitted from dialysis into the hospital, where during dialysis or sometime around dialysis they have a complication? That's probably a better indicator of quality.

DR. CROSSON: On this point?

DR. NERENZ: Exactly on this point. I thought, Paul, what you were raising is an example of the signal, the noise question; I used that expression a couple months ago. And, Nancy, I guess this is just an example, not today but as we get into deeper discussion of quality measures. You said it has a big effect. I'd be interested in knowing how big, exactly how big. And that was the point I was making a couple months ago.

DR. CROSSON: Okay. Kathy, last question.

MS. BUTO: This should be fairly quick. So I just wanted to be clear. We were talking about home dialysis and facility dialysis. Nancy, under home dialysis, is there a payment rate exactly -- is it a PPS rate that gets paid? And is it the same amount that the facility gets?

MS. RAY: Yes, there is --

MS. BUTO: Okay. There's no reduction for home dialysis.

MS. RAY: For adults, the home rate and the in-center rate is the same.

MS. BUTO: Okay, good. Because at one point the

program was paying a lot more for home dialysis, and there was a spike, and that was due to a reimbursement glitch, so to speak. Thanks.

DR. MILLER: The rates are the same, but then there is an additional payment for the education --

MS. RAY: For the training.

DR. MILLER: For the training.

MS. RAY: For the training.

DR. MILLER: So depending on what your question was asking, there is another block of dollars that goes along with the home --

MS. BUTO: But I think that's a one-shot deal, right?

MS. RAY: Right. So --

MS. BUTO: It's not every treatment.

MS. RAY: Right. They get up to -- what is it? -- 15 training treatments for one kind of home dialysis and 25 for the other kind of home dialysis.

DR. CROSSON: Okay. Nancy, could you put up the recommendation slide?

So this is the order of business. I'd like to hear from the Commissioners about support for the

recommendation or not, or other issues related to the recommendation. I'm seeing the appearance of thumbs. A lot of thumbs are in the air.

Bruce, you want to make a comment? Go ahead. Alternative view.

MR. PYENSON: I would like to see an estimate of the impact of biosimilars for 2018 to see whether we should recommend a split or a time difference, that is one action if biosimilars are not approved and the different action if biosimilars are approved. We're talking about 2018, and the world with respect to some of the major expenditure items could be different then. I'm not sure if that is practical from a recommendation standpoint for MedPAC, but that's my thought.

DR. CROSSON: So let me see if I understand. I think what you're saying, Bruce, is the support for this recommendation might vary if we were in possession of information about certain biosimilars and the likelihood of those being approved and marketed and used within the time frame that we're talking about, which is fiscal year 2018. So I guess the question is: Is such an analysis feasible or not?

DR. MILLER: No.

[Laughter.]

DR. MILLER: And I don't mean to be so cavalier about it, but this gets approved, it gets on the market, the price will be X. And I imagine there's a lot of people in the marketplace who would like to know the answer to that, and I don't feel particularly and I don't know that we're particularly equipped to do that. So I would have a very hard time kind of coming back with an analysis that says I think it's two points, you know, on the margin if the biosimilar exists and they use it.

Also, you know, I hear -- and, again, I defer to a whole set of drug folks down here -- you know, back and forth on how deep discounts you should be expecting when a biosimilar shows up. And then even if it does hit the market, the price effect I think could take awhile to work through. I'm not sure it would hit in 2018 and, you know, you'd see the thing right off.

MS. BUTO: I think the other side of this that I'm a little concerned about is the idea that even if we made an educated guess, the idea that we would recommend payment rates that might actually force a certain price

behavior, that really bothers me. So I think the issue of letting that price fall naturally through the use of biosimilars is appropriate and then maybe come back and recommend some rebasing. But to anticipate and in some sense force certain pricing -- I don't think that's -- I would think that's not a good role for the Commission.

DR. HOADLEY: I'm not necessarily averse to that notion of sort of putting pressure on, but I think in this instance the chances that this would be on the market and really in wide availability in that short time period seems less likely. But, in addition, as Mark said, the experience in sort of traditional drugs with generics, it can take a full 12 months before you start to see the price effects, and in some ways that gives us the chance to wait until a point when we know that the drug is, in fact, approved, what's the clinical reception to it, and so forth.

I mean, there are concerns that you could see price behavior in anticipation of in terms of some of the other products, and one of the things I do wonder about is whether some of the shifts in the market that we're seeing in the last year could be attempts to move to products that

are not the ones where the biosimilar competition would come in. But, again, I don't think we can -- I don't think there's a practical way to figure that into an estimate like this. I agree with Mark on that point.

MR. GRADISON: In addition to the variables Mark mentioned, I just would point out there are two dominant purchasers of these products -- two. Now, I don't know what the total significance of that is, but I think it's an important fact, and unusual, actually, when a new product comes along.

MS. BRICKER: I think there's great interest in anticipation of what biosimilars made do in the market, right? So we might just want to consider, as we're reviewing topics along the way, that we provide sort of pipeline information. I agree, you can't -- we're not going to be able, to Mark's point, to say that will result in a 2 percent reduction. But I think it seems as though because of -- we are hoping that biosimilars will allow some new behaviors in market to just have for all of us, as we're debating, just pipeline drugs that are expected to have a biosimilar into the market, and when and maybe how many, just so then we could have that dialogue. But I

don't think there's any way for us to say and that, therefore, will reduce pricing by X.

DR. MILLER: I could see us even more broadly than just the -- and I think that's your point more broadly. I think we could try and assemble here's what's at FDA, here's what's -- that actually is a good point. Once again, I want to say to Bruce and to the rest of the Commissioners, I wasn't trying -- the policy, take it in advance, take it behind, that's all for you guys to decide. For me, I just didn't feel like I could deliver that in, you know, in three weeks. That's really what I was reacting to.

DR. REDBERG: So like other things we've talked about, you know, it's not just how to do a better experience, but also was it needed in the first place? And you will be surprised to know there appears to be overuse of dialysis. And I'm not talking just about inpatients, you know, whose lives probably won't be benefitted or extended. I mean, we know that we dialyze many more patients in the United States than anywhere in the Western world, and our outcomes are poorer, our mortality rates are

higher. But there's also been a trend to starting dialysis earlier in this country, which I think probably was initially thought, you know, that would be better. But there has been clear data from randomized controlled trials as well as observational studies in the last five and ten years that we're starting dialysis much, much earlier and are just -- this is from an editorial from a nephrologist in the Archives of Internal Medicine, "Time to rethink the timing of dialysis initiation." So from 1995 to 2007, the average serum creatinine, which is a reflection of your kidney function, the level at which we start dialysis has dropped. So it went from 8.7 to 6.3, meaning that people still had a lot more kidney function. And the glomerular filtration rate, which is another indicator of when to start dialysis, has increased. So we're starting people on dialysis who have much better kidney function, and studies have shown -- this was a study by Rozanski -- that people who are started on dialysis with better kidney function do worse. They have higher mortality rates than the people that we wait. And I think part of this is related to the fact that there's a lot more checking of kidney function and people are getting staged; you know, they're told they

have Stage 1 and 2 and 3 and 4 kidney disease. It's basically an asymptomatic, pre-disease that's based on your kidney function. But I think if we are able to sort of tie glomerular filtration rates somehow into the whole bundle as well, it could -- as we saw positive effects and better quality of life for decreasing ESA use, I think this is not a good trend for beneficiaries to be starting dialysis, which clearly has a decrement in quality of life once we initiate dialysis at glomerular filtration rates that are way higher than people need to be started on and, in fact, they will have worse outcomes.

DR. CROSSON: Thank you.

DR. GINSBURG: I thought that Kathy and Jack and Amy's comments were along the lines of what I was going to say. I just want to go back to the general principle that came up -- I brought it up yesterday -- with the hospital market basket projection, that it's not a good idea for this Commission to become forecasters. And I think our system works quite well by quickly monitoring data, seeing what's happening, and adjusting our recommendations to that when we see it. But I think we just undermine our own credibility if we're going to go and forecast hospital

trends or if we're going to go and forecast what's going to be the price, you know, if a biosimilar is approved, and how is that going to affect a lot of other things? So I just wanted to say that on general principle.

DR. CROSSON: Thank you.

DR. HALL: Another related cost we haven't looked at -- and I'm not suggesting we do right now -- is that the cost of transportation to dialysis units is something that medical directors have to approve. And as I recall, the last time we looked at the ambulance cost, there seemed to be something wrong there, because very highly sophisticated ambulances similar to a space capsule were being used for people that could take a bus. And it was very, very high. So sometime we ought to make an asterisk there, take a look at that, as long as we're looking at costs and what happens when there's a relative monopoly in the marketplace.

DR. MILLER: And my quick recollection is -- and we could take another look at this, looking at various victims -- I mean, yeah, not for this next thing in January. We did look at it. I thought was actually some shift in that trend, so we did see some impact on the ambulance stuff because it got highlighted in many ways,

including our work, and it hit the newspapers and that type of thing, and there has been some shift. But I don't think we've looked back at it as of late.

MR. GLASS: There was a prior rule on that [off microphone].

DR. MILLER: Right. So we'll look back at it for you, Bill. You're right.

MS. RAY: So U.S. Renal Data System, the last time we looked at it, ESRD spending for ambulance services in 2011-2013 was trending up. Between 2013 and 2014, according to the USRDS data, it's going down a bit. And our preliminary estimate for 2015 is that it is declining relative to 2013.

DR. CROSSON: Okay. So, Bruce -- David, do you have a point?

DR. NERENZ: Well, in just listening to the last couple comments, I'm afraid Rita's excellent comment is going to get lost. I just want to make sure that we don't -- because it seemed like that leads fairly directly to a possible recommendation to say that payment is different or even non-existent for dialysis procedures in a certain set of clinical conditions. And that's an interesting track to

follow. We've been on the cusp of that many times. This may be a place to take it up, and I just didn't want that comment to be in the air and then dropped. We ought to end it thoughtfully somewhere.

DR. CROSSON: Well, I mean, I think that's fair enough, and I guess my thought here again, though, is this is basically a payment update, and to take on in the course of this process in December and January a question like should CMS or someone else be setting and enforcing through the payment system clinical guidelines as to who receives dialysis is something that we could take on, but it's a bit larger question, I believe.

DR. NERENZ: And that's okay. I don't actually disagree with that. I want it explicit so that it just doesn't fade off into the ether and we don't know where it ended --

DR. CROSSON: Yeah, fair enough.

DR. HOADLEY: To this point, maybe that's something to look at as a quality indicator or some kind of thing, at least, whether it's literally a quality indicator or something to track, is what are the trends at the stage of disease, and then we'd have better information.

DR. SAMITT: I would expand on that further. I also don't want to lose Rita's good point, and, you know, I was going to go where Jack was, which is should we be expanding our notion of quality measurement when we talk about quality dialysis -- you know, we've talked before, and I don't remember if I had seen it, you know, the transfusion rates. We just talked about the start of dialysis and the GFR at the start. And then we also talked about the costs of drugs that are not in the bundle. So it feels like perhaps there are other things at a minimum we should be measuring and tracking, with a discussion at a later date about whether we would recommend any policy changes as a result of the new things that we would begin to measure.

DR. CROSSON: Right, so -- and I think we've had similar experience yesterday as well, that in the course of making this determination, which is what we're going to do about the update, it allows us to focus on the broader question of the quality of care in many cases or other aspects of the policy appropriateness in this particular payment area and identify those for future work. And I think that's what I'm hearing, and I agree with that.

Okay. So, Bruce, having heard this discussion, will you allow the Gladiator to live or not?

MR. PYENSON: I think I'm the Gladiator, so yes.

[Laughter.]

DR. CROSSON: Okay. So I'm hearing a general consensus for the update here, and so we will handle this in January in the expedited presentation and voting mode.

One historical note. If we are going to be doing thumbs, there is a controversy about whether or not in the history of Rome and the gladiatorial games, thumbs up actually represented, "Let the Gladiator live," which is the common wisdom. Or, in fact, it was the opposite. So before January -- well, before next December, before we do this again, I think we need a MedPAC historical analysis so that we're properly employing our thumbs. Thank you.

DR. MILLER: No, we won't be. Not before January.

[Laughter.]

DR. MILLER: I'll bring you in that biosimilar thing then.

[Laughter.]

DR. CROSSON: Nancy and Andrew, thank you.

[Pause.]

DR. CROSSON: Okay. We're going to move to our next presentation, which is adequacy of payments for hospice services. Kim Neuman is here. Kim, you have the floor.

MS. NEUMAN: Good morning.

So first a few facts about hospice in 2015. In 2015, more than 1.3 million Medicare beneficiaries used hospice, including nearly half of all decedents. About 4,200 hospice providers furnished care to these Medicare beneficiaries, and Medicare paid them nearly $16 billion.

The Medicare hospice benefit offers beneficiaries a choice in the type of end-of-life care they'd like to receive. For beneficiaries that choose to enroll in hospice, hospice provides palliative and supportive services focused on symptom management, psychosocial supports, and quality of life. 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 this criteria.

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

Before we go through our indicators of payment adequacy, I'll quickly touch on issues with the hospice payment system that the Commission identified in 2009, and remind you of some changes that are underway related to the payment system and other initiative starting in 2016.

First, back in 2009, the Commission observed that there had been substantial entry of for-profit hospices, increases in length of stay for patients with the longest stays, and particularly among for-profit providers.

Looking at the payment system, we found it was misaligned with providers' costs, making long stays very profitable. So in March 2009, the Commission recommended that the payment system be changed from a flat payment per day to one that's higher in the beginning of the stay and at the end of the stay, near the time of the patient's death, and lower in the middle.

Congress gave CMS the authority to revise the

payment system as the Secretary determined appropriate, and beginning in January 2016, CMS implemented changes to the hospice payment rates for routine home care, in a manner that's consistent with the spirit of the Commission's recommendation. So beginning in 2016, there are two base rates for routine home care -- a higher rate for the first 60 days and a lower rate for days 61 and beyond. In the last seven days of life, hospices receive additional payments for registered nurse and social worker visits on top of the regular per diem rate.

CMS projected the new payment rates would be budget neutral in the aggregate but they would redistribute revenues across providers, meaning more revenue for provider-based, nonprofit, and rural hospices, and less revenue for other providers.

There are at least two other notable initiative related to end-of-life care that began in 2016. First, in 2016, CMS's innovation center launched a five-year demonstration to test concurrent palliative and curative care for certain hospice-eligible beneficiaries who are not enrolled in hospice. The idea is that this might lead these beneficiaries to receive palliative care earlier in

the disease trajectory.

Second, beginning in 2016, Medicare covers advanced care planning conversations between interested beneficiaries and their physicians or other practitioners. These services are payable under the Physician Fee Schedule.

Just one other note, all of the Medicare data that we're going to be seeing today predates these 2016 changes.

So here we have our update framework, and you've seen this in the other sectors. First we'll look at growth in the number of hospice providers.

The green line in this chart shows that the total number of hospice providers serving Medicare beneficiaries has been increasing for more than a decade. Each year on het, the program has been gaining 100 to 200 providers. In 2015, the number of hospice providers grew about 2.6 percent, a net increase of about 100 providers.

Looking at the other three lines in the chart, which show the number of providers by type of ownership, we see growth in the supply of providers is almost entirely due to growth in for-profits. The number of nonprofits and

government providers have been on a slight downward trend.

The next chart shows the growth in hospice use among Medicare decedents. Between 2014 and 2015, the share of Medicare decedents who used hospice increased from 47.8 percent to 48.6 percent. Over the years, hospice use has grown most rapidly for beneficiaries age 85 and over. In 2015, 57 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 rates have been increasing for these groups too.

Here we have more detailed utilization data. The number of hospice users grew about 4.3 percent in 2015, to more than 1,380,000 beneficiaries. Average length of stay among decedents declined slightly in 2015, because of a decrease in length of stay for patients with the longest stays, and you can see that the last line of the chart. Hospice length of stay at the 90th percentile decreased from 247 days in 2014 to 240 days in 2015. Hospice length of stay for shorter stays changed little.

And as you can see here, in this next chart, the length of stay varies by absorbable patient

characteristics, like diagnosis and patient location, so that providers that wish to do so have had an opportunity to focus on more profitable patients. Consistent with that, we see for-profit providers having substantially longer lengths of stay than nonprofits, 105 days versus 65 days, on average, and when we look at the margin figures later, embedded in those margins will be the effects of length-of-stay differences on providers' financial performance.

Next we have quality. Since July 2014, hospices have been required to submit quality data for seven process measures. A couple of examples of measures include documentation of treatment preferences and screening and assessment of pain. A report from a CMS contractor, RTI International, provides an initial look at performance on these measures. On six of seven measures, most hospices scored very high -- three-quarters or more hospices scored 91 percent or higher. Scores on the seventh measure were lower and more varied. That seventh measure relates to whether the hospice performed a comprehensive pain assessment within one day after a patient screened positive for pain.

As far as what to make of these seven measures, they are process measures and it is uncertain how much they affect quality from the perspective of the patient, and the high scores suggest some measures may be topped out.

There are some additional quality measures on the horizon. Hospice CAHPS, which surveys the family members of deceased hospice patients, has been underway since 2015. Data are not yet available but some aggregate data are expected soon. Also, CMS has added, for 2017, a pair of measures gauging the share of a provider's patients who receive certain types of visits in the last days of life.

With quality measurement in general, it has been the Commission's view that outcomes measures would be preferable to process measures. With hospice, clearly outcome measures are challenging, but it is noteworthy that CMS has expressed interest in developing a patient-reported pain measure.

Another measure that in some ways could be seen as an outcomes measure is live discharges. An unusually high rate of live discharge for a hospice provider may be a signal of poor quality or program integrity issues. Some live discharges from hospice are expected because sometimes

patients improve and no longer meet the eligibility criteria, or because a patient may change their mind about the type of care they would like to receive. But if a provider has a live discharge rate that's substantially higher than its peers, it may be a signal that the provider is not meting patients' needs or that the hospice is admitting patients that do not meet the eligibility criteria.

Across the entire hospice population, we have seen a decrease in the live discharge rate over the last few years, from 18.4 percent in 2013 to 16.7 percent in 2015. However, some hospices appear to have outlier live discharge rates. In 2015, 10 percent of hospices had a live discharge rate exceeding 50 percent.

So next we have access to capital. Hospice is less intensive than some other sectors in terms of its capital needs. Overall, capital access appears adequate for hospice providers. We continue to see growth in the number of for-profit providers with an increase of about 5 percent in 2015, which suggests that capital is accessible to these providers.

Reports from publicly traded companies and

private equity analysts also suggest that the hospice sector is viewed favorably by the investment community. In particular, some analysts report that post-acute care providers and hospitals are interested in acquiring or developing joint ventures with hospice providers.

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

So this brings us to Medicare margins. Different from other sectors, we have historical margin data through 2014, because 2015 margin data are incomplete. So for 2014, we estimate the aggregate margin at 8.2 percent, down from 8.5 percent in 2013.

One thing to note, as all is, we exclude non-reimbursable costs form our margin calculations, which means we exclude 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, 11.5 percent in 2014. 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, in part, to the allocation of overhead from the parent provider, and I can provide more details on that point on question, if you'd like.

If provider-based hospices had the same level of overhead as freestanding hospices, their margins would be 9 to 14 percentage points higher, and this would cause the overall Medicare margin across types of provider to increase about 2 percentage points.

The chart also shows margins by type of ownership. For-profit hospices have very strong margins, at 14.5 percent. The overall margin for nonprofits this year is negative, at -0.7 percent, but when we look at just freestanding nonprofit providers, the margin is positive, at 3.4 percent.

One other point to note here, like other sectors we have calculated the marginal profit, and we estimate

that that is 11 percent for hospices in 2014.

Next we show what's underlying some of the margin differences, as we've talked about before. In the left of this chart you see confirmation of the relationship between length of stay and profit. Providers with longer stays had higher margins. And in the right chart we see how margins increase with percentages 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 long stays, economies of scale from treating patients in one location, and overlap in services provided by the hospice and nursing home.

So next we have our 2017 margin projection. To make this projection, we start with the 2014 margin, and we take into account the market basket updates, including productivity adjustments and additional legislated adjustments that occurred between 2015 and 2017. We also take into account the phase-out of the wage index budget neutrality adjustment and other wage index changes.

In addition, we make assumptions about cost growth. We assume a higher than historical rate of cost growth in 2015 through 2017, because we anticipate hospices

may face additional costs related to new requirements for more detailed claims reporting, new quality initiatives, and revised cost reports.

So taking that all together, we project a margin in 2017 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-profits. The number of hospice users increased and average length of stay declined slightly due to a decrease in the longest stays. Limited quality data are now available. Access to capital appears adequate. The 2014 aggregate margin is 8.2 percent, and the 2014 marginal profit is 11 percent, and the 2017 projected 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 2018.

Given the margin in the industry and our other payment adequacy indicators, we anticipate that providers can cover cost increases in 2018, without any increase in their payment rates. So this recommendation is expected to

have no adverse impact on beneficiaries nor providers' willingness or ability to care for them.

And that concludes my presentation.

DR. CROSSON: Thank you, Kim. We will now do clarifying questions.

I have one. With respect to the mandatory bereavement services and the attendant costs that are not allowed, I know we've talked about this before but I can't remember. Can you tell me the rationale for that, (a), and (b) have we in the past made a recommendation that that should be allowed as a cost, or not?

MS. NEUMAN: We haven't opined on whether the cost should be considered allowed or not. The origin of it is that the statute says specifically that hospices are required to perform bereavement services, or to offer them, but it also says specifically that Medicare is not allowed to pay for them. And I'm not -- it's hard to know for sure the rationale, but Medicare coverage stems, you know, with the beneficiary, and when the beneficiary has passed, the provision of services outside of that -- you know, I don't know if that was one reason.

But regardless, we have, you know, every year,

looked at the costs associated with bereavement and we have reported it in our report. So this year -- and it's been very solid, unchanged throughout the last few years. It's about 1.3 percent is that cost. And if you wanted to take it out in your mind, that's how much you would subtract out of our margin.

DR. CROSSON: All right. Thank you.

MR. GRADISON: I think I can help with that question.

DR. CROSSON: Yeah.

MR. GRADISON: Having been involved in writing that legislation, what we tried to do was to mirror in statute what the practice was at the time in hospices that had been created in the United States, starting in Connecticut. And this particular aspect of it, that we're talking about, that you asked about, was out there. And so the idea was to design it in a way which would encourage -- you can say "require" but there's no real test. There's no inspectors going in there to see how much bereavement services you're doing. It was a sense, this is part of what you ought to do, but that it should be -- have a strong volunteer base, which was consistent with the fact

that all the hospices at the time, to the best of my knowledge, were not-for-profit too.

So it's just the environment at that time. It doesn't mean it has to be true in the future but that was pretty much the reason. I hope that's helpful.

DR. CROSSON: Thank you. Very helpful.

Okay. So we've got Amy, Jack, Rita, Bruce, and Paul -- and Craig.

DR. MILLER: And Sue.

DR. CROSSON: I'm sorry. I missed Sue.

All right. Let's try it again. Amy, Jack, Sue, Bruce, Craig, Paul, and Rita. Yeah.

MS. BRICKER: Okay. If we could go back to Slide 15, I just had a question about specifically -- and then also in the reading material -- on the hospital base, and the negative margins associated, and that it's accelerating. Any insight as to what's driving the acceleration of the loss in margin, and your perspective of will we see hospitals get out of the hospice business because of this, or what's driving that?

MS. NEUMAN: We've had -- it's dropped a bit. I think it was minus --

MS. BRICKER: Seventeen.

MS. NEUMAN: -- yeah, so it's gone down a little bit from last year to this year.

I -- there's a couple of components to that margin being negative. One, one piece of it is that we see, in the hospital-based as well as the home health-based hospices, higher administrative costs, and so if -- so some of that may just be an artifact of the fact that it is within a hospital and some of the infrastructure of the hospital cost is getting put on the hospice.

We also do see some higher -- we do see some higher costs for patient care as well. It's a smaller component of the cost differences but we do see that, and there's a few things about hospital-based hospices that are different from freestanding, and that is that they have much shorter lengths of stay. So -- and as we've said before, the payment system, as it's currently in this data, favors long stays strongly. So there's probably some of that going on. Also, economies of scale, they tend to be smaller. So those are a couple of reasons, I think, that you see the negative margins, beyond the fact that they have some substantially higher administrative costs.

MS. BRICKER: And do you think -- it doesn't show, you know, percent of hospice by type over time, right? It's just 13 percent as of 2014. Do you foresee that number decreasing? Page 41 in the reading material.

MS. NEUMAN: Yeah. So I'm going to go back, I'm going to flip back to a slide. Where is it? Here. No, we don't have that. I was thinking we had it by provider type there, but we do not.

MS. BRICKER: Just curious.

MS. NEUMAN: That first table, let me grab it. So we have seen the number of hospital-based providers going from about 700, near 800, to around a little over 500. In the last few years, we've been losing 10 to 20 a year, I would say. So, I mean, it is possible that it could continue to go down a bit. I think that hospitals also, though, see a benefit from having a hospice affiliated with them in terms of the continuum of care and so forth, and we did hear from analysts that hospitals are looking at hospices in an attractive way in terms of joint ventures and mergers and things of that sort. So I think there's a sort of mixed environment.

MS. BRICKER: Thanks.

DR. MILLER: And there has been a real shift in the structure of the industry over this period, I mean moved a lot from not-for-profit to for-profit, and lots of growth in freestanding hospices. So, you know, outside of the hospital, a lot of things are changing as well.

DR. HOADLEY: So my first question is deals with the demonstration you highlighted on Slide 5, and I know it's too early to know anything about that, but I'm wondering when we would first expect to see some results. I assume CMS has some kind of evaluation in place, and I guess, in particular, I'm wondering if they're doing both sort of quantitative stuff and qualitative, because it seems like you would want to know sort of how this has had an effect on the people who use these benefits.

MS. NEUMAN: So CMS will be doing an evaluation. We don't have the time frame for sort of when that will happen and when results will first be released. But my sense is that they're anxious to, you know, learn from this as well.

So as far as qualitative and quantitative, I believe both, but I can double-check that for you.

DR. HOADLEY: Okay. Thank you.

My other question had to do with the margin projection and the impact of the 2016 revisions to the payment system, and I'm assuming, from trying to read between the lines, that because that's budget neutral, that would have no effect overall on the average margin. Is that your expectation?

MS. NEUMAN: It would not, if there were no utilization changes.

DR. HOADLEY: Okay.

MS. NEUMAN: If there is a response, you could see an aggregate increase. We just don't know at this point.

DR. HOADLEY: But we would presume there would be some impact on the distribution of margins in the sense that you're expecting that sort of differential effect by different categories of providers. Is that right?

MS. NEUMAN: That's correct. And, you know, CMS in their rule for the 2016 payment system did estimate by broad categories how much money would be shifting, and, I mean, it's modest. You know, it's a few points between some of the big categories that we're talking about. And individual providers might be affected differently, but

categories as a whole, for-profit versus nonprofit, we're talking about a few points as to what they initially projected.

DR. HOADLEY: Okay. It might be useful to have a little bit more of that flavor included in what we report on. Thank you.

MS. THOMPSON: And my question really is underscoring Jack's question about when that data might be available, because even anecdotally in the Pioneer and our NextGen work, in terms of the high risk, rising risk, and certainly the patients with multiple chronic disease that became cared for by the palliative care program, separate from hospice, but as part of the continuum, when we began to think about palliative care in a continuum to hospice, a couple of really remarkable things happened. I'm thinking there should be good data from the folks who worked within the Pioneer and certainly those who are in NextGen now who are seeing patients wanting to stay in the palliative program much longer. The quality scores in terms of patient perception have gone up, and hospice days have definitely decreased.

So, again, I think there's something about a

continuum here between a palliative program and then hospice which has some value. So I'm really excited about this demonstration because I'm pretty hopeful, based upon anecdote and experience, but I think there's some good work for us to keep our eye on.

MR. PYENSON: Well, thank you very much, Kim. You noted in the report that the portion of decedents coming from Medicare Advantage plans is somewhat higher who use hospice than fee-for-service. Do you have -- I may have missed it in the report, whether the lengths of stay are different.

MS. NEUMAN: I don't think we have it in this report. We have looked at it before, and I would need to go back and look for the most recent year. But in the past, what we found was that they were relatively similar. There was slightly lower lengths of stay for Medicare Advantage people on the tail, so on the high end, but not by much. So it was relatively similar. We can put in here for 2015 what it looks like.

MR. PYENSON: Thank you. And I guess I've noted that MedPAC has recommended that Medicare Advantage pay for hospice, I think in the past.

Another question on the long-term care -- I'm sorry, nursing home patients, and you noted a high margin for patients in nursing home. To what extent do you think that is Medicare absorbing costs from Medicaid-eligible nursing home patients for their hospice stay?

MS. NEUMAN: Can you say a little bit more about sort of the mechanics you're thinking there?

DR. CROSSON: I think Bruce is asking, as the length of stay is increased -- correct me if I'm wrong -- what proportion of that is a consequence of patients, you know, who have conditions that would otherwise be cared for by Medicaid?

MR. PYENSON: That's perhaps an aspect of it, but at --

DR. CROSSON: I'm sorry. Go ahead.

MR. PYENSON: At least in the past, Medicaid-eligible nursing home patients who are covered by Medicaid would have their Medicaid daily rate in effect paid by Medicare as part of their care.

MS. NEUMAN: So I think, if I'm following, you're referring to the -- there's a sort of peculiar structure to how the room and board payments work when a beneficiary is

in hospice via Medicare and is in a nursing home and the NF part paid for by Medicaid. It's an artifact of Medicaid law, and the way it works is the room and board payments that the state normally makes to the nursing home now gets paid to the hospice, and then the hospice then pays the nursing home for that room and board. And the states often pay 95 percent of the room and board rate, and we hear anecdotally from hospices that then the nursing homes want 100 percent of the rate, and so it's common for the hospices to give the nursing home the full rate.

And so there is this weird thing -- it doesn't happen in all circumstances, but there is this weird thing where effectively the hospices are kind of subsidizing that 5 percent -- voluntarily, but they're choosing to subsidize it for Medicaid patients in nursing homes. And it's an artifact of Medicaid law.

MR. PYENSON: Thank you.

DR. SAMITT: So thanks for the great report. Slide 16, on the left, I'm curious to see if we've modeled the impact on margins in these groups by average length of stay given the CMS revised payment system in terms of the increase for shorter length and decrease for longer length.

What will this mean either by the average length of stay quintile in terms of margins or by types of organization for margins?

MS. NEUMAN: Right, so we have not taken the CMS current payment rates and imposed it on this chart and said here's what the margins would look like with the same utilization in 2014 but these different payment rates. We have not done that.

What I can tell you is that CMS, when they did their rule, they estimated sort of how margins -- or not margins, revenues would change for various provider groups, and so, for example, the nonprofits -- which, again, it's going to not be broken out exactly like this, but it gives you a sense -- they were going to go up between 1 and 1.5 percent, and the for-profits were going to go down by about a little bit under 1 percent. So you can see as categories the magnitude of the shifts. And then within, you know, providers and different ends of the spectrum, you could see it be a little bit more than that. But it's not going to be really, really big in general. It's going to be more modest.

DR. SAMITT: Thank you.

DR. REDBERG: Thanks for an excellent chapter. My question is just on the live discharge rate, because, you know, certainly 10 to -- I mean, it's hard to say the right number, but 10 to 20 percent sounds about right. So the higher numbers like 29 and 50 percent do sound high. I'm wondering if there is any data on how many hospice days there were on average before the live discharges.

MS. NEUMAN: So we've looked at that before, and there's kind of two scenarios. Some of the live discharges happen after people have been in hospice for a very long time, and then others of them are after much shorter stays, sometimes with the patient coming right back, sometimes not. And so we have not -- we don't have it for 2015, but we could certainly recall back to what we've done before and see whether we have the ability to update or not at this point.

DR. REDBERG: And I'm also wondering, was there any association with the type of hospice facility, like for-profit or nonprofit, and live discharge rate?

MS. NEUMAN: So we do see higher live discharge rates among for-profit providers. We also see it true of newer providers who've entered more recently. And hospices

that are above the cap or approaching the cap tend to have much higher live discharge rates than others.

DR. GINSBURG: Yes, my question is really not specific to hospices. It applies, I think, to a lot of the areas we've looked at, but I just thought of it now so that's why it's coming up now.

We've looked at operating margins in all of the segments, but operating margin is probably not the most relevant information about profitability, which would be return on equity. And, you know, particularly with some of these segments like hospices, like home health care, where the capital needs are very low, there's a possibility that we could have returns on equity that are very high numbers. I guess the problem is that except for when there's a publicly traded company that is a major provider and does mostly one segment, we probably just don't have the information. I don't know if the staff has ever, you know, run into this issue and seen if there's anything that can inform us to be able to say these hospice operating margins probably are really high given the low capital requirements.

DR. MILLER: Yeah, I don't think we've looked at

it that way, but I'll tell you what, we can go back and huddle and kind of ask ourselves whether there's information like that to bring to bear. I would think it would be particularly hard here because a lot of these are for-profit, freestanding, and often small operations -- I'm looking at Kim as I'm saying this -- although there are a couple of large, you know, companies where maybe you could get at that information. But it certainly wouldn't be global across the industry. Am I getting a nod out of you?

DR. DeBUSK: On a related note, you may have a problem there, too, because the capital structure -- you know, for example, in a hospice or home health, you would assume automobiles would be a significant portion of their assets. Well, depending on how you structured that, say leasing versus owning, that could dramatically distort the denominator that you'd use, too. But I do completely understand where you're coming from, because the returns on some of these companies could be incredible.

DR. CHRISTIANSON: Just a quick confirm. These are raw data, right? These are not incremental effective length of stay on margin. This is just without adjusting for anything, right?

MS. NEUMAN: No adjustment.

DR. CROSSON: Okay. Seeing no more questions, we'll put up the recommendation. The recommendation is the order of business. Comments on support for the recommendation or other issues related to the recommendation?

Seeing a small outbreak of thumbs, one finger.

DR. HOADLEY: I keep looking at this sector and the huge differential between the for-profit and the not-for-profit that we see in terms of margins, and obviously the evolution of the industry, in some ways it feels like it calls out for differential updates by profit status. I know that's not something we typically do. You know, initially I was going to say, well, you know, the 2016 changes would purport to make some movement in that direction and potentially change it, but it sounds like that movement is likely to be fairly small. So I'm not going to formally suggest that we modify the recommendation, but I did want to just sort of raise that issue.

You know, maybe it just calls for in the future looking harder at sort of what are the factors that are

more -- I mean, I know we've looked at this, but even more at what are the factors that are differentiating those categories of providers? And are there other policy levers that we can use -- it isn't as blunt as just going on the profit status -- to try to, you know, address the fact that the margins are so high in the for-profit part of this industry?

So, you know, having said that, I'm fine with supporting this recommendation, but I did want to sort of put that on the record.

DR. MILLER: Yeah, and the two -- I do think there is some caution to attaching updates to the specific label on a door, because that's kind of -- you know, whether we want to reverse, but generally I've tried to go in the direction of we pay for something for the beneficiary, and we're more agnostic about how that happens, although these here, there are big distortions, and, you know, both Jim, who did a lot of this work early on, and then Kim will remember how years ago people came to us and said, you know, this industry is changing overnight.

I'd be more inclined to go after your point on returning to the payment structure and saying maybe it was

too shallow, it wasn't deep enough, and thinking of things that were raised like the live discharge and saying is this -- or some other sets of measures, and if you see an association, which you will, with your point and saying now the payment ends up getting adjusted on these factors and try and drive change that way, as opposed to not-for-profit/for-profit.

DR. HOADLEY: I'm certainly comfortable with that kind of approach. One of the questions might be -- and I don't remember how -- whether there was much differentiation between what CMS did in their 2016 revisions versus what we recommended. If our recommendations were for a bigger shift in terms of that pattern, you know, maybe that's something to go back and say, you know, what was done in 2016 was great but didn't go far enough, if that's an accurate characterization of --

DR. MILLER: It is.

DR. HOADLEY: I thought it was. yeah.

DR. MILLER: I hate to get in line in front of Kim, but I almost think we said that in like a comment letter or something somewhere. It's like you definitely took a step in our direction, but you didn't take the whole

way. And my sense is they were more shallow in terms of their adjustments than the way we were thinking about it.

DR. HOADLEY: And maybe a descriptive -- you know, some reference to that comment or some repeat of that comment in this chapter would be just a way to continue to keep that theme alive.

DR. MILLER: I agree. I just want to make sure, Kim, that was right in your recollection?

MS. NEUMAN: Yeah. I agree.

DR. NERENZ: I was just going to hold this until the last just because the comment relates to all these segments, but since Jack put it on the table, I'll say it now. I will support the recommendation. I think on our future agenda I would really love to see a focused section on this issue of freestanding/for-profit on the one hand and then not-for-profit hospital-based. We're just seeing it over and over again, and there's growth, and there seem to be positive margins on the one hand. There's lack of growth, negative margins, or at least zero margins on the other hand. And I'd really like us to dig in and see what does it really mean.

I don't know whether we could actually do

conditional update recommendations. It's not part of today's discussion, I think, but as a focused issue. And the reason I was going to bring it up is that there's at least some risk of us getting into a penny-wise, pound-foolish kind of orientation where, when we look at specific units of service and specific silos, we see that certain kind of entities are low cost. The counter -- and, you know, we can keep doing that separately.

The counter view -- and it's typically brought up by proponents of organized system integration -- is that when you put the pieces structurally together you get efficiencies that you only see at the episode level or the per capita level. There's precious little empirical evidence for that, but it seems like that's something that we ought to try to take up.

Now, whether we can reach any kind of conclusion, I don't know, but it just seems every single time we walk through one of these -- and it's not even just this year -- we see this phenomenon. And I guess I'd like to have a general sense of do we think these trends are good or bad, if we could inform such an impression. But a separate issue, spring issue, sometime, but I'd like to see it on

the agenda.

DR. CROSSON: Pat.

MS. WANG: Speaking for myself, I would be very cautious about trying to draw lines between hospital-sponsored versus freestanding not-for-profit versus for-profit. There's a lot of reasons that I think some of these services may be better provided by freestanding for-profit providers who are specialized. For example -- and I think that there are examples of not-for-profit health systems in the book -- or I guess it was under the dialysis section -- who are entering into joint ventures because somebody else can do that business more efficiently than them. So I would be a little careful about the labels.

That said, given the big shift in all of these sectors, which I also agree is kind of like what's going on here, I think it becomes -- where I would put the leverage or the emphasis for MedPac's examination is on accuracy of payment, ensure that there are not disincentives for taking care of the sickest patients, because there is a little bit of a trend in some of the things that we've discussed that the more complex patients seem to be cared for more in certain sectors than in other sectors.

To me, sort of the approach to assess payment adequacy with all these factors -- and I agree with this recommendation -- are very sound in saying there's enough money in the sector. Through this analysis, there's enough money in the sector.

But what you're bringing up and what Jack has brought up and everybody has talked about in different ways is there does seem to be a second really big question about is it being distributed appropriately within the sector, and on that, I would really go towards beneficiary characteristics, need, ensuring that there are plenty of incentives in place to take care of the sickest Medicare beneficiaries.

This sector bothers me because there are these really disparate statistics around length of stay, live discharges, program integrity issues. So I think there's a really good reason to keep looking at it, but I would really try to stay away from labels of sponsorship and really go after beneficiary characteristics and quality, personally, and make sure that the payment system, regardless of sponsorship, is really paying for what we want it to pay for.

DR. CROSSON: And I have to say I agree with that strongly.

I think over the last few years, we have seen -- and we observed again -- that something is different. The hospice -- the use of the hospice benefit is changing compared to what the expectation was when Bill worked on it.

Oftentimes, when we look at sectors and we analyze that and we see the sudden growth of for-profit entities, entrepreneurial entities, it can be an indicator that something with respect to choice of beneficiaries, risk, modes of treatment is askew compared with what it used to be. And to the extent that that's not the right thing for the program, not the right thing for the beneficiaries, then it's at that level, I think, that we would want to be doing a closer look.

I think, Kim, at least in the last couple of years, you have focused on some of those issues, but I think you're hearing support for a continuation of that analysis.

DR. MILLER: And I would say, too -- and I think you put it extremely well and on point -- that you focus on

the patient's characteristics and quality because the organization of the system may be changing, maybe should be changing, and if you start attaching payments to things, then they'll become those things. We're going to see emergency rooms grow because of some of the site-neutral policies that are out there now, and so that's why, in some ways, I think her point is fairly strong.

DR. CROSSON: Alice.

DR. COOMBS: So something that Jack said resonated with me specifically about the hospitals, and it is a trend, but I was reflecting back to the dialysis piece. And I know for a fact that dialysis in the freestanding dialysis, away from the hospital, they have a different labor criteria. So, when you see the labor units in the dialysis unit, they're very different than the labor units in the ICU. We have ICU nurses that run the dialysis nurses. It's very different. That goes beyond the usual VSRN. Most of them have master's, and they've had years of experience. So that labor unit by itself is extraordinarily expensive.

I don't necessarily think it's the capital model that's there, more so the infrastructure and availability

of extra resources in that unit. My concern is if there is an isolation, geographic isolation, what does that hospital unit mean for hospice or dialysis? In thinking about it, I think that's the greatest threat to the beneficiary is if that unit proves to be a sanctuary site, where there's not a lot of other units in the same area. I don't think we've heard that, but that would be my greatest concern, and that that unit suddenly disappearing would be a significant change for beneficiaries, whether it's hospice, dialysis, or the like.

So while quality is really important, with quality there must be some quantity in your geography. So I think quality is the other piece of it, because a for-profit comes in, in an area where they can actually make a profit, and we've had this scenario where they're not necessarily going to Compton, California. They're going to the place where there is the ZIP code and the average income and the housing market and everything is a robust environment, so that the hospital doesn't have -- you know, a hospital may be in an area where it's been for years, and the area may have changed, but this other issue about what happens when a hospice goes under in an area and the

beneficiaries are left to either kind of fend or do they make different decisions when geography becomes a limitation.

So I understand, and it did resonate with me.

DR. CROSSON: Okay. So I think, again, I have the sense that there is a consensus for the recommendation. Seeing no objections, then we will bring this forward in January through the expedited presentation and voting process.

Kim, thank you very much. Nice job.

We will move on to the final presentation for the morning.

[Pause.]

DR. CROSSON: Stephanie Cameron is here, and we're going to talk about the adequacy of payment for long-term care hospitals.

Stephanie?

MS. CAMERON: Good morning. Today we are here to discuss how payments to LTCHs should be updated for fiscal year 2018. First, I will summarize some of the background information included in your mailing materials.

To qualify as an LTCH under Medicare, a facility

must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay for certain Medicare cases of greater than 25 days. Care provided in LTCHs is expensive -- the average Medicare payment in 2015 was over $41,000.

Similar to a short-stay acute care hospitals, Medicare pays LTCHs on a per discharge basis with an upwards adjustment for cases with extraordinarily high costs. Unlike the acute care hospitals, LTCHs also have a downward payment adjustment for cases with extremely short lengths of stay.

Beginning in fiscal year 2016, an LTCH discharge either needs to have three or more days in the referring hospital's ICU or receive an LTCH principle diagnosis that includes prolonged mechanical ventilation to qualify for the full LTCH standard payment rate. Discharges that don't meet these criteria will receive a site neutral payment equal to the lesser of an IPPS comparable rate or 100% of costs. As you'll recall, the criteria to qualify for the full LTCH standard payment rate are consistent with the direction of Commission's 2014 and 2015 recommendation for chronically critically ill beneficiaries.

The Pathway for SGR Reform Act also changes the calculation of the 25-day average length of stay requirement to exclude Medicare fee-for-service cases paid the site neutral rate as well as cases paid by Medicare Advantage. It also created a moratorium on new facilities and additional beds, with some exceptions, through September of 2017.

Although the dual-payment policy began in fiscal year 2016, because of the multi-year phase-in and range of hospital cost report periods, we don't expect to see the full effect of implementation until our December 2020 analysis.

I will now turn to the question of how payments to LTCHs should be updated for fiscal year 2018, 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. The absence of LTCHs in many areas of the country makes it particularly difficult to assess the adequacy of supply.

Even though 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 quite a bit of variation in the number of LTCH days per fee-for-service beneficiary by county. For example, the median utilization for LTCH care is 6 days per 100 fee-for-service beneficiaries, where the top ten percent of counties use over 21 days and the bottom 10 percent use fewer than 2 days. The top 10 percent of counties are concentrated in four states; therefore most beneficiaries receive care in acute care hospitals. Research has shown that outcomes for the most medically complex beneficiaries who receive care in LTCHs are no better than those for similar patients treated in other settings.

To gauge access to services, we typically look at available capacity. Here we show the cumulative growth of LTCHs and beds since 2006. A 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 the growth of LTCHs starting in 2009.

You'll note the second dashed lines between 2012 and 2015. This year, similar to the last two years, the

number of facilities and beds calculated based on the cost report data is artificially low because of a larger than average number of LTCHs that changed their cost reporting periods and therefore were not included in our analysis based on our long-standing data screens.

Because of this, we also analyzed the number of beds and facilities for active LTCHs in Medicare's Provider of Services file. Based on data from this file, we find that the number of facilities increased by about 0.3 percent between 2014 and 2015, and further estimate that there was an approximate 1 percent increase in beds during that time period. This file likely overestimates the number of facilities and beds based on a lag between when a facility closes and when it is reported as such. Given this, we estimate that there were likely some small declines in the number of available beds and facilities but not likely to the extent suggested by our analysis of the cost report data.

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 fee-for-service beneficiaries. Volume further declined 2 percent between 2014 and 2015, to equal 34.7 cases per 10,000 fee-for-service beneficiaries. Unlike in prior years, this decrease in volume was not observed across other inpatient settings during 2015.

In terms of quality, LTCHs began submitting quality data on a limited number of measures to CMS in fiscal year 2013. CMS has expanded the number of measures required for reporting over the past four years. None of these data are currently available for analysis. We expected CMS to begin releasing some data publicly this fall; however, public reporting on two of the four measures has been delayed until next spring. In the meantime, we continue to rely on claims data to assess gross changes in quality of care in LTCHs.

Between 2010 and 2015, mortality and readmission rates were stable or declining for most of the common LTCH diagnoses. The aggregate mortality rate reminds us of how sick some patients in LTCHs are. On average, about one-quarter of LTCH patients die in the facilities or within 30

days of discharge. 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 4 percent for patients treated for aftercare with complication or comborbidity. During this same time period, the unadjusted aggregate 30-day readmission rate was just under 10 percent.

Access to capital allows LTCHs to maintain and modernize their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of Medicare payments since Medicare accounts for about half of LTCHs' 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 of 2015, LTCHs have been working toward adapting their admission patterns, costs, and case mix to mitigate the effect of the payment reduction for cases that don't meet the new criteria.

While the increased certainty of the rules

governing LTCH payment policy would typically increase the availability of capital, the 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 cost per case when payments per case change. As you can see here, payment per case increased rapidly after the PPS was implemented.

After 2007, the growth in cost per case stabilized to less than 3 percent per year. Between 2014 and 2015, the average cost per case increased by 2.1 percent. Starting in 2012, Medicare payments increased more slowly than the rate of increase of provider costs and beginning in 2013, cost growth exceeded payment growth.

Increase in cost growth relative to payment growth between 2014 and 2015, resulted in a 2015 aggregate Medicare margin of 4.6 percent, and a 6.8 percent margin for Medicare qualifying cases that I will discuss momentarily. The marginal profit assesses whether

providers have a financial incentive to expand the number of Medicare beneficiaries they serve. Because the average LTCH marginal profit was close 20 percent in both 2014 and 2015, we contend that LTCHs have a financial incentive to increase their occupancy rates with Medicare beneficiaries.

As you can see, there is a wide variation in the Medicare margins, similar to what we see in other settings, with the bottom quarter of LTCHs having an average margin of minus 14.6 percent and the top quarter having an average margin of 17.8 percent. The margins shown here of 4.6 percent for urban facilities and 2.8 percent for rural facilities deviate from the historical trends of similar LTCH margins across geographic area. This year's variation is from technical changes to the definition of CBSA based on new data -- based on the 2010 Census.

Consistent with other sectors, the for-profit facilities, accounting for 84 percent of cases, have the highest average margin at 6.4 percent while the nonprofit facilities have the lowest margin at negative 6.0 percent. There are a number of reasons why LTCHs have lower costs and higher margins that we will discuss on the next slide.

This slide compares LTCHs in the top quartile for

2015 margins with those in the bottom quartile. As you can see in the top line, high-margin LTCHs tend to be larger and to have higher occupancy rates, so they likely benefit more from economies of scale. Low-margin LTCHs had standardized costs per discharge that were 35 percent higher than high margin LTCHs.

High margin LTCHs have fewer high cost outlier cases and fewer short stay cases. As you remember, these short cases are paid differently from the standard PPS rate, given their comparability in length of stay with similar cases in acute care hospitals. Lastly, high-margin LTCHs are more likely to be for-profit based on their demonstrated ability to restrain costs in this sector and across other provider types we've discussed over the past two days.

Turning to the margin calculation that only includes only cases that would qualify to receive the full LTCH standard payment rate. To calculate a margin for these qualifying cases, we used 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 2015 margin of 6.8 percent. We

project that this margin will decline in 2017. Updates to payments in 2016 and 2017 were reduced by PPACA-mandated adjustments.

We expect cost growth to be higher than current law payments for the qualifying cases as the LTCH dual payment structure is implemented. Using the projected growth in the LTCH market basket, we project that LTCHs' Medicare margin for qualifying cases paid under the LTCH PPS will be 5.4 percent in 2017. While we expect significant changes to admission patterns and per case cost associated with the implementation of the new patient-specific criteria, the extent of these changes is less certain. If we assume the relationship between costs and payments for the cases that qualify to receive the LTCH standard payment amount change to reflect the current overall book of business, a conservative margin estimate for 2017 would be closer to 3.2 percent.

The extent that LTCHs continue to provide care to beneficiaries who do not qualify to receive the full LTCH standard payment rate will determine the aggregate total margin in 2016 and beyond.

In sum, growth in the volume of LTCH services per

fee-for-service beneficiary declined about two percent. We have little information about quality in LTCHs but unadjusted 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 2017 will equal 5.4 percent assuming the current underlying cost structure for these cases.

CMS historically has used the market basket as a starting point for establishing updates to LTCH payments; however MACRA requires a 1 percent payment update for LTCHs in fiscal year 2018. Therefore, this year, we are making our recommendation to the Congress. With that, the Chairman's draft recommendation reads, The Congress should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2018.

Eliminating this update for 2018 will decrease federal program spending relative to the MACRA-specified 1 percent payment update.

We anticipate that LTCHs will continue to provide Medicare beneficiaries with access to safe and effective

care and accommodate changes in costs with no update to the payment rates for qualifying cases in LTCHs in fiscal year 2018.

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

DR. CROSSON: Thank you very much, Stephanie. Very clear.

We're open for clarifying questions. Bruce.

Sorry. Bruce, Kathy, Jack.

MR. PYENSON: Yeah. Thank you very much, Stephanie. On page 15 of the report you note that some of the decline in LTCH use is consistent with the growth of Medicare Advantage plans, which seems to suggest Medicare Advantage plans don't use LTCH services very much. In the section on inpatient rehab, we did have a comparison of patient use for Medicare Advantage patients compared to fee-for-service patients. I thought that was very useful.

Is it possible to do the same for LTCH, or are there simply not enough Medicare Advantage patients going to LTCH?

MS. CAMERON: That's actually not the issue at all. I believe the IRF data came from the IRF PAI, which is the assessment instrument which is required for IRF

patients, not just Medicare fee-for-service beneficiaries but all of IRF patients.

The LTCH care data set, assessment data, is not yet available for analysis in the LTCH, so we, at this point, don't have access to that level of data. Perhaps in the future we will, and I will be happy to report it at that time. It's not an issue with not having the data or few beneficiaries using the service, although I think we do expect a fewer number of Medicare Advantage beneficiaries currently use LTCH services relative to, say, Medicare Advantage use of the inpatient acute short-stay hospitals, but it's more of a matter of data availability at this time.

MR. PYENSON: Thank you.

DR. CROSSON: Kathy.

MS. BUTO: Several questions. Stephanie, on page 18 of the mailing materials there is a really helpful table that lists some of the -- I guess the top 25 MS-LTCH DRGs. So two questions about this chart. One is, these are unique to the LTCH system of categorizing patients, but I assume that some of these, or all of them, track back to an acute care DRG. Do we have a sense of how those are

distributed? For example, pulmonary edema, you know, related to CHF admission in the acute care hospital. Do we have any sense of which are the predominant acute care DRGs that track to LTCH? Or maybe it's all over the map. I don't know.

MS. CAMERON: It is a bit all over the map. The LTCH MS-DRGs are the exact same in terms of the number and the description as the DRG, MS-DRGs that are used in the acute care hospital setting. So there an exact crosswalk.

MS. BUTO: Okay.

MS. CAMERON: The difference is the weights that are assigned to the LTCH MS-DRGs, and then, obviously, the standardized payment amount is different in this setting.

MS. BUTO: Right, right.

MS. CAMERON: The difficult part in doing comparisons with acute care hospitals is there's a sheer volume differential. I believe there are upwards of 10 million short-term acute care hospital claims --

MS. BUTO: Right.

MS. CAMERON: -- where LTCHs have about 130,000.

MS. BUTO: Yeah.

MS. CAMERON: So doing comparisons is somewhat

difficult because we don't know if we're comparing just on looking at DRGs, kind of on this aggregate level, who is getting mixed in.

MS. BUTO: Right. Okay.

The second question about these DRGs or these diagnoses or categories is, in areas that don't have LTCHs, where do these folks go? Do we have a sense of that? I assume SNFs. I assume some stay in the hospital. But I'd be curious to know what you know about that.

MS. CAMERON: That's exactly right.

So our understanding is that some do, in fact, stay in the hospital. Perhaps they stay in the hospital longer and then receive SNF care, and that is their course of action.

Areas that don't have LTCHs, as I mentioned in the presentation, there are many areas of the country where people do travel for some LTCH use, and when we looked at the data, we found that beneficiaries who come from areas without LTCHs use certain services and LTCHs more than others. So vent services, for example, are used more by beneficiaries in areas without LTCHs, who travel for LTCHs, than beneficiaries in areas who have existing LTCHs.

MS. BUTO: Okay. Another question, are most of these patients coming directly out of an acute care stay, or all of these patients, or do any of them come from the community?

MS. CAMERON: So, at this juncture -- I'm going to answer your question in two parts because I think the data here reflect data from 2015, which was before the dual payments, the criteria was implemented. And I believe our latest estimates were about 85 percent of beneficiaries are admitted to an LTCH directly from an acute care hospital discharge.

MS. BUTO: Okay.

MS. CAMERON: The criteria that was effective starting in fiscal year 2016, which we will start to see in next year's data, in order for an LTCH beneficiary to qualify for the higher payment rate, they have to meet certain criteria, and one of those criteria is a three-day-or-longer prior stay --

MS. BUTO: In an ICU?

MS. CAMERON: -- in an ICU in an acute care hospital.

MS. BUTO: Okay.

MS. CAMERON: So one would expect -- although we don't have data yet, one would expect that 85 percent will in fact increase.

MS. BUTO: Thank you.

DR. CROSSON: Jack.

DR. HOADLEY: So I have a question about the margin calculation, and I want to make sure I'm understanding correctly the difference between the 5.4 and the 3.2. As I hear it, 5.4 is assuming a behavioral response from the industry. It sort of parallels the historic kind of response pattern that you've seen, and the 3.2 essentially would assume less behavior response, more sort of just continuing the current patterns? Is that it? Or correct me.

MS. CAMERON: Absolutely. So the 5.4 percent was looking only at the cases that currently would have qualified, so taking the 2015 cases, and in last year's analysis, as you'll remember, we also did a similar exercise. And we only looked at cases that would have qualified if the criteria had been in effect at the time of discharge. Based on the available cost and payment information on a claim-by-claim basis for only those cases

that would have qualified, we project out the 5.4 percent margin.

The 3.2 percent conservative margin is based on the other cases that LTCHs currently see. So LTCHs' entire book of business right now actually has a lower margin than just the qualifying cases, and knowing their current cost structure across all the cases does, in fact, have a lower margin. If we apply that cost structure to the qualifying cases, that's where we get the 3.2. However, the data to date has shown the higher margin, and that's why we projected it out to the 5.4.

DR. HOADLEY: And in projecting further or at least in thinking about the effect of the 2016 changes, are we assuming that there will be some changes in the distribution of margins -- urban, rural, for-profit, not-for-profit, et cetera?

MS. CAMERON: We did not do that level of analysis because --

DR. HOADLEY: Has CMS given you anything on that?

MS. CAMERON: Not at this juncture.

When we look at the cases that would qualify, there's not a lot of difference, for example, in the

percentage of cases that quality in the for-profits versus the not-for-profits. So different facilities are approaching this legislation and these policies differently. So really only time will tell.

To the extent that length of stay for cases that don't meet the criteria will shorten, we don't know the extent to that. We expect it will happen. We just don't know.

DR. HOADLEY: Thank you. Very helpful.

DR. CROSSON: Rita.

DR. REDBERG: Thanks.

Very informative chapter, Stephanie.

My question is on the quality measures because you listed a lot of them in Text Box 4. Do we have data -- and they started in 2014. Do we have data on any of them?

MS. CAMERON: We do not. CMS was expecting to release data on four of the measures publicly this fall. Two of the measures, those collected by the CDC, have been delayed until next spring, and two measures -- one is for a pressure ulcer measure, and the other is for readmission -- is still slated to be released this fall, using, I guess, the meteorological definition. We are hopeful, based on a

call I listened to last week, that in the next couple weeks, the data will be released, and we will analyze that as soon as it becomes available.

DR. REDBERG: I know that's what you've said, but then when I thought it's been reported since October 2013, so I'm a little puzzled why it's still -- we've been talking about this for years now. I look forward to that, before December 21st.

Do we have any data on how many people get off the ventilator who are admitted to LTCHs?

MS. CAMERON: I don't have that offhand. I can certainly look to see what studies have been done to date, but that's not a number I have at my fingertips.

DR. REDBERG: To me, that would be an interesting quality measure because I think that's sort of the main driving reason people would go to LTCHs, and it's not clear to me what that data shows.

DR. CROSSON: Okay. So let me see who I've got. Pat.

MS. WANG: Stephanie, going back to the chart on page 12, the slide, I am not sure I am understanding this, particularly the difference between the high-margin and

low-margin LTCHs and what might be driving differences in performance.

I see that for the low margin, for example, occupancy rate is lower, cost is higher, payment is lower. Case-mix index is lower, but high-cost outlier payments are require a bit higher. I don't understand this profile. What's going on here?

MS. CAMERON: I'll start by saying that this chart actually looks oddly similar to the charts that we provided back when we started doing the analysis almost a decade ago, and historically, this has really been the pattern.

We think that a lot of the difference, for example, in the standardized cost per discharge stems from the smaller facilities, the slightly longer length of stay, and the increase in outlier payments, when you sum up the Medicare payment per discharge with the outlier payments, the payments do actually come out a little bit closer together.

The low-margin LTCHs have had many more historically high-cost outlier cases and short-stay outlier cases. So it is tough to tease out, but then you look at

the occupancy rates, and the low-margin LTCHs clearly have a lot more empty beds.

MS. WANG: Okay. I don't understand it, but it's a strange profile.

Where do most people upon discharge from LTCH go?

MS. CAMERON: So some go to skilled nursing facilities. Some also use -- are discharged home with home health, but of those survivors, many do go to skilled nursing facilities.

MS. WANG: And just the final question, do you see any interaction here between -- especially after the three-day ICU stay is put in place, between LTCH stay and hospital outlier, high-cost outlier pool? Do you think there's going to be an interaction there, a reduction in outlier claims? Because it's not available, right?

MS. CAMERON: That's right.

MS. WANG: But where it is and especially where there might be an affiliation discharge from hospital, which will increase, do you think there's going to be an impact on the other sector?

MS. CAMERON: It is tough to say. About 15 percent of current LTCH cases were outliers from an acute

care hospital. That is under kind of our prior law 2015 data. We, again, don't have data on what's happened since criteria was put in place; however, when you look at the numbers, we're kind of dealing with a volume issue, because, again, we go back to short-term acute care hospitals have so many cases relative to those that are sent to -- that are in an LTCH, that it's tough to determine. Small changes, which could be big in an LTCH setting, really don't even show up in the acute care hospital setting.

We are going to be looking at over time -- we've started tracking the use of some of the more common diagnoses in LTCHs and the more somewhat LTCH-specific diagnoses, like prolonged ventilation use and looking at that in an LTCH versus an acute care hospital, because that may be where we'll see some differences. But within all of these diagnoses, it gets very muddled due to the volume.

DR. CROSSON: Kathy.

MS. BUTO: One last question about what you know. Are LTCHs a Medicare creature versus -- what percentage of use is really by the private sector or other payers, maybe Medicaid? But I'd be curious to know that.

MS. CAMERON: About, I believe, on average, 65 percent of discharges in LTCHs are Medicare. So, predominantly, when you look at the entire industry, it is a highly concentrated Medicare industry.

There are facilities, however, that do quite a bit of work in the Medicaid sector. So I think it does vary based on when the LTCH was created, for example, and what its original mission was.

MR. GRADISON: On that point?

DR. CROSSON: Bill.

MR. GRADISON: My recollection is that, in a discussion of this with Peter Butler -- said that in Chicago, a number of the hospitals recognized that each of the acute care hospitals -- they each recognize they had a handful of cases like this, and they might be better off to concentrate them in a new facility. I don't know how general that was, but that stuck in my mind because it might explain some of the things that have happened in urban areas, which, in a sense, that's Medicare-specific, but, in a sense, it really isn't.

DR. CROSSON: Brian.

DR. DeBUSK: Back to Table 3 on page 18, where

you list the common LTCH MS-DRGs, I understand there's a one-to-one relationship, obviously, with the acute care DRG with the LTCH DRG, but I would assume that you are discharged from the acute care hospital under a variety -- there are a number of DRGs that would then map to a different LTCH DRG. My primary diagnosis in the acute care setting would be different, say, than the LTCH. Do we track or do we even have a way to track the acute care DRGs that are mapping into the LTCH DRGs?

MS. CAMERON: We certainly could do an analysis such as that using claims data. I haven't specifically looked at that during my time here, but that is something we could do in the future, if there was interest in that.

DR. DeBUSK: Could there be -- and I guess where I'm leaning to is, could there be a handful, a subset of inpatient DRGs that are really driving this? And back to this idea, is this a creation of Medicare? I mean, is this something that could be addressed?

MS. CAMERON: I think, again, while that -- yes, we could certainly map beneficiaries from an acute care hospitals -- discharge DRG in the acute care hospital to their discharge DRG in the LTCH. I am very concerned that

you're going to be dealing with a volume issue because, again, 10 million discharges in an acute care hospital translating to 130, at best, discharges from the LTCH, I mean, it's really difficult to tease out what's going on.

DR. DeBUSK: Okay. So, for example, this septicemia without ventilator support, it's not just going to map back to two or three or four MS-DRGs. You're saying there's going to be this huge variety that's going to funnel into that one LTCH DRG?

MS. CAMERON: That's true, yes.

DR. DeBUSK: Okay.

MS. KELLEY: That is right. When we looked at this a few years ago, when we first made our recommendation for LTCH criteria, we did do a fair bit of work that matched LTCH claims with their previous acute care hospital claims, and what we found was that there was a wide variety of DRGs that led to LTCH stays. A lot of them were sort of major surgical DRGs, and my sort of nonclinical thinking about it was that these were surgeries that had gone badly wrong, patients ending up on the -- I'm sure Alice could tell us about this -- patients ending up on a ventilator or with sepsis, and then they would be admitted to the LTCH

with a sepsis DRG or a ventilator DRG.

DR. CROSSON: Okay. Thank you very much.

I see no further clarifying questions, so we'll move to the recommendation slide. The recommendation is before you, so I'd like to get an indication of support or lack thereof, other items related to the recommendation. I see Kathy's hand, and I see Alice's hand.

Kathy.

MS. BUTO: I support the recommendation. I have serious questions about this category of provider in the sense that, number one, there are very few -- as you say, only 130,000 or patients. I wonder, if this category didn't exist, whether -- I believe these individuals would be taken care of either through the outlier policy in the acute-care hospital, and actually the hospital would then be accountable for these issues, which are surgeries gone badly wrong or whatever. So it strikes me as something that it's a creature in a way of Medicare, of an opportunity to create this category, or SNFs, and where appropriately much of this care could go on.

So I just raise that. It's a broader question. Obviously, Congress has questions about it, or they

wouldn't have put a moratorium on it. And I think this is the second time. When I was at the agency, we tried to actually eliminate the category altogether. So I don't see a compelling reason for the provider category. I do think it provides a valuable service. But I also think there's some accountability of acute-care hospitals to manage some of these issues.

So I support the recommendation, but that's my concern.

DR. COOMBS: Thank you, Kathy. That sounds vaguely familiar. I've heard that before.

So I think as an ICU doctor, in certain regions your hospital may be able to accommodate these type of patients for longer periods of time. But in our regions, an LTCH is very valuable to me as an ICU doctor because if you have a patient who's on a vent, who requires a VAC, and maybe needs even dialysis, you can house them in your ICU, and you can house them in your ICU for an extended period of time. But that means that the ICU beneficiary who rolls up in the ED, they don't get an ICU bed, and they sit in the ED until an ICU bed becomes available. So in certain regions, the LTCH is an incredible way to decompress the

ICU, but not just decompress the ICU; their weaning protocols are actually better than many acute-care hospitals, and they know how to wean the chronic vents because they have protocolized therapy, and they have some robust strategies in terms of the right personnel at the right time for follow-up.

That's not everywhere, but in certain regions of the country, LTCHes are very valuable for what they do. And you're not going to find -- most SNFs are not going to be, oh, I want the wound VACs, I want the dialysis patients, and I want all the vents. They're not coming in. Those are really high resource patients, and they require a lot of input from respiratory therapists. You have dialysis. I mean, those patients are very complex.

So I would say that before we say the LTCHs have no role in our lives, the LTCHs have a definite role. And in certain regions, they can be the rate-limiting step for why a patient who's a Medicare beneficiary has access into the ICU. I've had this conversation before, and I would say that for me it's very important. Our unit is majority Medicare and Medicaid beneficiaries, and so it becomes important for me to be able to treat the next septic

patient who arrives in the ED quickly and get them stored away in terms of what we need to do for them in the ICU.

MS. WANG: I really appreciate Alice's comment. I support the recommendation. I think the thing that's vexing about the LTCH and the thing that I mainly see as the benefit is the -- without being a clinician, is the capacity for ventilator-dependent patients. There really is no place for a lot of people to go, and, you know, Alice just painted a picture of folks who are even more complex than that. But, you know, they really should not be staying in the hospital for 25, 30 days just because they need -- they're vent-dependent. Many SNFs do not offer this service.

So, you know, my main issue with LTCHs is that I think that they provide an important service in this particular area. I don't know about all of the other conditions that they treat. But the fact that they're so uneven in their distribution and availability is sort of if it's an important resource, then is there a better way to make it more broadly available, because I think that the situation that Alice just described is probably a need that's felt uniformly in many, many parts of the country

that are not served by LTCHs.

MS. BUTO: I guess my question would be: How are those other parts of the country dealing with it? Because they have the need, too, for ventilator-dependent care. So I just feel like we don't know enough about that, but it's something we ought to look into.

DR. HALL: I support the recommendation. I look on LTCHs -- I don't use an LTCH because we don't happen to have one, but I think of them as a place for what might be called the diseases of medical progress. In the course of treating people for other more conventional disease, like pneumonia or bad congestive heart failure or a botched surgical procedure, long-term antibiotic therapy, these are not sort of typical diseases. They're diseases that have been caused by -- not by malpractice, but by just the limits of technology. To the extent that this occurs everywhere in the United States, people who have access to an LTCH, such as Alice mentioned, it's very useful. But I don't think it's applicable in a way to every part of the country, and I think the outlier program is one way -- upgrading SNFs and having them have special ability to handle this would be a much better model for the entire

country.

So I think for now we need to make these recommendations, but for the long term, I have serious doubts as to whether this is something that should spread around the country. And the data suggests that that opinion is shared pretty much universally, or otherwise, we'd have many more LTCHs and no moratorium.

MS. THOMPSON: I can speak to a part of the country where we don't have a good number of LTCHs, and for patients who do require long-term ventilator care, which does include younger patients, too, with head injuries, which would make up some of that 35 percent non-Medicare, these patients are traveling two and three areas for an LTCH bed, and waiting a long time to even have one of these beds open up. So I also want to just emphasize the comments that Alice made. This is a highly skilled, very intensive set of services that this LTCH setting offers.

However, I'm going back to our chapter on inpatient and reflecting on the fact we have an overall 62 percent occupancy of our inpatient beds across this country, 41 percent in the rural areas. So were there not this designation and were we to propose these patients be

cared for in an outlier status, I suspect inpatient settings would dedicate beds and appropriate staff with the skill sets to care for these patients on a long-term basis.

So I think the beds are available. Obviously, it's a matter of the right skill sets. And from a therapy, respiratory, physical, occupational, not to mention just overall intensive nursing care, these are a very special set of patients that do require special services.

DR. REDBERG: I still think we need the quality measures and to understand how well we're doing on these ventilator-dependent and if they're coming off or not.

MS. THOMPSON: I agree.

DR. HOADLEY: This last round of discussion is reminding me of some work I did with the Commission well before I was a Commissioner where we did interviews around the country in both communities that had LTCHs and communities that didn't, and I think, you know, you've captured some of the things in some of the answers you gave, and others have -- you know, SNFs would provide care in some places, but it did require a community to have a sort of very well equipped SNF that was designed to deal with ventilators or so forth.

The one thing that hasn't come up that I remember -- and it was one particular interview, so, again, I don't want to overgeneralize from it, but it was one place that did not have an LTCH where the person we talked to really felt like it was encouraging them to have more end-of-life discussions with some of the patients, and that at least in this one person's perception, you know, the fact that an LTCH might have been available might have said, well, that's something we can do, rather than really have that talk with the family about whether -- you know, what's the long-term quality of life for this person who's on the ventilator? And, again, be wary of overgeneralizing from a single person's response, but I think that's just another potential element, and it sort of goes to that question of quality. There are many cases, clearly, where the LTCH is doing the right thing for people, but there may be others where it's just allowing a delay of other kinds of decisions.

DR. MILLER: And I did recall that, and it's one of the rare occasions I was allowed to leave the office -- I don't know how I slipped through -- and went on some of those trips. And I also had the hospice discussion -- it

was in Louisiana, and this is, I think, different than yours, and basically the medical director said there's a number of the people who are here who really should be in hospice, but, you know, they aren't. And exactly how that decision set was made was very peculiar to both the patients and the presence of the LTCH. And my recollection is similar to yours. You would go into the communities that didn't have them, and they had more souped-up SNFs and/or, you know, a setting in the hospital where this was being taken. You know, maybe we should revisit that exercise to sort of see what's going on out there.

I think Kathy's point is does the delivery system, you know, respond to the presence of the LTCH, is I think her basis point here. Or to Alice's point, is this created because there is a unique need? I think we could get back out into the field and ask those questions.

DR. CROSSON: Okay. Good discussion there.

Again, I think I saw -- and I'll ask to be sure -- consensus support for the recommendation before us. Seeing no objections, we'll, therefore, carry this forward into January for the expedited discussion -- presentation, rather, and voting process. Stephanie, thank you very

much. This concludes our discussion period, and we are now at the point where we will invite comments from the public. If you have a comment that you wish to make about items that have been discussed here, please come to the microphone so we can see who you are.

So I will ask you to identify yourself and your organization, if there is one.

Please keep your comments to about two minutes. When this light comes back on, that is an indication that the time is up, and we will ask you to conclude.

I will point out, as we often do, that there are other avenues for individuals and organizations to provide input to the Commission and staff, particularly through the website or through direct communication with Mark and his staff.

Please go ahead.

MS. GRIFFITH: Thank you. I think we're together, so can we have four minutes? He gets two, I get two?

DR. CROSSON: I think if you're representing an organization and you have an organizational perspective to provide, then that should be done by one person.

MS. GRIFFITH: Okay. Well, I'm Ellen Griffith, and I am a kidney patient, and I am on the advisory board of Home Dialyzors United, and he is not with -- okay.

Basically, this is our first time coming to MedPAC. I am -- myself, I have never been on dialysis, by the grace of God. I was given a transplant in January of this year, and so I managed to skip the dialysis process.

Going real quickly, our concerns about the way the reports -- the way the data has been analyzed -- and it may be too late to do this for this year -- first of all, there is no one-size-fits-all dialysis. There are about five or six different kinds of dialysis. They each have individual cost structure, which are not right now being identified when payment rates are developed. Their payment rates are developed across the line without regard to modality. That creates incentives to provide one kind of dialysis versus another. They all have different clinical outcomes for patients, and they have different impacts on patient lifestyle.

I'm with Home Dialyzors United because we believe that home dialysis, and particularly home hemodialysis is underutilized in this country, and that there are

substantial reasons for that, including payment implications.

We would recommend, in this study or in future years, to separate out PD and home hemo. They are very, very different. Not all patients can do PD because they are, for instance, diabetes -- dialysis is very, very sugary, and so patients with diabetes really can't do PD.

The training payment, which came up in the discussion, most PD is not covered by the training payment -- for the training for PD, because most PD patients are new patients. And so there is a new patient adjustment that is paid -- that supersedes all other payment adjustments. So your PD training generally is built into that new payment adjustment. It doesn't show up in the data for home training.

The home hemo patient --

DR. CROSSON: Please conclude your remarks. Thank you.

MS. GRIFFITH: Okay. I'll submit something to you through the website.

DR. CROSSON: Thank you very much.

MS. GRIFFITH: Thank you.

MR. WHITE: Hi. My name is David White. I did dialysis for six years locally, within walking distance from here, and I'm a kidney transplant recipient, about 17 months out.

I'm a full-time advocate. I advocate for more organizations than I can count, so I don't play favorites. The two that I'll mention are the American Association of Kidney Patients -- I'm a member of the board of directors -- and I am the acting chair of the Kidney Health Initiative's Patient Family Partnership Council.

One remark I have is that the quality of life measures that were mentioned in the dialysis payment recommendation presentation, mortality, hospital admissions and readmissions, paradoxically patients don't care about those. It sound weird, but we care about how we feel and how we're treated.

CMS is aware of this, and they're adding an ICH CAHPS in-center hemodialysis consumer assessment of health care provider systems measure for the payment year 2019, and that survey is given by third-party vendors.

Ms. Buto -- I hope I'm saying your name correctly -- you had a question about do QIP reductions lower the

quality of care. QIP scores are posted in dialysis clinics and they're reported publicly on a website called Dialysis Facility Compare, so probably not.

And finally, Ms. Coombs, you had a question about the difference between annual cost of dialysis versus transplant. When I advocate on Capitol Hill, I always point out that the difference is $50,000 to $55,000 a year. Transplant is about $35,000 a year, whereas dialysis is $85,000 to $90,000 a year.

Thank you very much for your time.

DR. CROSSON: Thank you.

MR. KOENIG: Hi there. I'm Lane Koenig, President of KNG Health Consulting, also Director of Policy and Research for the National Association of Long Term Care Hospitals.

I wanted to make just a couple of points. One, in the slide there was a statement that outcomes -- or research indicates outcomes are the same for patients who go to long-term care hospitals and those that go to other settings. I just want to make the Commission aware that there was a peer-reviewed study, and there are very few peer-reviewed studies on outcomes for long-term care

hospitals, published in Medical Care, that showed for the most critically ill -- so those with three or more days in ICU or on multiple organ failure -- outcomes are pretty positive for long-term care hospitals. So I encourage you all to take a look at that study.

The other point I wanted to make was on the margin projection, and I know it's been talked about before but just to make clear that for the site-neutral cases, the payment for those cases, starting in 2018, is going to be the lower of the IPPS amount or the cost. So for the site-neutral cases, starting in 2018, there is no margin that can be made, and so the conservative margin that was presented, which included sort of all of those -- all patients qualifying and non-qualifying, that the non-qualifying, unlike in the past where an LTCH could make a margin on those cases, starting in 2018 they will not be able to make a margin, and that's going to have an effect on what our expectations will be, in terms of the margins going forward.

Thank you.

DR. CROSSON: Thank you. Seeing no further individuals at the microphone, the meeting is concluded.

We will reconvene in our January meeting.

Thank you very much. Happy holidays to everyone. Safe travels.

[Whereupon, at 11:31 a.m., the meeting was adjourned.]