

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:

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
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

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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

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

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

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

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

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

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

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

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

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

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

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

14 On this chart you can see trends over the last
15 seven years, but to save time let's just walk down the
16 2017, or right-hand, column: 99 percent of
17 Medicare beneficiaries have at least one plan available; 95
18 percent of beneficiaries have an HMO or local PPO plan
19 operating in their county; 74 percent have a regional
20 PPO available up from 73 percent as there is now a plan
21 being offered in the Maine/New Hampshire region; 45
22 percent have a private fee-for-service plan available, down

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

4 The average number of plans available in each
5 county increased slightly to 10. When weighted by the
6 number of beneficiaries in each county, the number of
7 average plan choices available to the average beneficiary
8 is 18. In either context, the decline from 2011 levels is
9 due to the decrease in private fee-for-service offerings.

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

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

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

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

4 While plan bids average 90 percent of fee-for-
5 service, that number is kept down because HMOs are bidding
6 88 percent of fee-for-service on average. The other plan
7 types bid much higher, and local PPOs are bidding 101
8 percent of fee-for-service.

9 Now, in 2017, the quality bonuses add an average
10 4 percent to the benchmarks and 3 percent to payments. So
11 even though the bids are often well below fee-for-service,
12 on average Medicare is still paying about 100 percent of
13 fee-for-service because the benchmarks, including quality,
14 average 106 percent of fee-for-service. And without the
15 quality bonuses, they would average 102 percent. Carlos
16 will shed some light on the quality benchmarks shortly.

17 Now, here, finally, note that all the numbers on
18 this slide assume that risk differences are properly
19 accounted for, and remember last month Andy found that
20 coding intensity increased MA risk scores by an average of
21 4 percent more than CMS' adjustment.

22 So payments would average 104 percent of fee-for-

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

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

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

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

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

15 As a result, there has been progress toward
16 financial neutrality with Medicare fee-for-service. If
17 there were no risk coding differences, MA plans would be
18 paid on average roughly the same as fee-for-service in
19 2017.

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

1 inequities that could be addressed.

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

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

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

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

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

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

22 There are several issues arising from the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3 MR. ZARABOZO: Before getting to the update on
4 quality, we would like to address two questions from a
5 prior meeting that Rita asked. One question you raised was
6 regarding response rates for the CAHPS patient experience
7 measures. In your mailing material, we show recent CAHPS
8 data indicating that such measures were about the same for
9 fee-for-service as they were for MA. The response rate for
10 the fee-for-service CAHPS survey in 2014 was 41 percent.
11 For the MA plans, each plan contracts with a survey vendor
12 to survey the plan's members, and the response rates vary
13 by plan. In 2014, the median response rate among plans was
14 45 percent.

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

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

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

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

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

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

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

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

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

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

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

1 policy options to address the concerns.

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

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

6 We'll take clarifying questions. Paul.

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

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

15 DR. GINSBURG: Yes.

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

21 DR. CROSSON: Okay. Bill Gradison.

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

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

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

16 DR. CROSSON: Thank you, Bill.

17 Jack.

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

1 DR. HARRISON: We believe so, yeah.

2 DR. HOADLEY: Okay.

3 DR. CROSSON: Jon.

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

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

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

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

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

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

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

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

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

19 Brian.

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

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

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

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

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

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

12 DR. CROSSON: Pat and then Bill.

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

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

21 DR. CROSSON: Bill.

22 DR. HALL: The 12 percent of the population

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

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

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

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

11

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

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

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

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

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

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

9 DR. HARRISON: So, I mean, you know about getting
10 --

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

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

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

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

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

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

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

16 DR. CROSSON: Brian.

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

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

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

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

6 DR. CROSSON: Alice.

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

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

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

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

12 DR. CROSSON: Bill.

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

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

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

8 Thank you.

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

11 MR. GRADISON: Excuse me. Yes.

12 DR. CROSSON: Okay. Jack.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

21 DR. CROSSON: Okay. Pat.

22 MS. WANG: I support the Chairman's

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 DR. CROSSON: Rita, on this point?

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

1 problem is a very big field.

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

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

17 I'm thinking specifically about the text on page
18 30, and then, Scott, you mentioned this when you were
19 showing Slide 9. It's not actually on Slide 9, but you
20 mentioned Albuquerque, Denver, Portland as areas that have
21 particularly high numbers of people who are A-only. Those
22 are the regions who would benefit financially, and I wonder

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

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

10 Now, in many other of our discussions of MA,
11 we've talked about how we want to actually try to ratchet
12 payments down to get them equal to fee-for-service, and the
13 data you showed, Scott, seems to suggest that has now
14 finally occurred. We used to see numbers like 105 percent,
15 104 percent, relative to fee-for-service.

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

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

1 good reason for doing it.

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

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

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

1 effect of increasing payments as you describe.

2 MR. GRADISON: On that point, may I?

3 DR. CROSSON: Yes.

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

7 DR. CROSSON: Yeah.

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

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

14 [Laughter.]

15 DR. NERENZ: It happens.

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

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

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

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

19 DR. CROSSON: Amy, on this point?

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

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

1 spend is about 190...?

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

4 DR. MILLER: Right.

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

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

10 DR. CROSSON: Okay --

11 DR. MILLER: Annually, Amy.

12 DR. CROSSON: On this point, Paul?

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

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

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

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

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

7 DR. GINSBURG: I like Brian's amendment.

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

14 DR. MILLER: 2005.

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

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

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

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

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

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

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

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

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

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

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

13 Those are my comments. Thank you.

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

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

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

5 Those would be my comments.

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

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

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

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

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

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

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

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

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

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

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

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

1 is risky for me --

2 [Laughter.]

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

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

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

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

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

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

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

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

4 DR. MILLER: Yes.

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

12 So do I see a general agreement there?

13 [No response.]

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

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

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

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

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

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

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

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

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

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

9 [Laughter.]

10 DR. CROSSON: Good point.

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

15 DR. CROSSON: Okay. So --

16 DR. MILLER: We'll talk.

17 DR. CROSSON: Right. Right.

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

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

22 [Laughter.]

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

3 [Pause.]

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

8 MR. GAUMER: Yes, sir.

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

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

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

21 To evaluate the adequacy of Medicare payments, we
22 use a common framework across all sectors. When data are

1 available, we examine provider capacity, service volume,
2 access to capital, quality of care, as well as providers'
3 costs and payments for Medicare services. When we discuss
4 costs and margins, we will present Medicare margins for
5 2015, projected margins for 2017, as well as all-payer
6 margins and those of relatively efficient hospitals.

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

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

1 the past three years.

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

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

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

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

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

1 hospital bond offerings jumping from about \$25 billion to
2 \$36 billion in the first 11 months of 2016.

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

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

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

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

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

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

1 quality of hospital care has been improving, as a growing
2 proportion of Medicare hospital inpatient payments are
3 affected by hospitals' performance under three different
4 quality programs: the hospital readmission reduction
5 program, the hospital value-based purchasing program, and
6 the hospital-acquired condition reduction program.

7 We find that potentially preventable readmission
8 rates for Medicare patients continue to fall, with
9 reductions in potentially preventable readmissions for
10 conditions covered by the readmission reduction program and
11 for all conditions through 2015.

12 In addition, this year we developed a new all-
13 condition 30-day post-discharge mortality measure using
14 3M's APR DRGs and its risk of mortality measure along with
15 adjustments for age and gender.

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

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

1 preventable readmissions and risk-adjusted mortality.

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

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

12 This current pattern of low cost growth compares
13 to 2001 to 2008, before the recession, when costs were
14 increasing much faster than input price inflation and input
15 price inflation was also much higher.

16 So let's move on and discuss margins.

17 We assess the adequacy of Medicare payments for
18 the hospitals as a whole. We include Medicare payments for
19 all outpatient care services and uncompensated care and
20 compare them to allowable cost for providing services to
21 Medicare fee-for-service beneficiaries.

22 We find that the overall Medicare margin is

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

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

12 While the average margin was minus 7.1 percent in
13 2015, rural and for-profit hospitals had relatively higher
14 profit margins.

15 Next, we look at marginal profits, a concept we
16 introduced to all of our update frameworks last year, where
17 we basically ask the question of whether providers have an
18 incentive to take another Medicare patient. If payments
19 are more than marginal costs, a provider has a financial
20 incentive to take the patient, but if marginal payments do
21 not cover the marginal costs, the provider may have a
22 disincentive to take the patient.

1 To operationalize this concept, we compare
2 Medicare fee-for-service payment rates to the marginal
3 costs of providing those services. Marginal cost excludes
4 expenses for building and fixed equipment.

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

9 While Medicare margins continue to be low, all
10 payer margins continue to remain at historically high
11 levels, with an aggregate overall total all-payer margin of
12 6.8 percent in 2015 and the operating margin, which
13 includes revenues and costs from hospital operations, but
14 excludes income from investments and endowments, and that
15 rose to 6.4 percent in 2015, the highest level we have seen
16 over the past 10-plus years.

17 These high all-payer margins are supported by
18 private insurers paying about 50 percent above the cost of
19 care on average and declining uncompensated care costs.
20 This increase in the operating margin is an indication that
21 hospitals continue to grow their private-sector revenues
22 faster than costs.

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

4 Next, we turn to our relatively efficient
5 hospitals, where we identify a set of hospitals that
6 perform relatively well on quality of care measures while
7 also doing relatively well on cost measures.

8 In this year's analysis, we identified about 14
9 percent of hospitals that we had usable data on as having
10 been relatively efficient for three straight years. That's
11 from 2012 to 2014.

12 We then look at these hospitals' performance in
13 2015 -- and that's the first column in this table -- and we
14 see that these historically efficient hospitals had 6
15 percent lower mortality, while keeping costs 9 percent
16 lower than the national median.

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

20 It is important to remember that when we talk
21 about efficiency, we are talking about quality and cost.
22 These relatively efficient providers are spread across the

1 country and have a diverse set of characteristics, but they
2 are more likely to be larger nonprofit hospitals because
3 these hospitals tend to have better performance on their
4 quality metrics we analyze.

5 We project margins for 2017 based on margins in
6 2015 and policy changes that take place in 2016 and 2017.

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

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

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

21 So, to summarize our payment adequacy findings,
22 access to care is good. Access to capital remains strong.

1 Quality is improving. Medicare margins are low for the
2 average provider, but payments cover the marginal costs of
3 treating Medicare patients.

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

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

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

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

22 As this recommendation would provide current law updates,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 Just two very quick questions. On Slide 18, what
20 percentage of the total number of freestanding EDs is that
21 400?

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

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

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

12 MR. GAUMER: Yes.

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

17 MR. GAUMER: That is correct.

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

19 MR. GAUMER: Yeah.

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

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

3 MR. GAUMER: Yes.

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

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

14 DR. NERENZ: Okay.

15 DR. CROSSON: Rita.

16 DR. REDBERG: Thanks for an excellent chapter.

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

22 DR. STENSLAND: They generally have more beds.

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

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

4 DR. REDBERG: Okay. Thanks.

5 DR. CROSSON: Jack, then Brian and Sue.

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

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

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

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

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

15 DR. HOADLEY: Thank you.

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

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

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

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

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

17 [Laughter.]

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

1 I'm sorry. For Jeff.

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

5 MR. PYENSON: Yes.

6 DR. STENSLAND: It would basically be about that
7 6 percent more, because, you know, they're -- what's
8 variable and what's fixed isn't that different for them, so
9 maybe more on the order of 15 percent marginal profit.

10 MR. PYENSON: Okay. Thank you.

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

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

14 On Slide 7, taking a look at the annual percent
15 change in case-mix adjusted cost growth, going back to 2001
16 to 2008, where it was running along at an average clip of
17 5.2 percent, dropping down to 1.4 percent. From your
18 analysis of cost reports or whatever, what's driving the
19 reduction in costs for hospitals?

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

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

6 A three-part question.

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

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

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

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

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

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

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

1 DR. DeBUSK: But it's possible --

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

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

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

11 DR. DeBUSK: Yeah.

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

18 DR. CROSSON: Okay. Alice.

19 DR. COOMBS: So several questions I have. Of the
20 400 EDs, do we know how many of those are recent
21 acquisitions?

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

1 ventures or recently built facilities?

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

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

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

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

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

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

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

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

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

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

7 DR. COOMBS: Right.

8 MR. LISK: -- on the outlier --

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

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

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

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

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

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

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

22 DR. COOMBS: Right.

1 DR. MILLER: -- or a separate point?

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

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

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

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

22 DR. CROSSON: Kathy.

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

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

11 MS. BUTO: I wanted to discuss it again.

12 [Laughter.]

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

17 DR. MILLER: Yeah, that's --

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

20 MS. BUTO: Okay.

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

22 MS. BUTO: I think --

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

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

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

17 Are you saying that you want to --

18 DR. NERENZ: Who said I wasn't?

19 [Laughter.]

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

22 DR. CROSSON: He was hallucinating and you

1 weren't.

2 DR. MILLER: Well, maybe that was it.

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

6 MS. BUTO: No.

7 DR. MILLER: No.

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

10 DR. MILLER: To the outlier --

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

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

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

7 DR. CROSSON: On this point, Brian.

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

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

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

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

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

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

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

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

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

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

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

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

12 [Laughter.]

13 DR. CROSSON: Okay. Clarifying questions?

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

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

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

14 MR. PYENSON: Thank you.

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

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

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

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

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

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

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

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

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

20 DR. CROSSON: It can be done.

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

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

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

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

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

19 On Draft Recommendation 2, I support it as
20 written.

21 DR. DeBUSK: I support the recommendations as
22 written.

1 DR. HALL: I support the recommendations.

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

5 [Laughter.]

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

8 DR. CROSSON: Go ahead. If you can.

9 [Laughter.]

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

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

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

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

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

16 DR. NERENZ: Sorry?

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

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

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

22 DR. GINSBURG: I support both recommendations. I

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

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

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

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

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

21 [No response.]

22 DR. CROSSON: I see no one coming to the

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

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

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AFTERNOON SESSION

[1:15 P.M.]

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

8 [Laughter.]

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

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

12 [Laughter.]

13 DR. CROSSON: Okay.

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

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

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

1 we are required by law to do.

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

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

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

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

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

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

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

1 Starting with physician and other health
2 professional services, the services are paid under Medicare
3 Part B and occur in all settings. In 2015, Medicare paid
4 \$70 billion for these services, or about 15 percent of fee-
5 for-service benefit spending. Services were billed by
6 582,000 physicians, 183,000 advanced practice registered
7 nurses and physician assistants, and 155,000 therapists and
8 other providers.

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

16 So starting with access, we have two original
17 sources of data -- a yearly telephone survey of
18 beneficiaries and privately insured individuals, and focus
19 groups and site visits of beneficiaries and providers. We
20 also look at other sources of data and surveys.

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

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

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

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

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

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

1 over 99 percent of claims are paid on assignment. The
2 ratio of providers to beneficiaries is similar to prior
3 years. The ratio of primary care is unchanged, specialists
4 fell slightly, and advanced practice nurses and physician
5 assistants increased.

6 Medicare's payments to physicians and other
7 health professionals averaged 78 percent of private PPO
8 rates, similar to prior years.

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

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

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

22 MR. WINTER: The next indicator of payment

1 adequacy is volume growth. We measure the change in volume
2 for each billing code as the change in the number of
3 services multiplied by the relative value units for each
4 code.

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

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

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

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

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

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

12 In the context of the fee schedule, volume growth
13 is affected by shifts in setting. This is because practice
14 expense RVUs, which are part of the volume calculation, are
15 often lower when services are provided in a facility
16 setting, such as an outpatient department, than in a
17 freestanding office. So, even if the total number of
18 services are the same, volume will appear to be lower when
19 services are delivered in a setting with lower RVUs.

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

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

7 During the same period, payment updates, the
8 yellow line, increased cumulatively by 10 percent. Volume
9 growth accounts for most of the difference between the
10 payment updates and spending growth.

11 The red line shows that there was a small
12 increase in spending per beneficiary in 2015 of 0.6
13 percent. Several factors influenced this change: the 1.6
14 percent increase in volume in 2015; the small increase in
15 the conversion factor; and payment adjustments outside of
16 the update process, such as the physician quality reporting
17 system payment adjustments.

18 The Commission has expressed concern that
19 mispricing in the fee schedule contributes to an income
20 disparity between primary care and specialty physicians.
21 This chart is based on physician compensation data from
22 2015. As in prior years, average compensation was much

1 higher for some specialties than others.

2 The specialty groups with the highest average
3 compensation were radiology, with an average of \$560,000,
4 and the nonsurgical procedural specialties, which consist
5 of cardiology, gastroenterology, dermatology and pulmonary
6 medicine, which had an average of \$545,000. By contrast,
7 average compensation for primary care physicians was about
8 \$264,000. Previous Commission work showed that such
9 disparities also existed when compensation was observed on
10 an hourly basis.

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

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

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

1 paying a monthly fee for non-face-to-face chronic care
2 management services. To bill for this service, providers
3 must furnish at least 20 minutes of care management
4 services in a month to beneficiaries with two or more
5 chronic conditions that place them at a significant risk of
6 death, acute exacerbation, or functional decline.

7 Providers must also meet certain billing requirements.

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

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

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

22 TCM services pay for managing care for 30 days

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

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

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

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

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

22 As Kate mentioned earlier, the current law update

1 for 2018 is 0.5 percent.

2 In terms of implications, there would be no
3 change in spending, and this would maintain beneficiaries'
4 access to care and providers' willingness and ability to
5 furnish care.

6 This draft recommendation does not address
7 broader issues in this sector, and we are planning future
8 work in the following areas. To address disparities in
9 specialty compensation, we will continue to discuss options
10 to better support primary care, such as partial capitation.
11 We will also be exploring options to address the mispricing
12 of services in the fee schedule and looking at ways to
13 group CPT codes into larger families of codes.

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

16 Now I will hand things over to Dan.

17 DR. ZABINSKI: Okay. Ambulatory surgical
18 centers. Important facts about ASCs in 2015 include that
19 Medicare payments to ASCs were nearly \$4.1 billion. The
20 number of fee-for-service beneficiaries served in ASCs was
21 \$3.4 million, and the number of Medicare-certified ASCs was
22 5,475.

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

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

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

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

19 Finally, relative to OPD patients, ASC patients
20 are less likely to be dual eligible, minority, under age
21 65, or age 85 or older. There appears to be a number of
22 underlying causes for this, including the fact that ASCs

1 tend to be in higher income locations.

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

7 On this table, the values for measures of payment
8 adequacy in the second column indicate a stable situation
9 in 2015. First, the number of fee-for-service
10 beneficiaries served and the volume of services per fee-
11 for-service beneficiary both increased, as did the number
12 of Medicare-certified ASCs and Medicare payments per fee-
13 for-service beneficiary. In fact, the rates of increase in
14 2015 were higher than the average rates of increase over
15 2010-through-2014 period.

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

1 0.2 percent.

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

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

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

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

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

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

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

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

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

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

1 all ASCs.

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

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

14 So to summarize our ASC findings, indicators of
15 payment adequacy suggest a stable situation.

16 There was an increase in the number of ASCs,
17 which indicates that access to capital has been at least
18 adequate.

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

22 There was a particularly strong rate of increase

1 in Medicare payments to ASCs per beneficiary.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 0.5 percent update. Does that mean there's something else
2 that's going down that makes that no change? Are you
3 projecting less volume, or how does spending get to be no
4 change there?

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

9 DR. CHRISTIANSON: Okay, relative to --

10 MR. WINTER: As a result of --

11 DR. CHRISTIANSON: Not relative to --

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

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

18 MR. WINTER: Okay. We can clarify that.

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

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

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

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

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

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

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

4 DR. HOADLEY: Okay. Thank you.

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

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

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

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

21 DR. DeBUSK: Yes, MGMA data --

22 MR. WINTER: Right. This is not showing just

1 Medicare revenue. So --

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

5 MR. WINTER: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5 DR. CROSSON: Bill, on this point?

6 MR. GRADISON: No.

7 DR. CROSSON: Okay.

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

17 MR. WINTER: Going back to 2000 or --

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

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

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

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

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

21 DR. CROSSON: Okay. Thank you, Paul.

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

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

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

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

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

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

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

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

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

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

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

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

12 MS. BLONJARZ: Sure. Yeah.

13 MS. BUTO: Thank you.

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

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

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

4 DR. CROSSON: Alice.

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

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

14 DR. COOMBS: Right. Right.

15 MR. WINTER: -- to benefit dollars.

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

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

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

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

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

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

6 MR. WINTER: Yeah.

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

9 MR. WINTER: That's right.

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

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

16 DR. COOMBS: Or time, or --

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

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

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

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

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

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

1 just had some issues within our state about incident to
2 billing, with private insurers saying, "Let's stay at the
3 85 for no matter what the claim is that comes in." It is
4 very difficult to disaggregate which happens, even in a
5 very robust system whereby you have, you know, an elite
6 academic institution actually have an assignment for
7 quality measures and things of that nature. I think it's
8 very, very difficult to kind of allocate that.

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

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

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

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

22 And I looked up some data. A neurosurgeon can

1 pay anywhere from \$90,000 to \$200,000 for malpractice
2 insurance alone. Do we get our arms around that? Can
3 anyone understand that? I mean, that's like a lot of cash
4 and a lot of coverage. And then OB/GYN -- and it varies in
5 geography -- a primary care doctor can be as high as
6 \$13,000 in some states and as low as \$3,000.

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

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

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

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

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

22 So I think I'll stop there.

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

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

6 MR. WINTER: Yes. The update does not.

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

9 MR. WINTER: Okay.

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

11 DR. MILLER: I think it does.

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

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

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

1 delay care.

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

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

9 DR. MILLER: I see.

10 DR. COOMBS: -- versus --

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

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

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

22 DR. CROSSON: Craig.

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

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

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

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

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

14 MR. WINTER: We can look into that.

15 DR. CROSSON: Okay. Yeah, Rita.

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

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

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

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

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

1 clearer path, and some are easier than others.

2 DR. CROSSON: Jack.

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

13 DR. CROSSON: Agreed.

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

17 MR. WINTER: January.

18 DR. MILLER: Oh, in January.

19 DR. CROSSON: January.

20 DR. MILLER: Well, early spring and --

21 MR. WINTER: The early spring.

22 [Laughter.]

1 DR. CROSSON: Early spring.

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

5 DR. CROSSON: Okay. So once again --

6 DR. MILLER: Paul.

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

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

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

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

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

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

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

8 MR. WINTER: Yes.

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

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

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

3 The 1,000 units, it's not per ASC. It's for all
4 ASCs. The idea is identify a service, a particular
5 service, where the total volume across all ASCs is at least
6 1,000. It's just to provide some degree of assurance that
7 they're being done in ASCs, just for the reason it would
8 seem at least somewhat safe and that they're doing them
9 safely in ASCs.

10 DR. CROSSON: Okay. Jack.

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

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

17 DR. HOADLEY: Thank you.

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

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

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

6 That's all.

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

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

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

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

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

16 Alice.

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

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

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

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

12 DR. CROSSON: Okay. Bruce.

13 MR. PYENSON: Thanks, Jay.

14 Terrific report. A question for Zach. On page
15 10, there's a description of risk scores, comparing HOPD to
16 ASCs, and I'm assuming there, you used the HCC risk score
17 for the patients.

18 DR. ZABINSKI: Correct.

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

22 DR. ZABINSKI: Yeah, that's right.

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

2 DR. ZABINSKI: Prospective.

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

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

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

17 MR. WINTER: Daniel?

18 DR. ZABINSKI: Yes. Be my guest.

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

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

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

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

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

21 MR. WINTER: Oh, the actual numbers?

22 MR. PYENSON: Yes.

1 DR. ZABINSKI: Let's see.

2 MR. PYENSON: Maybe they are in the report.

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

4 MR. WINTER: The average.

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

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

9 DR. ZABINSKI: Bi,

10 MR. WINTER: The actions of cost data --

11 DR. ZABINSKI: Yeah.

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

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

1 environment, you could do that, I suppose.

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

3 MR. PYENSON: Thank you.

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

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

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

11 [Laughter.]

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

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

22 MR. PYENSON: Well, it might be correlated with

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

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

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

1 but it's something to think about.

2 MR. PYENSON: Okay.

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

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

15 So we looked at whether the physician practice
16 expense, the MEI -- that's a proxy that includes practice
17 expense for physician practices -- whether that would be a
18 better proxy for ASCs, and we were looking at some fairly
19 old cost data that were collected by GAO from a survey in
20 2004 and found that the cost structure of ASCs is pretty
21 different from a physician practice, and so I would be
22 concerned about using the physician RVUs as a proxy for ASC

1 relative cost.

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

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

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

8 [Laughter.]

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

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

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

1 ASCs.

2 DR. ZABINSKI: Yeah.

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

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

13 MR. WINTER: No. No.

14 DR. MILLER: And so we see your point.

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

19 MR. PYENSON: Thank you.

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

22 DR. GINSBURG: I was just getting into this

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

10 DR. CROSSON: Helpful points.

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

14 Kathy.

15 MS. BUTO: I support the recommendation.

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

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

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

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

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

22 Okay. Other -- Amy, yes.

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

3 DR. CROSSON: Okay. Thank you.

4 Alice?

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

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

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

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

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

9 DR. COOMBS: Right [off microphone].

10 DR. CROSSON: Is that what I was hearing?

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

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

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

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

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

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

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

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

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

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

22 DR. CROSSON: Okay. All right.

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

2 MR. PYENSON: Yes.

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

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

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

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

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

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

9 MR. GAUMER: No. Right, right.

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

15 DR. MILLER: You guys --

16 DR. CROSSON: Well, go, you finish

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

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

2 DR. ZABINSKI: That's correct.

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

5 [Laughter.]

6 DR. ZABINSKI: Another point on the suppressed
7 reporting, so far CMS has only allowed it for two years,
8 '13 and '14, and also on a limited set of the data
9 measures. As far as I know, CMS has not extended that
10 allowance to suppress the data. I haven't heard about them
11 doing so. So in the future, hopefully, it will not occur
12 anymore.

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

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

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

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

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

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

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

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

10 DR. CROSSON: Okay.

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

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

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

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

7 DR. HOADLEY: Just following on this point, it
8 may be that it's going to become a moot point, but I don't
9 recall any other sector where institutions have been
10 allowed to have data reported suppressed, and it just seems
11 like a strange policy. And maybe that's worth just a
12 sentence somewhere to comment on it. It sounds like it
13 doesn't at this point raise to recommendation status, but -
14 -

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

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

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

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

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

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

8 MS. WANG: Yeah.

9 DR. CROSSON: Yeah, okay.

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

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

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

19 [Laughter.]

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

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

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

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

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

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

1 know, as soon as -- or immediately.

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

12 MR. WINTER: Yes [off microphone].

13 DR. MILLER: All right.

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

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

21 [Pause.]

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

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

3 DR. CARTER: Great.

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

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

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

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

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

1 three SNFs, and less than 1 percent of beneficiaries live
2 in a county without a SNF or swing-bed facility. Occupancy
3 rates were down slightly but remained relatively high, at
4 86 percent. However, about one quarter of facilities have
5 occupancy rates below 75 percent, indicating some capacity
6 for additional volume.

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

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

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

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

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

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

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

17
18 The average facility rates of discharge back to
19 the community and readmission rates improved between 2014
20 and '15, but the function measures were essentially the
21 same. The chapter shows the variation in rates and
22 indicate there is plenty of room for improvement.

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

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

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

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

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

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

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

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

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

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

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

22 In assessing the level of fee-for-service

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

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

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

20 In considering how payments should change for
21 2018, the broad circumstances of the SNF industry have not
22 changed significantly from last year. The PPS continues to

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

6 The continued trends support the Chairman's draft
7 recommendation that reads: The Congress should eliminate
8 the market basket for 2018 and 2019 and direct the
9 Secretary to revise the prospective payment system for
10 skilled nursing facilities. In 2020, the Secretary should
11 report to the Congress on the impacts of the reformed PPS
12 and make any additional adjustments to payments needed to
13 more closely align payments and costs.

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

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

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

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

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

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

3 DR. CROSSON: Thank you, Carol.

4 Clarifying questions? Pat.

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

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

18 DR. CARTER: Timing, yeah.

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

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

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

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

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

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

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

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

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

22 DR. CROSSON: Jack, is your hand up?

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

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

11 DR. HOADLEY: Right.

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

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

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

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

14 DR. CROSSON: Kathy.

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

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

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

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

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

22 MS. BUTO: Right. So this is not a question.

1 DR. CROSSON: It didn't sound like it, but --

2 [Laughter.]

3 DR. CROSSON: So I just want to -- we'll come
4 back to this point, because I think you have a very
5 substantive point here. But I want to finish with the
6 questions. Is that all right?

7 DR. MILLER: I shouldn't have --

8 MS. BUTO: My question --

9 DR. MILLER: -- she drew me in.

10 [Laughter.]

11 MS. BUTO: You started this, and my question
12 actually was going to start with, did we consider --

13 [Laughter.]

14 MS. BUTO: -- something like a negative update,
15 but we can talk about that --

16 DR. CROSSON: Did we consider that I have an
17 entirely different idea?

18 [Laughter.]

19 DR. DeBUSK: I think I'm responsible for this.

20 DR. REDBERG: I'm learning the trick. You have
21 to direct the question at Carol.

22 [Laughter.]

1 DR. REDBERG: So Carol, I'm asking you -- no. Is
2 there evidence, and is there credible evidence that the
3 over-provision of these therapy services may actually be
4 hurting patients? And Rita, I apologize if I've hijacked
5 your issue.

6 [Laughter.]

7 DR. DeBUSK: I feel like I've stolen something
8 from you. I apologize.

9 [Laughter.]

10 DR. DeBUSK: But when I was going through the
11 reading, I mean, that was -- the one -- there was sort of
12 this overarching theme of is there -- is it possible that
13 this over-provision is actually hurting patients?

14 MS. CARTER: So we don't have information on
15 that, and I would say, in general, sort of -- Rita, I'm
16 going to channel you right now -- I don't think there is
17 good information on the value of therapy. I will say that
18 over the years, as we've looked at sort of the functional
19 improvement of patients, we're not seeing that, at least in
20 the measures that we use. And so at least in terms of
21 patients getting more therapy, but is there functional
22 improvement? Do we see larger improvements in functional

1 status, and we're not seeing that, which is different than
2 what you're asking, which is do people get harmed. I'm
3 looking at the benefit side.

4 DR. DeBUSK: But are we certain that there's no
5 harm?

6 MS. CARTER: We don't have information on that.

7 DR. CROSSON: Okay. Questions. Paul.

8 DR. GINSBURG: I learned a lot about SNFs from
9 reading your paper. It was really helpful. And I kept
10 having a question in my mind about, to what degree are
11 hospitals able to steer patients that are being discharged
12 to particular SNFs that they might feel would be good for
13 the patients, or is this strictly they can suggest
14 something but it's up to the patients?

15 MS. CARTER: So what we hear is that, of course,
16 beneficiaries always have freedom of choice, but there is
17 sort of what I would call some soft steering that goes on,
18 where hospitals -- and particularly with the readmission
19 penalty, hospitals, I think, have really narrowed down the
20 number of different SNFs that they refer to. And I hear
21 that when I talk to capital -- the financial analysts, but
22 also just in the trade press, about SNFs are being demanded

1 to show to hospitals their quality measures, including
2 readmission rates and other things, because they want to be
3 in the network of a hospital's referral, the choice
4 provider.

5 So I think -- and, of course, beneficiaries will
6 have things like, is the SNF close to my home, which is an
7 important consideration. But I think there is some soft
8 steering, and I think it's increased over time as provider
9 -- on the hospital side, they're very focused on the
10 readmission rates.

11 Is that helpful?

12 DR. GINSBURG: Very.

13 DR. CROSSON: Bruce.

14 MR. PYENSON: Thank you, Carol. It's a terrific
15 report.

16 Yeah, on page 22, you talk about the SNF volume,
17 the expectation that SNF volume will decline with bundled
18 payments and CJR and so forth. Do you have a view of how
19 much that would be and whether that would change the mix of
20 patients who actually need therapy -- diminish the portion
21 of patients in that category?

22 MS. CARTER: We don't have information on that,

1 although I do think that you're seeing that a little bit in
2 the days, the reduction in days. I think we are hearing,
3 anecdotally, that some ACOs are bypassing SNFs entirely and
4 sending patients from the hospital directly home with
5 either home health care or outpatient. So we are seeing a
6 little bit of decline in just even SNF admissions relative
7 to that. I know admissions, overall, were up. And we did
8 see, in the data, overall, that -- and Craig and I were
9 just looking at these numbers yesterday -- that the
10 referrals from hospitals to SNFs actually went up last
11 year. But that doesn't mean that for particular
12 alternative models they're using SNFs less.

13 DR. CROSSON: Clarifying questions.

14 So seeing none, Let's move to a discussion of the
15 recommendation, and I think, Kathy, I'd like to go back to
16 you, because I think what we have on the table -- and I'd
17 kind of ask you to reformulate it again -- is a proposal --
18 and I'll just say, grossly -- to construct a more
19 aggressive recommendation. So go ahead.

20 MS. BUTO: Yeah, and this was, in part, driven by
21 -- I read ahead to the IRF recommendations, and the reason
22 I did that was I was trying to understand, because we have

1 similar -- there are some similar issues and they also
2 share some patients, and we've had issues between the two
3 kinds of facilities, so I wanted to get a sense of where we
4 were going there. And I saw, you know, without getting too
5 far into it, a different kind of recommendation, and
6 wondered if we had considered a more aggressive
7 recommendation here, because I think we've noted the last
8 two years that I've been here that, you know, not much
9 progress going on with that PPS reform in this area.

10 So is there something that we could actually
11 recommend that would say, and if no progress is made, at a
12 minimum we would like to see some adjustment made, really,
13 at sort of a gross level, to recognize those facilities
14 that are taking advantage of the current system, and
15 potentially having a lower update for those kinds of
16 facilities going forward, not in '18 but maybe '19?

17 So that was my thinking.

18 DR. CROSSON: Yeah. I think what I'd like to do
19 at this point is ask -- people can provide any perspective
20 they want on anything here relative to the recommendation,
21 but on this point I would like to focus on that and get a
22 sense from the other Commissioners for moving in that

1 direction, that is, a more aggressive, more pointed kind of
2 recommendation, or not.

3 While we are doing that, Kathy, what I would ask
4 you to do is actually draft a substitute recommendation.
5 Do you feel like you could do that?

6 MS. BUTO: Sure. Yeah.

7 DR. CROSSON: So we'll continue the discussion
8 and then depending upon the nature of the discussion, we
9 could put up, you know, both for consideration.

10 DR. MILLER: But can I just say one thing about
11 that, and asking Kathy to do it is actually a great
12 innovation and work load.

13 [Laughter.]

14 DR. MILLER: I strongly support that kind of
15 action before I say what I'm about to say, which is I
16 think, you know -- and I know you want to put this
17 conversation to develop -- you know, my reaction to Kathy
18 was going to be, I think if everybody wants to consider
19 that, we can consider it, but the metric would be a little
20 bit hard for me to fill out and write in right now. And
21 that's -- so I'm wondering what Kathy would write there.
22 But because that's what -- I would really want to spend

1 some time with Carol in kind of going in, because we don't
2 want to just say "I don't think, profitable, unprofitable,"
3 we want to look at a particular behavior and feel like
4 we're targeting those places that we think are off -- you
5 know, off track a bit.

6 MS. BUTO: You're totally right about that, which
7 is why I wasn't going to try to write this until Jay asked
8 me to.

9 DR. CROSSON: Okay. All right. All right.

10 MS. BUTO: But -- no, because I actually think
11 the staff has a much better feel for where those boundaries
12 would be, and we may not want to get specific but describe
13 the characteristics.

14 DR. MILLER: It's more complicated than red hair
15 --

16 MS. BUTO: It's more complicated than just
17 writing up new words.

18 DR. MILLER: There you go.

19 DR. CROSSON: So, right. But let me go after
20 this again.

21 So a third way of doing this is to come back with
22 a different recommendation in January, following the

1 considerations that we've described. Now, how -- just help
2 me -- how have we done that in the past? Are we close
3 enough here that we could consider the recommendation,
4 having been read twice?

5 DR. MILLER: So my best shot at this -- and this
6 would be messy, and I think it means that we would probably
7 have to come back and have a whole session on this --

8 DR. CROSSON: Yes.

9 DR. MILLER: -- and I think, as a staff person,
10 what I would try and do is I'd come back with this, and
11 then I'd come back with an alternative that said "you did
12 agree" -- and this assumes that everybody agrees, and we
13 haven't even had that part of the conversation yet. But if
14 everybody wanted to go in this direction, I'd have an
15 alternative, try and be able to explain as best as possible
16 what that targeting is, and then, in that session, you
17 would say, "I don't like this" and we would retreat, or you
18 say, "I love it. Kathy drafted the perfect
19 recommendation," and we go that way.

20 But it probably really couldn't be litigated
21 until the next meeting --

22 DR. CROSSON: Right.

1 DR. MILLER: -- would be the way I see it.

2 DR. CROSSON: So that's another alternative, and
3 probably a better one.

4 So I saw Jack and then Alice and then Pat and
5 Paul. Jack, Alice, Pat, and Paul.

6 So, but let's -- while people may have other
7 issues, let's try to adjudicate this one first. Are people
8 in favor of the direction Kathy has proposed, without the
9 specifics, and the notion that we would come back in
10 January with this idea, but an additional idea, and then we
11 could determine which one -- which direction we want to go?

12 MS. BUTO: Well, Jay, I would just humbly suggest
13 someone might have a better idea about -- along these
14 lines, so maybe before --

15 DR. CROSSON: Right. I'm saying you have a
16 general direction, but I want to hear from everybody else.
17 So I'd -- now I lost it. Jack, Alice, Pat, and Paul.

18 DR. HOADLEY: So I do like the notion of, you
19 know, having -- I mean, our stance, as stated here, is
20 still a good one, that if both parts of a sentence were
21 done, we would have a revised PPS and we would have a path
22 and a timing to get there. So it's not even necessarily

1 like we have to completely abandon this approach to be more
2 aggressive, because this is an aggressive approach.

3 It seems to me there might be one other
4 alternative, which is to use the text around this to say
5 something like "and if this recommendation is not pursued,
6 our intent next year would be to," or, you know, because
7 we're really talking about a 2019 recommendation, and this
8 continued sort of thing, and we could state -- therefore,
9 it could be the softer, non-bolded language as we talked
10 about in the last conversation, to say "our intent would be
11 to come forward with an approach," and then we could
12 describe it a little more squishy terms, about the goals we
13 were trying to accomplish. And if we have by then, by the
14 time we're writing this in a few weeks, in January, we have
15 a sense of what that -- you know, some suggestions of how
16 that would work, obviously we could say those.

17 But the notion would be to sort of give the
18 fallback position in the text, and use that as part of the
19 message, to say, you know, this really does capture the
20 preferred route over the next three-year period, but if
21 that is not done, we have another notion of where we will
22 go, and that gives people sort of the same fair warning.

1 The other thing I was going to suggest, before
2 this came up, I mean, we also have one other track going,
3 because we spent all of last year on the revised overall
4 PPS, and I was sort of struck by the absence of any
5 reference to that, and my suggestion was simply going to be
6 put a text box, that might even appear in each of the PAC
7 chapters, since a lot of people read our reports chapter by
8 chapter, not the whole report, that would just quickly
9 explain -- and it could be very brief, but quickly
10 explaining all of what we talked about last year and then
11 reference people to that.

12 But in this context it would also -- I mean,
13 there's a point at which this becomes a moot discussion if
14 that other process goes forward. I know the time frame is
15 a lot longer there. And so, again, the text can be used to
16 sort of mention that. But we've also said, in that report,
17 some thought about how to move forward more quickly if
18 there was a will to do so. So it seems like bringing that
19 in gives us another way of sort of saying, you know,
20 "Here's a series of options. This is the one we're
21 recommending, because it addresses the problem quickly and
22 efficiently, but if you guys don't go there, we have this

1 other thing," that's sort of the Kathy line, "and,
2 furthermore, we have a longer-term thing which could be
3 accelerated as we discussed last year," reference all that
4 report.

5 DR. CROSSON: Okay. So Jack has a third proposal
6 --

7 DR. HOADLEY: Not to complicate things.

8 DR. CROSSON: -- a third proposal, which is the
9 text solution. So that's on the table as well.

10 Did you have a -- on this point?

11 DR. DeBUSK: I had a comment. First of all,
12 Jack, I completely agree with you on this idea of the
13 unified PACs model, but what strikes me is, knowing that
14 we've got 2019, could we use the inputs that were already -
15 - that we've already vetted, or in the process of vetting
16 for the united PACs models, as the inputs for the
17 prospective SNF PPS? If anything, it would help us
18 validate the PACs model, because it would get us used to
19 using, for example, those functional and cognitive measures
20 and things that we needed in that model.

21 So this could really be a stepping stone to
22 impact and would avoid duplicative work.

1 DR. CROSSON: Okay. I'm going to -- just hold
2 for a second, because I've got another idea to put on the
3 table.

4 DR. MILLER: I'd let it run.

5 DR. CROSSON: You want to go further, and then
6 give the other idea.

7 DR. MILLER: Right. Let's do that.

8 DR. COOMBS: So first of all, I would divide that
9 into two, because it might be a little bit more palatable,
10 so separating the two concepts.

11 But, Jack, you went right into the bedroom I was
12 going to go into --

13 [Laughter.]

14 DR. COOMBS: -- because we spent that time --
15 Carol Carter got her ribbon last year for bringing the PAC
16 PPS. The thing that I would be more concerned with, Kathy,
17 is that if you gave a negative update to one in tandem with
18 the other ones that we need to discuss going forward, what
19 does that do, if you don't give the rest of them the same
20 kind of -- degree of update, whether it's negative or
21 whether it's zero or whatever, because it would shift
22 things. And what we said, via consensus, is that we agree

1 that it is the resources required for treatment, the
2 modeling that you did was really excellent, and I would
3 like to stick with that piece and this as an entity going
4 forward, because I think that PAC PPS will move the meter
5 in terms of getting the same care, at different places,
6 with the same resource utilization, and also a similar type
7 of cost correlated with that.

8 MS. BUTO: Yeah, but where I was going, a little
9 bit, was, just to respond to that point, was I remember
10 raising the question Carol, with the PAC PPS, whether we
11 really needed to do anything on SNF PPS. Why not just go
12 directly in the direction of the PAC PPS? And I thought
13 you said that it would be helpful to have this series of
14 changes made in order to sort of -- as a glide path into
15 the PAC PPS.

16 So I'm thinking if we wait until 2019 -- I'd
17 forgotten what -- our report is 2020, for the final
18 recommendation for the structure of the thing -- that's
19 waiting a bit long. So that's really what motivated me to
20 think of, is there an interim measure that would accelerate
21 getting into that glide path -- and maybe there isn't.
22 Maybe we just go --

1 DR. COOMBS: I'm just saying that you have three entities
2 for which there are choices that hospitals make about where
3 to send patients, and if you adversely affect one more
4 significantly in a different fashion than you do the other,
5 then your paternalistic choices are going to be made based
6 on that, what you decide to assign to SNFs versus IRFs
7 versus LTCHs.

8 DR. CROSSON: Pat.

9 MS. WANG: I don't want to make this more
10 complicated.

11 [Laughter.]

12 MS. WANG: My concern -- and the conversation is
13 all really relevant -- my concern is that SNFs that are
14 providing higher shares of medically complex and special
15 care not be hurt while all this other good stuff is going
16 on, because the zero percent update recommendation is based
17 on high margins in the aggregate that seem to be driven by
18 sort of following the incentives of the current
19 reimbursement system, which is not in the special care
20 area.

21 So I wonder whether it would be simpler simply to
22 say -- this is why I asked the question before about the

1 timing, because even a year of a zero update for a facility
2 whose Medicare margins are low, because they are providing
3 all of this very complex care, could be very harmful, is to
4 say that, you know, unless PAC or the PPS or something is
5 implemented by 2018, that the zero update factor will be
6 comprised of a positive update factor to facilities that
7 provide whatever the median share of medically complex
8 special care cases, whatever the right metric is, and a
9 negative update for all others, so that the zero update --
10 because this is in the context of how much additional money
11 should be put into the system, and I think that the
12 assessment here is that there is enough money in the
13 system.

14 My concern is that facilities that are kind of
15 doing the right thing not be hurt in the interim, that
16 there be -- so that's another way. Instead of trying to
17 come up with a, you know, definition of how much therapy is
18 too much therapy, who is a good guy, who is a bad guy, is
19 to focus instead on what it is we're trying to support,
20 which is care for medically complex patients.

21 DR. MILLER: And I want to -- but I do want to
22 give you one piece of information on this, and for you guys

1 to think about, and it has to do with hurt. Now I want to
2 be clear -- there's always a distribution, and there are
3 high margins, just in the abstract way. If somebody has
4 really high costs, they're just inefficient, and
5 everybody's, you know, not doing their job, you know, we
6 don't want to reward that, that type of thing.

7 And, Carol, SNFs that are low therapy, high
8 medical, their margins are in the six to eight range?

9 MS. CARTER: I'm not sure. Well, I could look it
10 up. That sounds about right.

11 DR. MILLER: Yeah, and I want to say, you know,
12 page 31.

13 MS. CARTER: Yeah, exactly. So low therapy,
14 seven; medically complex, high shares, eight.

15 I wondered whether you were going to be going,
16 just to point out that the revisions to the PPS redirect
17 money to medically complex, low therapy providers, in
18 substantial ways, and part of the thinking behind the
19 timing of this recommendation was to actually put some
20 pressure to change the payment system, because we have been
21 recommending that the PPS get changed since 2008, and
22 that's a long time.

1 So I think we were hoping that the -- because we
2 had a different timing for a couple of years, and we
3 shifted trying to put some pressure on change. And so it's
4 true that there's a distribution, and Mark's right. There
5 are providers that, even with the redistribution that's
6 going to happen with the revised payment system, that
7 doesn't fix if they have a high cost structure. Right?
8 The PPS doesn't do -- doesn't address that. And so there
9 would still be a distribution.

10 DR. MILLER: And what I wanted you to have in
11 your head -- and, you know, you still end up wherever you
12 want to be. There is something there of a margin for the
13 actors that I think most of you are referring to, that even
14 if there were some limit -- a limit or, you know, no
15 updates for a few years, I don't think it drives them into
16 the reg immediately. So if you thought they were operating
17 out at zero, I don't think they're quite there.

18 DR. CROSSON: And if we were going to make a
19 recommendation to essentially revise the PPS in this way,
20 revise the payment to SNFs in this way, the way you
21 describe, the Secretary would still have to do that and
22 would still take an implementation time; whereas, this

1 recommendation is simply saying to revise it, and as Carol
2 said, we have a good indication of how that's going to be
3 revised, which is the way you say.

4 DR. GINSBURG: What I've been thinking about, and
5 it keeps getting augmented as people make comments, is, to
6 the degree that we could actually use our update
7 recommendations to move in a crude way in the direction of
8 a better PPS system, so that perhaps we can say that
9 therapy should have a negative update, and the addition for
10 complex patients should have a positive update. And what
11 this reminds me of is actually the way that we got to the
12 physician fee schedule back in the 1980s, that there was
13 initially in 1988 recommendations by the Physician Payment
14 Review Commission to reduce the payment rates for selected
15 services that the Commission believed there was strong
16 evidence were paid too much. And the next year, there was
17 a proposal for a full-blown resource-based relative value
18 scale fee schedule. And I was just thinking that, to the
19 degree we could, do have the ability to make separate
20 update recommendations for different parts of the package
21 in the SNFs now, it could perhaps foster the industry to
22 get behind a revised PPS, because we're heading that way in

1 a crude way anyway.

2 DR. CROSSON: Right, I'm getting a little
3 confused by a chicken and egg here because essentially
4 you're proposing a version of a revised payment system, and
5 we're asking for the Secretary to revise the payment
6 system.

7 DR. GINSBURG: I'm talking about some very crude
8 steps with our update recommendations in the direction of
9 where we know a revised payment system would come out. And
10 it just would be, you know, just one year's changes, and
11 you know, we'll hope that the Secretary produces the full-
12 blown revamped PPS system so that we don't have to do this.

13 DR. CROSSON: Okay. So I -- Kathy.

14 MS. BUTO: I totally know where Paul is going
15 with this, which is the impetus for doing the PPS has to
16 come from the industry. They have to want to do it. And
17 if they want to do it, then the agency will want to do it.
18 And so the question of how to make the alternative, which
19 is the status quo, less attractive is kind of the challenge
20 here. And, you know, there are a number of ways to do
21 that.

22 What I want to just put in the mix here is if --

1 let's say nothing happens and 2019 comes along, isn't that
2 too late, really, to be implementing a PPS system before --
3 if we assume that PAC is going to -- potentially could be
4 rolled out two years later or so? What do you think? I
5 mean, I'd just be interested in knowing, because maybe this
6 is really the best we can do and 2019 is going to be too
7 late anyway [off microphone] just because.

8 DR. CARTER: I think CMS has spent a lot of time
9 and made really good progress one designing this new PPS,
10 so I think they're further along in that than the PAC PPS.

11 I think that what it would encourage from the
12 provider standpoint are the same in the sense that both --
13 you know, the SNF PPS design is -- that was foundational
14 work for the PAC PPS work. They are using patient
15 characteristics rather than services to set payment, and so
16 I think last year when you -- in June or May, when we were
17 talking about whether one was a good glide path to the
18 other, I said I thought so because they would be
19 encouraging providers to do the same things. So then it
20 really does become an issue of timing and whether they
21 could get -- CMS could get to this sooner than a PAC PPS,
22 and I said I would think so, yes.

1 DR. CROSSON: So let me add one other idea and
2 then see if we can't figure out what we're going to do
3 here. So, Kathy, as I was reading the PAC papers, I was
4 coming to, I think, a same -- maybe just simply the same
5 level of concern or even worse than you were as well, which
6 is that we've been making, not just in this area but in
7 other areas, recommendations repeatedly based on what are
8 high margins, which are costing the Medicare program money
9 as well as beneficiaries, and that in many cases we have
10 not had responsiveness to that, and that perhaps one thing
11 we might do this year would be to put a front piece or a
12 mini paper ahead of the PAC reports which could contain a
13 number of things. Jack, it could contain your text box on
14 the PAC PPS. But we could also take a look, either
15 prospectively or retrospectively, or both, you know, at the
16 consequences of our recommendations across the PAC areas,
17 the consequences to the program and to beneficiaries of the
18 fact that those recommendations had not been implemented.
19 And I think, you know, adding it all up, particularly if we
20 did it both retrospectively and prospectively, it would be
21 a very large sum of money and, you know, move the
22 Commission to a more aggressive stance in general about the

1 collection of these PAC areas. And I guess what I'd like
2 to say is I think we should do that.

3 So assuming that we're going to do that, then we
4 have, you know, kind of on the table -- because I've heard
5 both sides a little bit here. Let's just go ahead with
6 this for now or let's come back in January with this and
7 specific to this update recommendation, in addition to the
8 kind of global -- little global chapter I was talking
9 about, let's come back with a choice so that we can pick
10 one or the other for this update recommendation. I think
11 those are the -- that's what we have on the table.

12 So I think I'm going to ask for some hands here,
13 because I can't eyeball this too easily. One notion would
14 be that we would take this on more aggressively across the
15 areas of post-acute care, which have extraordinarily high
16 margins and for which there has been no activity that we
17 can discern, and then this would be the recommendation.
18 That's Choice 1.

19 Choice 2 would be the little chapter I described,
20 plus coming back in January with this recommendation, plus
21 another one, which, Kathy, help work on with the staff.

22 MS. BUTO: By the way, I'm very comfortable with

1 the approach that you laid out where we lay out the mini
2 chapter. I would also add to that some sense of the
3 timeline --

4 DR. CROSSON: Yes.

5 MS. BUTO: -- the flow from whatever PPS into
6 PAC, and then going with this recommendation, rather than
7 trying to come up with another recommendation in that time
8 frame.

9 DR. CROSSON: Okay.

10 MS. BUTO: I think that might work better. And
11 since we don't have the specificity, I'm not sure how we do
12 that in the time we have.

13 DR. CROSSON: Okay. So Kathy has put that one
14 choice on the table. The second choice was, to a large
15 degree, a consequence of the position she brought forward.
16 She's now said she's comfortable with the one alternative
17 that I described, which is the small chapter laying out in
18 rather stark terms the consequences to the program and to
19 beneficiaries of not having moved aggressively or not
20 moving aggressively in the future, or both. And this is
21 then our recommendation that we would bring forward in
22 January. Do I have support for that position? Without

1 objection, okay. Then that's what we'll do.

2 Thank you, Carol. Appreciate it.

3 [Pause.]

4 DR. CROSSON: Oh, by the way, for the
5 Commissioners, I haven't really mentioned this, but in
6 terms of the mailing for January, we've made note of a
7 number of changes to the text, for example. So you will be
8 getting these chapters again in its revised version, with a
9 notice to what's new and what's not new, as well as other
10 issues we're going to be taking on in January. So plan on
11 checking your luggage on your January trip.

12 Okay. Dana is here, and we're going to talk
13 about updates for inpatient rehabilitation facility
14 services. Dana?

15 MS. KELLEY: Okay. Good afternoon.

16 After illness, injury, or surgery, many patients
17 need intensive rehabilitation care, including physical,
18 occupational, or speech therapy. Sometimes these services
19 are provided in inpatient rehabilitation facilities.

20 In 2015, Medicare spent \$7.4 billion on care
21 provided in 1,180 IRFs nationwide. There were about
22 381,000 IRF stays in 2015, and on average, Medicare paid

1 more than \$19,000 per case. Per-case payments to IRFs vary
2 depending on patient's condition, level of impairment, age,
3 and comorbidity. Medicare accounted for about 60 percent
4 of IRFs' discharges in 2015.

5 To qualify as an IRF, a facility first must meet
6 Medicare's conditions of participation for acute care
7 hospitals. In addition, IRFs must have a medical director
8 of rehabilitation and a preadmission screening process to
9 determine that each patient is likely to benefit
10 significantly from an intensive rehab program.

11 An IRF also must demonstrate that it is primarily
12 focused on treating conditions that typically require
13 intensive rehab. To that end, IRFs must meet the
14 compliance threshold, known as the 60 percent rule. Under
15 this rule, at least 60 percent of all patients admitted to
16 an IRF must have 1 of 13 conditions, specified by CMS, such
17 as stroke, hip fracture, and brain injury. If an IRF does
18 not meet the compliance threshold, Medicare pays for all
19 its cases on the basis of the inpatient hospital PPS,
20 rather than the IRF PPS.

21 For beneficiaries to qualify for a covered IRF
22 stay, they must be able to tolerate and benefit from

1 intensive therapy, and they must need at least two types of
2 therapy, one of which needs to be physical therapy.

3 Last year, we presented the results of analyses
4 that showed that high-margin IRFs have a different mix of
5 cases than other IRFs do. We also found evidence to
6 suggest that patient assessment may not be uniform across
7 IRFs. These findings raised concerns that patient
8 selection and coding may contribute to disparities in IRF
9 profitability. I will briefly review our findings.

10 As you will recall, in our analysis, we ranked
11 IRFs by their Medicare margins and sorted them into five
12 equal-sized groups. Quintile 1 had the lowest margins; and
13 Quintile 5, the highest. As you can see, high-margin IRFs
14 have a different mix of cases than low-margin IRFs.
15 Looking at the red bars, IRFs with the highest margins,
16 Quintile 5, have a smaller share of stroke cases, and they
17 have a much larger share of cases with neurological
18 conditions, shown here in green. Neurological conditions
19 include multiple sclerosis and neuromuscular disorders like
20 ALS and muscular dystrophy.

21 We also found differences across IRFs in the
22 types of stroke and neurological cases admitted. IRFs with

1 the highest margins have many more stroke cases with no
2 paralysis. They also have many more neurological cases
3 with neuromuscular disorders, as opposed to multiple
4 sclerosis or Parkinson's disease.

5 We've also noticed some interesting patterns of
6 coding in IRFs. We matched IRF claims and assessment data
7 with data from patients' preceding acute care hospital
8 stays. Then we looked at the relationship between
9 patients' conditions in the acute care hospital versus that
10 in the IRF. We found that patients in high-margin IRFs
11 were less severely ill during their preceding hospital
12 stay, compared with patients in low-margin IRFs. High-
13 margin IRFs cared for patients who had a lower average
14 hospital case-mix index. Their patients were less likely
15 to have been in an ICU or CCU. Patients who had been in an
16 ICU had shorter stays there, on average, than patients in
17 low-margin IRFs. Patients in high-margin IRFs were also
18 less likely to have been high-cost outliers during their
19 preceding hospital stay.

20 But once patients were admitted to and assessed
21 by IRFs, the patient profile changed, with patients in
22 high-margin IRFs appearing to be more impaired, on average.

1 Patients in high-margin IRFs had lower motor and cognition
2 scores, indicating greater functional impairment. These
3 lower scores generally increase payment. This pattern was
4 evident across case types.

5 In fact, we found that at any level of patient
6 severity, as measured in the acute care hospital, patients
7 in high-margin IRFs were coded with greater impairment.

8 This slide illustrates the kinds of differences
9 in coding we see. Here, we are looking at average motor
10 scores at IRF admission for patients with two types of
11 stroke -- stroke with paralysis and stroke with no
12 paralysis. We would expect stroke patients without
13 paralysis to have better motor function than patients with
14 paralysis, and if we look down the columns, that is exactly
15 what we see here.

16 If you look in the middle column, which I have
17 highlighted in yellow, for the lowest-margin IRFs, you can
18 see that patients with paralysis have, on average, a lower
19 motor score, 29.2, than patients without paralysis, who
20 have an average motor score of 35.3. The lower motor score
21 indicates a lower level of motor function and generally
22 increases payment.

1 We see the same in the right-hand column for the
2 highest-margin IRFs. Stroke patients with paralysis have a
3 lower motor score, 24.6, than patients without paralysis.
4 In part, because of this lower level of motor function,
5 overall, stroke patients with paralysis have IRF stays that
6 are more than two days longer on average than stroke
7 patients without paralysis.

8 But we also see something very unexpected in this
9 chart. In the highest-margin IRFs, the average motor score
10 for stroke patients without paralysis is 29.0. This is
11 almost exactly the same as the average motor score for
12 patients with paralysis in the lowest-margin IRFs. All
13 else equal, the payment for these two cases, with a motor
14 score of 29, would be the same. This raises questions
15 about the inter-rater reliability and the assessment
16 process, and that's a problem for any payment system.

17 Medicare's payments should be aligned with
18 patients' costs, with higher payments made for patients
19 with greater resource needs. For that to happen, patient
20 assessment needs to be reasonably consistent across
21 providers, but our work suggests it may not be.

22 Our findings led Commissioners to make two

1 recommendations in March 2016. First, MedPAC recommended
2 that CMS ensure payment accuracy through focused medical
3 record review, and we encouraged the Secretary to reassess
4 inter-rater reliability across IRFs.

5 Second, MedPAC recommended that CMS reduce
6 potential misalignments between IRF payments and costs by
7 redistributing payments through the high-cost outlier pool.
8 Expanding the outlier pool would increase outlier payments
9 for the most costly cases. This would ease the financial
10 burden for IRFs that have a relatively high share of these
11 cases. This was intended to be a short-term solution to
12 patient selection and coding issues, but it's only a kind
13 of rough justice. CMS needs to ensure that the IRF case-
14 mix groups adequately capture differences in patient acuity
15 and cost across cases and providers.

16 I will turn now to our review of payment adequacy
17 for IRFs. We have used our established framework that you
18 have seen in earlier presentations today. We will start by
19 considering access to care.

20 We first look at the supply of IRFs. In 2015,
21 there were about 1,180 IRFs nationwide, with more than
22 36,000 beds. IRFs tend to be concentrated in States that

1 have large Medicare populations, but each State and the
2 District of Columbia has at least one IRF.

3 As you can see in the facilities column on the
4 chart, only 22 percent were freestanding facilities.
5 However, because they tend to be larger and have more beds,
6 they accounted for almost half of Medicare discharges from
7 IRFs in 2015. The number of freestanding IRFs has been
8 growing, and the pace of that growth picked up in 2014 and
9 2015.

10 Overall, 30 percent of IRFs were for-profit
11 entities. These accounted for half of all cases in 2015.
12 The number of for-profit IRFs grew, on average, 4.6 percent
13 per year between 2013 and 2015.

14 This slide shows the number of IRF cases on a
15 fee-for-service basis. Beginning in 2004, tighter
16 enforcement of the 60 percent rule resulted in a
17 substantial drop in IRF volume. This drop was expected.
18 Tighter enforcement of the 60 percent rule was intended to
19 help ensure that beneficiaries who used IRFs really needed
20 that level of care. As a result, fewer lower-severity
21 cases, such as knee replacements, were admitted to IRFs.
22 But since 2008, you can see that use of IRF services has

1 been very stable. The number of cases per fee-for-service
2 beneficiary increased 1.7 percent in 2015.

3 To assess the quality of care furnished in IRFs,
4 we worked with a contractor to develop use six risk-
5 adjusted measures. Overall, we found that the measures
6 have been stable or improved since 2011. On average, IRFs'
7 patients gain almost 24 points in motor function during the
8 IRF stay and about 4 points in measured cognition.

9 The risk-adjusted community discharge rate was
10 about 76 percent, while the rate of discharge to SNF was
11 almost 7 percent.

12 We found that the risk-adjusted rate of
13 potentially avoidable readmissions during the IRF stay was
14 2.4 percent in 2015 and was 4.2 percent during the 30 days
15 after discharge. These rehospitalization rates are low
16 compared with those of other PAC settings, but that's not
17 unexpected. Remember that IRF patients are selected
18 because they can tolerate and benefit from intensive
19 therapy, which means they tend to be less frail than, say,
20 SNF patients, and IRFs are themselves certified as
21 hospitals.

22 Turning now to access to capital. As I noted

1 earlier, more than three-quarters of IRFs are hospital-
2 based units, which access needed capital through their
3 parent institutions. As you heard this morning, hospitals
4 maintained good access to capital markets in 2015 and 2016
5 due to hospitals' high level of profitability and continued
6 low interest rates.

7 As for freestanding IRFs, about half are
8 independent or local chains with a small number of
9 facilities. The extent to which these providers can access
10 capital is unclear. One large chain dominates the
11 freestanding IRF market, accounting for 46 percent of all
12 freestanding facilities in 2015.

13 Expansion of capacity through construction of new
14 IRFs reflects good access to capital for this chain. The
15 chain also acquired one of the nation's largest providers
16 of home health care in late 2014. This is part of a
17 vertical integration strategy that we are seeing in several
18 large post-acute care companies. The companies believe
19 that providing a continuum of post-acute services will
20 allow them to respond to reimbursement pressures and make
21 them desirable participants in coordinated care delivery
22 models and bundled payment arrangements.

1 In 2015, the Medicare margin increased more than
2 one point to 13.9 percent. As you can see, financial
3 performance varied across IRFs. The aggregate margin for
4 freestanding IRFs was 26.7 percent. Hospital-based IRFs
5 had an aggregate margin of 2 percent. There was a similar
6 spread between for-profit and nonprofit IRFs. Of course,
7 these two categories are highly correlated. Most
8 freestanding IRFs are for-profit. It's not shown on this
9 chart, but only 14 percent of freestanding IRFs are not-
10 for-profit. In 2015, the aggregate margin for these
11 freestanding nonprofit IRFs was 14 percent.

12 Why do we see such a disparity between hospital-
13 based and freestanding facilities? There a number of
14 factors at play; first, economies of scale. Hospital-based
15 IRFs tend to be much smaller than freestanding IRFs, and
16 they have fewer total cases. Their occupancy rates are
17 also somewhat lower.

18 Hospital-based IRFs are also far more likely than
19 freestanding IRFs to be nonprofit. So they may be less
20 focused on reducing costs to maximize returns to investors.

21 Recently, CMS began collecting data from IRFs on
22 the amount and type of therapy provided to patients. Our

1 preliminary analysis suggests that hospital-based IRFs may
2 provide more therapy to patients and use higher-cost
3 modalities, which could help explain their higher costs.
4 This is something we plan to look into further as more data
5 are available.

6 We also can't rule out unmeasured differences in
7 case complexity. We have noted differences in the mix of
8 cases in freestanding and hospital-based IRFs. Hospital-
9 based IRFs also have many more high-cost outlier cases,
10 which could in part reflect unmeasured case complexity.

11 Despite the comparatively low margins, Medicare
12 payments to hospital-based IRFs exceeded marginal costs by
13 a substantial amount, 20.5 percent in 2015. This compares
14 to a marginal profit of over 41 percent in freestanding
15 IRFs.

16 One last thing to note, IRF units may be
17 beneficial to their host hospitals. Our analysis has found
18 that acute care hospitals with IRFs have higher margins
19 than acute care hospitals without them.

20 Unlike most of the other providers MedPAC
21 analyzes, margins for IRFs increased in 2015, and we
22 project that they will continue to grow, albeit at a slower

1 pace. We project an aggregate Medicare margin of 14.3
2 percent for 2017. This projection includes the effects of
3 current law, such as the sequester and PPACA adjustments,
4 as well as statutory updates and changes to high-cost
5 outlier payments in 2016 and 2017. We assumed a historical
6 rate of cost growth that has been below market-basket
7 levels. Overall, we project that payment growth will
8 continue to exceed cost growth.

9 So, to summarize, we observe capacity that
10 appears to be adequate to meet demand. Our risk-adjusted
11 outcome measures are stable or improved since 2011. Access
12 to capital appears adequate. We estimate that the margin
13 was 13.9 percent in 2015, while marginal profit was 20.5
14 percent for hospital-based IRFs and 41.5 percent for
15 freestanding IRFs. We project a margin of 14.3 percent in
16 2017.

17 The Commission has recommended that the update to
18 IRF payments be eliminated for every year since fiscal year
19 2009. However, in the absence of legislative action, CMS
20 is required by statute to apply an adjusted market basket
21 increase; thus, payments have continued to rise. But
22 growth in costs per case has been low.

1 As you can see here, from 2009 to 2015, the
2 cumulative increase in payments per case was 14.2 percent.
3 Costs per case have grown just 8.3 percent. The gap
4 between payment and cost growth has been particularly wide
5 for freestanding IRFs.

6 In 2015, margins for freestanding IRFs reached an
7 all-time high of 26.7 percent. The aggregate margin for
8 IRFs in 2015 of almost 14 percent indicates that Medicare
9 payments substantially exceed the costs of caring for
10 beneficiaries.

11 So the Chairman's draft recommendation reads as
12 follows: For fiscal year 2018, the Congress should reduce
13 the Medicare payment rate for inpatient rehabilitation
14 facilities by 5 percent.

15 We don't expect this recommendation to have an
16 adverse effect on Medicare beneficiaries' access to care or
17 out-of-pocket spending. Even with a 5 percent reduction in
18 the payment rate, we project that the aggregate margin for
19 IRFs will remain above 8 percent. This recommendation may
20 increase the financial pressure on some low-margin
21 providers, but this effect would be eased by our
22 recommendation from 2016 that the high-cost outlier pool be

1 expanded.

2 You will recall that expanding the high-cost
3 outlier pool would reduce potential misalignments between
4 IRF payments and costs, so it would redistribute payments
5 within the IRF PPS. Currently, the outlier pool is set at
6 3 percent of total IRF payments. Expanding the outlier
7 pool to 5 percent would increase outlier payments for the
8 most costly cases. The expanded outlier pool would be
9 funded by an offset to the national base payment amount.

10 Reducing the payment rate for IRFs by 5 percent
11 and expanding the outlier pool from 3 percent to 5 percent
12 would decrease total payments to IRFs by 5 percent.
13 Because of the expanded outlier pool, the impact would be
14 smaller for hospital-based IRFs, nonprofit IRFs, and IRFs
15 with low margins.

16 And that concludes my presentation, and I'm happy
17 to take any questions.

18 DR. CROSSON: Thank you, Dana.

19 We have time for clarifying questions. I have
20 one myself, just a consequence of my own ignorance. So, if
21 you could turn to the slide -- and I have it in the packet
22 as No. 8 -- which has the motor score by paralysis -- that

1 one, yeah. So, in the paper, as I read it, these ratings
2 are based on a 91-point scale; is that correct?

3 MS. KELLEY: Well, these are motor scores.

4 DR. CROSSON: Right.

5 MS. KELLEY: Yes. Yes, it is.

6 DR. CROSSON: Right. So I think the question to
7 me -- and maybe, Bill, you could give some help here -- to
8 what degree are these differences clinically meaningful, A
9 and B? Are we -- irrespective of that, do we, in fact,
10 have a different kind of rehabilitation directed at the
11 patients without paralysis that might be inherently less
12 expensive than the types of rehab that are directed towards
13 patients with paralysis?

14 MS. KELLEY: So I'm not sure I understand your
15 question, but these are scores that are given based on
16 motor function deficits.

17 DR. CROSSON: Right.

18 MS. KELLEY: So they're not -- I'm not sure I --

19 DR. CROSSON: So on a 91-point scale -- I guess
20 my question is a clinical one -- how much difference is
21 there between 24.6 and 29?

22 MS. KELLEY: Ah. That depends on the case mix

1 group or the case type. Within each case type -- stroke,
2 brain injury, neurological conditions -- are several case
3 mix groups that are differentiated primarily on function
4 scores, although also sometimes age and comorbidity also
5 impacts that.

6 The difference between case mix groups within
7 each case type, it varies. So there's not necessarily --
8 having a 29.0 functional score in a stroke patient does not
9 necessarily -- although the level of functional impairment
10 is similar, the costs of dealing with that within a stroke
11 patient may be different from --

12 DR. CROSSON: Thank you, and that's what I was
13 getting at. Just thinking about it, as a former clinician,
14 one would imagine different -- Bill, do you want to help
15 me? -- different types of rehab directed at the stroke
16 patient with paralysis than at the stroke patient without
17 paralysis. Right?

18 MS. KELLEY: Well, yes, and that's a slightly
19 different question, I think, or maybe has a slightly
20 different answer. So a stroke patient without paralysis
21 may need far -- may need a different kind of care. They
22 may need, for example, gait training; they may need more

1 cognitive therapy. These indicate the motor scores, but
2 the real deficit for a patient without paralysis may be one
3 of cognition, in which case their therapy would be focused
4 more on that.

5 DR. CROSSON: Right, okay. But you can't make
6 any kind of global thought about the relative cost of the
7 two.

8 MS. KELLEY: No. I think you need to have more
9 than just the functional score information. It's also
10 relevant, the type of condition that they have and the
11 comorbidities they have as well.

12 DR. CROSSON: All right. Thank you. Bill, do
13 you want to comment on that?

14 DR. HALL: Yeah, I had trouble with --

15 MS. KELLEY: Can I interrupt for one second? I'm
16 sorry.

17 DR. HALL: Sure.

18 MS. KELLEY: I just want to clarify. But for
19 this particular example, these are all patients with
20 stroke.

21 DR. CROSSON: Yes.

22 MS. KELLEY: So one would assume that these

1 patients -- the 29.2 indicates a similar level of
2 impairment, and all the patients without paralysis --
3 obviously, people differ, but the standard of care one
4 would assume would be relatively similar.

5 DR. CROSSON: Okay. I think I understand. I'm
6 not sure.

7 DR. HALL: I had some of the same concerns about
8 Slide 8. I guess the reason that we're taking stroke is
9 that it's a -- we all feel we have an understanding of what
10 stroke is and that some had paralysis and some did not.
11 But there might be some impact of whether you were in a
12 low- or a high-margin institution. Do I have this right so
13 far?

14 MS. KELLEY: What this slide shows is that
15 patients in low-margin IRFs who have paralysis get a
16 similar functional score on average as a patient in a high-
17 margin IRF without paralysis.

18 DR. HALL: Right.

19 MS. KELLEY: We know that a patient without
20 paralysis typically has better function than a patient with
21 paralysis. So for them to get the same functional score
22 does seem unusual. Everything else equal about these

1 patients -- comorbidities, age -- the payment for these two
2 patients would be the same, even though patients without
3 paralysis have a length of stay that's two days shorter
4 than patients with paralysis.

5 DR. HALL: Okay.

6 MS. KELLEY: So on average, we're paying the same
7 for these two patients even though what we know about
8 patients with and without paralysis and what we know about
9 their conditions in general and the comorbidities, et
10 cetera, would suggest that their payment should not be the
11 same.

12 DR. HALL: So the only point I would make on this
13 is that if, in fact, the diagnosis was stroke and some did
14 not have paralysis, we don't have much granularity here.
15 For example, if I'm right-handed and I have a stroke and it
16 turns out to be on my left side, I will get better with
17 motor function very quickly or not have any at all, but my
18 ability to phonate, to express myself, and lots of other
19 things will be considerably impaired. So I guess what I
20 worry about this is this is kind of a -- if someone wanted
21 to attack us, they might say, well, this is really a
22 question not understanding the clinical implications of a

1 stroke that produces dominant motor features and one that
2 doesn't. So I'd be a little worried about it. That's all
3 I would say. And maybe I could think about this a little
4 bit more.

5 DR. MILLER: Can I add something here? When you
6 went through this last year, you looked at a couple other
7 conditions, too.

8 MS. KELLEY: Sure. We've looked at all the top
9 conditions, including neurological conditions. We looked
10 at lower extremity fractures as well.

11 DR. MILLER: And my second point was what I would
12 ask -- and, you know, there were patterns that you were
13 seeing that were similar. It was more was -- why are we
14 seeing this pattern consistently different between a high-
15 margin and a low-margin SNF? So even if for some reason
16 here selecting this example clinically, we weren't on top
17 of it as much as we might have needed to be, there was a
18 whole set of other things that she -- right, okay.

19 DR. HALL: There's ample evidence, right.

20 DR. REDBERG: With due respect, I don't think
21 it's likely that the difference in margins, there were also
22 differences in sides of strokes and dominance, and that's

1 pretty dramatic differences on a motor score. And I assume
2 the motor score, you told us what score was used. It's
3 computed by the facility or someone at the facility?

4 MS. KELLEY: The assessment is done by the
5 facility, yes.

6 DR. REDBERG: Yeah.

7 DR. CROSSON: Okay. Other clarifying -- better
8 clarifying questions?

9 MR. PYENSON: Thank you very much for your report
10 [off microphone]. We saw for both IRF and nursing home
11 that hospital ownership is associated with higher cost, and
12 I'm wondering if that is a cost allocation issue or if you
13 can tell the difference between how costs are allocated
14 versus something else. And, in particular, the issue of
15 the therapy involved -- and this is my ignorance. It's not
16 -- is therapy a cost driver?

17 MS. KELLEY: So taking your first question, I
18 don't know what the case is in SNFs. Carol would have to
19 address that. And in IRFs, we don't see the allocation
20 issues as being that large here. The major difference
21 between hospital-based and freestanding IRFs is in their
22 direct care costs. And, yes, therapy is a large driver of

1 the cost.

2 MR. PYENSON: So just a question on that therapy.
3 Of course, outpatient physical therapy is a relatively low
4 cost service. But in an inpatient setting, it's a
5 different therapy, so it's a different cost?

6 MS. KELLEY: In the inpatient setting, a major
7 driver of the costs are the therapy. There's not -- you
8 know, the other direct -- you know, there's nursing,
9 obviously, but it is a lower-cost service on an outpatient
10 basis, that is true. These patients usually, typically
11 receive up to about three hours a day of therapy.

12 MR. PYENSON: So a cost an hour of therapy I'm
13 thinking in the outpatient side might be -- Medicare might
14 pay \$100 or something in that order for that?

15 MS. KELLEY: Offhand I don't know.

16 MR. PYENSON: Okay.

17 DR. CHRISTIANSON: Other clarification questions?

18 [No response.]

19 DR. CHRISTIANSON: Everybody is clear. So we
20 should move on to the Chairman's recommendation and get
21 some feedback on that. Anybody want to comment
22 specifically on that? Obviously, it's a more aggressive

1 recommendation than the one we just talked about.

2 DR. NERENZ: I am probably going to be willing to
3 support this, although you already pick up the hesitation
4 in the comment. You know, the updates are always a blunt
5 instrument, and they just have to be because they apply
6 across the board, and that's just what it is. And so I'm
7 sort of willing to support it in the spirit of that's
8 what's in front of us. And given everything that we see,
9 this seems reasonable.

10 But I guess if we could flip back to Slide 5, I'm
11 wondering then somewhere in our near future work agenda,
12 this seems really important to me, because we see it here,
13 this difference in case mix expressed across these
14 different quintiles of margin. But it seems like you see
15 it woven through the issue of the hospital-
16 based/freestanding; you see it for-profit/not-for-profit.
17 It just keeps showing up over and over again. And I'm
18 wondering if -- well, I'll just express it, rather than the
19 blunt instrument, is there a less blunt instrument that,
20 say, the problem is really in the prospective payment
21 system. The problem is that we're paying too much for the
22 green bars and we're not paying enough for the orange bars.

1 Or maybe the two don't imply each other.

2 Now, that's not the issue in front of us, and I
3 understand that's not what we're being asked to debate.
4 But is that a direction we can talk about in the future?
5 Or are we already going down that path with our talks about
6 not only PPS here but the whole PAC system in general?

7 MS. KELLEY: So last year in your recommendations
8 to Congress, there was a discussion about the need to look
9 into variation in profitability across case types, so that
10 would address that very problem.

11 DR. NERENZ: Okay. So we've got that out there
12 already.

13 MS. KELLEY: It's something we've already talked
14 about, we've raised as an issue in the past, year.

15 DR. NERENZ: Okay.

16 DR. MILLER: But your instincts are right on
17 target. The other part of the --

18 DR. NERENZ: I'm not hallucinating?

19 [Laughter.]

20 DR. MILLER: The only good thing that's happened
21 today is we can now assign work to Commissioners, and what
22 I like about it is surprising them in public with it.

1 Your instincts are right. In addition to what
2 she said, there's also, don't forget, the outlier pool is
3 out there to do rough justice. But a reasonable question
4 might be: Why aren't we more in a granular way going
5 inside the payment system and analyzing where the PPS is
6 misfiring, like we did in SNF and like we did in home
7 health? And the problem is the granularity in the
8 classification here doesn't give us the same opportunity.
9 Is that a fair comment?

10 And so we are kind of stuck more with these blunt
11 instrument tools, but your instinct, exactly the same as
12 ours, and then as we got in there, it doesn't quite afford
13 you the same tools to get in and fix it.

14 And then, you know, like in other settings --
15 this is the last thing I'll say -- you know, you go into
16 the PPS, you realign what you're paying, then the dollars
17 flow in the directions that you're talking about to these
18 types of providers and not those types of providers, that
19 type.

20 DR. CHRISTIANSON: So, David, remind me, when you
21 started out, did you say you supported or not supported?

22 DR. NERENZ: Yes, I will, recognizing that it's

1 the blunt instrument that's in front of us, yea or nay, and
2 I just extended the thought.

3 DR. HOADLEY: Yeah, I do support this
4 recommendation, and I had, you know, even just reading the
5 chapter, before we saw the recommendations, definitely had
6 the thought that a negative recommendation -- a negative
7 update, you know, could make some sense. But I think,
8 again -- and you really just made this point -- last year's
9 two recommendations are going to be reprinted in this
10 chapter. They showed up. And we talked in the last
11 conversation about this introductory chapter, or whatever
12 you're going to call it, that will put it in the context of
13 the broader PAC system, broader strategy across these
14 different PAC elements. And I think that's part of what
15 creates the context for this to sit here, you know, this
16 isn't working, we have this -- you know, we have some
17 patchwork fixes, we have an update, but we also have a
18 vision for a larger change down the road that, you know, we
19 hope by design will work better.

20 DR. CHRISTIANSON: Yeah, I would agree with that.
21 Is that something, Mark, that you were contemplating?

22 DR. MILLER: Absolutely true [off microphone].

1 MS. BUTO: I would support the recommendation,
2 particularly in light of the fact that all of our payment
3 recommendations have basically not happened over the years.
4 At a bare minimum, this seems reasonable.

5 The other thing I would try to mention, because
6 I'm assuming this is going to fall under that umbrella
7 preamble that Jay was talking about, is we had a very good
8 discussion -- I think it was the year before last -- about
9 the interaction between SNFs and IRFs, and I think it was a
10 pretty granular discussion because there was a lot of talk
11 about whether, in fact, there was a subset of patients who
12 could, you know, easily be taken care of by SNFs or not and
13 how that might affect the IRF benefit.

14 I think a little bit of that has to be in there,
15 because we're going to be talking about all of these
16 entities together, and I still have some concern about
17 making sure that we aren't undermining really necessary
18 services that IRFs are providing at the same time that we
19 think there are some patients who could be adequately
20 treated in SNFs and paid more appropriately.

21 So all of this is woven together with revising
22 SNF PPS and eventually getting to a PAC PPS. But I hope

1 the overview will take care of that.

2 DR. GINSBURG: Yeah, I support the recommendation
3 as well and just have an observation that it's almost the
4 theme of the day that so many segments we've looked at in
5 the aggregate, their margins appear to be excessive. But
6 because of shortcomings in the payment system for the
7 distinct services, distinct types of patients, we're
8 hesitant because we're likely to drive margins too low for
9 some subsegments. That just reinforces the need to
10 overhaul our payment systems. But I think it's useful to,
11 you know, have some aggregate constraints almost to force
12 it.

13 DR. CROSSON: And as I mentioned before, I think
14 it would be eye-opening, hopefully for us and others, to
15 actually look at the amount of money in play here over a
16 multi-year period of time.

17 DR. REDBERG: I was just going to support the
18 recommendation as well, and also I wasn't sure with your
19 last comment whether you were suggesting -- but if you
20 were, I would support it -- to include in the text in this
21 chapter also an estimate of how many billions of dollars
22 have been spent because of the failure to heed previous

1 MedPAC's recommendations on the payment updates for IRFs.

2 DR. CROSSON: So just to be clear, what I was
3 proposing, that we actually have a mini chapter before the
4 PAC chapters that brings it all together.

5 DR. REDBERG: Okay.

6 DR. CROSSON: But it's up to the staff as to how
7 to do this, but essentially, you know, could present an
8 overall view of how much extra money is being spent across
9 the post-acute-care segments, both by the program and by
10 beneficiaries, at least as a consequence of, you know,
11 failure to implement the recommendations that we've had on
12 the table over a significant period of time. So it would
13 be part of that.

14 DR. REDBERG: And the other point perhaps is
15 because there seemed to be clear differences in the margins
16 between freestanding and hospital-based IRFs, whether we
17 would want to have a more negative update or some other
18 kind of corrective action.

19 DR. CROSSON: Right. If I understand what you're
20 saying -- and I agree with that -- it is that as Paul was
21 saying, when the payment system is revised, it's revised in
22 such a way that takes account of that.

1 DR. REDBERG: When it is revised [off
2 microphone].

3 DR. CROSSON: Yeah.

4 DR. CHRISTIANSON: But I think to Bruce's point,
5 I'm not sure we know how much of that difference is a
6 result of differing allocations of fixed costs in hospital-
7 based IRFs versus freestanding. So that complicates, I
8 think, what you just said.

9 DR. MILLER: I took her point and your response
10 differently, but I may have missed it, so I took that
11 exchange as if you had a unified assessment instrument that
12 allowed you to then in turn create a unified payment
13 system, you would be moving to this rebalancing across the
14 PPS. You would have a new PPS system, next paragraph and
15 next thought, by the way, that moves dollars around between
16 freestanding and hospital-based and not-for-profit and for-
17 profit and that type of thing, as opposed to, well, I'm
18 going inside each of those entities and figuring out their
19 fixed and variable costs. That's the way I took their
20 exchange.

21 DR. CROSSON: Okay. So while I -- yes, David.

22 DR. NERENZ: Just one more point to add to that,

1 because we see it over and over again, this issue of the
2 cost allocation. We've already seen it a couple times.
3 We're going to see it again in home health, this issue of
4 the hospital-based. Sometime or other it would be nice if
5 we could actually see examples of that, and I'm not quite
6 sure how you get at it. Maybe it's site visits, maybe it's
7 case examples. But, you know, we talk about it as a
8 plausible thing. We have indirect evidence of it. I guess
9 I'd like to see it directly somehow, if we could. I'd like
10 to see an example of somebody's cost report or something
11 that says here's a freestanding and here's the
12 administrative cost, tunk, tunk, tunk, tunk, tunk. Here's
13 hospital-based or hospital-owned, same size, same
14 similarity. Here are the administrative costs allocated,
15 tunk, tunk, tunk, tunk, tunk. Much bigger number, much
16 longer list. I want to see what the difference is. Is
17 there any way we could do that? Because this -- every year
18 we see this. It doesn't go away.

19 DR. MILLER: Yeah, and remember, some of it is --
20 just like the exchange we had here, some of it is which
21 types of patients they take and what the PPS we're doing.
22 And then I think what you're saying is beyond that, what

1 would the cost structure look like?

2 So what my recollection is is that a number of
3 years ago -- yeah, okay.

4 DR. CARTER: Right. So we didn't find -- we've
5 looked at this issue, and there are not cost allocation
6 issues for both SNF and IRF, and at least in the SNF
7 sector, they have -- hospital-based have higher costs per
8 day, and it's higher costs across the whole variety of cost
9 categories. And it includes things like rounding on
10 patients and not stopping orders on ancillary tests and
11 labs and drugs and therapy and you name it. So it's really
12 a higher cost. And, you know, they have -- they pay their
13 nurses more typically, at least in the SNF setting. So
14 it's higher costs kind of across the board, and it's not a
15 cost allocation issue.

16 DR. NERENZ: Okay. Although -- again, I'd have
17 to go flip to the chapter -- I think it's at least maybe
18 mentioned in passing. Maybe it's in the home health that
19 we see it more clearly. It just seems like even in past
20 years it has come up fairly frequently.

21 But even what you just said is actually quite
22 helpful, and I think to the extent any of those examples

1 could just be popped into the chapter, that would help,
2 because then people could see much more clearly where it is
3 or is not happening, both ways.

4 DR. CROSSON: Okay. Thank you. So, again, while
5 I missed some of this, I did get the sense when I came back
6 -- I got a lot of different impressions when I came back
7 in. But one of them was that there was general agreement
8 here in support for this, and so we will put it into the
9 category of facilitated, expedited presentation and vote in
10 January.

11 Thank you, Dana.

12 Our last discussion for today is home health care
13 services, payment update. It's going to be presented by
14 Evan Christman, who used to be named Zach, as I remember,
15 but that was a while ago.

16 Evan, you have the floor.

17 MR. CHRISTMAN: Good afternoon. Now we will
18 review the framework as it relates to home health.

19 Just a brief summary here. This presentation is
20 going to have three parts. I'm going to do a brief
21 overview of the benefit, a brief review of the recent
22 issues the Commission has noted with home health, and then

1 we'll proceed to the payment adequacy framework.

2 As an overview, Medicare spent \$18.1 billion on
3 home health services in 2015. There were over 12,300
4 agencies. The program provided about 6.6 million episodes
5 to 3.5 million beneficiaries.

6 Here are some of the issues that we flagged in
7 prior years. First I would note that home health is an
8 effective service when appropriately targeted, and can be
9 an important service for serving frail, community-dwelling
10 Medicare beneficiaries. However, eligibility for the
11 benefit is poorly defined and does not encourage efficient
12 use. As I will note in a minute, there has been rapid
13 growth in episode volume, which raises particular concerns
14 in the current fee-for-service environment that rewards
15 providers for additional service.

16 The benefit also has an unfortunate trend of
17 program integrity problems. There has been significant
18 recent activity on this front, including a moratorium on
19 new provider enrollment and some areas and efforts to
20 implement a pre-claims review process. The Secretary and
21 the Attorney General have made a number of efforts to
22 address fraud in this benefit, but many patterns of unusual

1 utilization suggestive of fraud remain.

2 We have also noted significant geographic
3 variation and utilization, which program integrity and the
4 poor definition likely contribute to.

5 In terms of the payment system the Commission has
6 noted two problems. First are issues with the incentives
7 in the current system. The current PPS uses the number of
8 therapy visits provided in an episode as a payment factor.
9 Payments increase as more therapy visits are provided in an
10 episode, sometimes increasing by hundreds of dollars for a
11 single additional visit. The share of episodes qualifying
12 for these payments has increased ever year under the PPS.
13 This trend, and the fact that more profitable HHAs tend to
14 favor therapy episodes, raised concerns that financial
15 incentives of the payment system may be influencing the
16 type of care provided.

17 The second issue is the high level of payments.
18 Medicare has overpaid for home health since the PPS was
19 established in 2000. The fact that home health can be a
20 high-value service does not justify the excessive
21 overpayments. As discussed in the paper, Medicare margins
22 have averaged better than 16 percent in the 2001 to 2014

1 period. These overpayments do not benefit the beneficiary
2 or the taxpayer.

3 As a reminder, rebasing is a payment reduction
4 for home health in PPACA designed to bring payments more in
5 line with costs. While PPACA intends to lower payments, we
6 have been concerned that the reductions are too small and
7 this table shows why.

8 Every year rebasing will reduce payments by about
9 \$81 an episode, or 2.8 percent. However, this decrease
10 will be offset each year by a payment update of about 2.1
11 percent that will add back much of what is cut. Across the
12 years, the net payment reduction for the 60-day episode
13 will be about 3 percent. As I will report in a few slides,
14 margins have remained substantial in 2014 and 2015, despite
15 these reductions. And I would note that these are only
16 cuts to the base rate. Agencies have historically been
17 able to offset payment cuts like these by keeping cost
18 growth low and increasing average payment by focusing on
19 more profitable therapy services.

20 As a reminder here is our framework. It is the
21 same one other sectors have followed in earlier
22 presentations.

1 We begin with supply. As in previous years, the
2 supply of providers and the access to home health appears
3 to be adequate. Ninety-nine percent of beneficiaries live
4 in an area served by one home health agency, and percent
5 live in an area served by five or more.

6 Turning from access to supply, the number of
7 agencies was over 12,300 by the end of 2015. There was a
8 net decline of 115 agencies in 2015, but we're still near
9 the all-time high of providers, hit in 2013. And the
10 decline is concentrated in a few areas, such as Texas,
11 Florida, and Michigan that have been the target of efforts
12 to reduce fraud. These areas that experienced rapid higher
13 utilization in growth and supply in previous years.

14 Overall, the supply of agencies in 2015 was 63
15 percent higher than 2004.

16 Next we look at volume. Episode volume in 2015
17 increased slightly. The small increase in 2015 reverses
18 the trend of modest declines we have seen observed since
19 2011. The number of users and the share of fee-for-service
20 beneficiaries using the benefit increased slightly, while
21 the number of episodes per user decreased slight, and total
22 payments increased by 2.3 percent to \$18.1 billion.

1 This figure gives you a sense as to how
2 utilization has changed since 2002. Turning first to the
3 yellow line, the national average, you can see that
4 utilization increased through 2011, and has declined
5 slightly in subsequent years, with a small uptick in 2015.
6 The other two lines split the 50 states into two groups for
7 this period. The top line shows the trend for the five
8 states with the biggest decline in utilization since 2011.
9 As you can see, these states grew substantially faster than
10 the rest of the nation prior to 2011.

11 The dotted line at the bottom shows utilization
12 in the other 45 states. As you can see utilization grew
13 relatively fast through 2011, and since then growth has
14 been more incremental.

15 Overall this graph suggests that the decline in
16 volume since 2011 has been concentrated in areas that
17 previously had experienced high growth, and home health
18 utilization in most of the county has increased since 2011.

19 The paper includes a more detailed discussion of
20 utilization changes in 2011 through 2015, and I can speak
21 to that on question.

22 Our next indicator is quality. The first rows

1 show the risk-adjusted rates of functional improvement.
2 Across the years, you can see that the rates of functional
3 improvement for transferring and walking have increased on
4 an annual basis. In contrast, hospitalization rates have
5 been flat in 2004 through 2014, but for the first time show
6 a decline in 2015.

7 I would note two key cautions about these data,
8 first that they represent self-reported information from
9 agencies and may reflect variation in agency assessment
10 practices, and second, functional data is only collected
11 for the subset of patients that are not hospitalized, and
12 this may bias the functional improvement measures.

13 Next we look at capital. It is worth noting that
14 home health agencies are less capital intensive than other
15 health care providers. Also few are part of publicly
16 traded companies. In general, financial analysts have
17 concluded that the publicly traded agencies have adequate
18 access to capital, and we have seen a recent uptick in
19 acquisition activity. For example, Almost Family bought
20 Community Health, LHC Group expanded its supply of
21 providers, and the big action this year was that Kindred
22 bought the second-largest home health company in the

1 country, Gentiva. All of these activities suggest that
2 companies have adequate access to capital for entry or
3 expansion.

4 Before we turn to margins, I want to frame the
5 issue and remind commissioners about recent trends in costs
6 and payments. The average payment per episode has
7 increased in 2015, and it is higher than the level prior to
8 rebasing in 2013. Despite the cuts to the market basket,
9 the average payments have increased because agencies are
10 billing for a higher level of case-mix. A major
11 contributor to this phenomenon of higher-billed case-mix is
12 a problem with the PPS I mentioned earlier. Agencies can
13 raise their payments by providing more therapy visits in an
14 episode. In effect, under the current payment system,
15 agencies can offset cuts to the base rate by providing more
16 therapy visits to push up payments.

17 The story with costs has also been favorable. In
18 general, cost growth varies from year to year, with some
19 variability, but on average it has been low, with a 5-year
20 trend of -0.1 percent. The ability to increase payments
21 while keeping costs has been a cornerstone of the high
22 margins we have observed.

1 Turning to 2015, we can see that margins were
2 15.6 percent for free-standing providers. The trend by
3 type of provider is similar to prior years, with for-
4 profits having better margins than nonprofits, and urbans
5 having higher margins than rurals, but the differences are
6 relatively small.

7 The marginal profit for home health agencies was
8 18.1 percent in 2015. I would also note that these data
9 rely upon the home health cost report. CMS audited a
10 sample of 2011 cost reports and found that costs were
11 overstated by 8 percent. If reported margins were adjusted
12 for this error, our home health Medicare margins for 2011
13 would have exceeded 20 percent. While it is speculative to
14 apply the 8 percent to other years, the results suggest
15 that the margins we report for home health could be higher.

16 Data for 2014 and 2015 allow us to assess the
17 financial impact of the first two years of rebasing.
18 Recall that the Commission has been concerned that PPACA
19 rebasing would not adequately address overpayments, and the
20 margin results for 2014 and 2015 bear this out. Margins in
21 2015, the second year of rebasing, are almost three
22 percentage points higher than 2013, the year before the

1 rebasing reductions went into effect. The double-digit
2 margins we report for these two years contrast with an
3 earlier estimate of the policy's impact produced by the
4 home health industry. In 2013, an industry analysis
5 projected that the first two years of rebasing would look
6 significantly worse than the actual reported financial
7 performance. The analysis projected that margins for 2014
8 would be 5 percent and margins for 2015 would be a half-
9 percent, and this obviously contrasts with the actual
10 results for these years.

11 This year we also examined the performance of
12 relatively efficient home health agencies. Recall that we
13 define relatively efficient providers as those that are in
14 the lowest third of providers of cost, or the best
15 performing third of providers for quality, without having
16 extremely low performance on either measure. About 15
17 percent of agencies met this standard.

18 Relatively efficient providers had a median cost
19 per visit that was 12 percent lower than other agencies,
20 and Medicare margins that were 11.8 percentage points
21 higher. Relatively efficient providers were typically
22 larger in size, with the median efficient provider about 28

1 percent larger than the median for other agencies.
2 Relatively efficient providers had lower hospitalization
3 rates, they provided about the same mix of nursing, therapy
4 and aide services to their patients, and they also
5 delivered similar numbers of outlier and low-use episodes.
6 However, efficient providers tended to serve a more urban
7 mix of patients compared to the mix of patients served by
8 other providers.

9 We estimate margins of 11.1 percent in 2017.
10 This is a result of several payment and cost changes.
11 There is a 3 percent add-on in effect for rural areas in
12 both years. The base payments will decrease slightly to
13 reflect rebasing required under PPACA. There will also be
14 an adjustment for case-mix growth.

15 We assumed cost-growth of one-tenth of one
16 percent in 2016 and 2017, and also assumed nominal average
17 payment growth of 1 percent a year. These are close to
18 recent trends, but assume that payment growth will be a
19 little lower than observed in 2015, and cost growth will be
20 a little higher than the five-year average.

21 Turning back to our framework, this is a summary of
22 our indicators. Beneficiaries have good access to care.

1 The number of agencies has reached 12,300. The number of
2 episodes and users increased slightly in 2016 -- excuse me,
3 in 2015. Quality measures have improved in 2015, access to
4 capital is adequate, and the margins for 2015 are 15.6
5 percent, agencies had a margin profit of 18.1 percent, and
6 the estimated margins for 2017 are 11.1 percent. And
7 again, these are average margins, and our review of the
8 quality and financial performance for efficient providers
9 suggests that better-performing agencies can achieve better
10 outcomes with profit margins that are significantly higher
11 than other agencies.

12 This brings us to the draft recommendation for
13 2018. This recommendation has two parts. First, we're
14 going to bring the level of payments down, and end the use
15 of therapy as a payment factor, which would be budget-
16 neutral but redistributive.

17 The recommendation reads that Congress should
18 reduce payments by 5 percent in 2018, and implement a two-
19 year rebasing of the payment system, beginning in 2019.
20 The Congress should direct the secretary to revise the PPS
21 to eliminate the use of therapy visits as a factor in
22 payment determinations, concurrent with rebasing.

1 The impact of this change would be to lower
2 spending relative to current law. The impact to
3 beneficiaries should be limited, and it should not affect
4 most providers' willingness to serve beneficiaries.
5 Eliminating therapy as a payment factor would be budget-
6 neutral in aggregate, but redistributive among providers.
7 Nonprofit agencies would see their aggregate payments
8 increase, while for-profits would see a decrease.

9 This completes my presentation. I look forward
10 to your questions.

11 DR. CROSSON: Thank you, Evan. So we are open
12 for clarifying questions. Kathy.

13 MS. BUTO: So, Evan, the -- in terms of rebasing
14 and eliminating use of therapy visits, so what we would do
15 or what we would recommend they do is take some kind of
16 average of therapy visits that's provided and build that
17 right into the episode payment? I mean, how would you --

18 MR. CHRISTMAN: I guess the --

19 MS. BUTO: -- how would you go about doing that,
20 exactly?

21 MR. CHRISTMAN: I mean, I guess it's -- the
22 easiest way I could explain this is right now the case-mix

1 system uses your -- sets your payment using your clinical
2 and functional characteristics and the number of visits,
3 and we would simply eliminate the part that uses the number
4 of visits and set payment for all -- right. So we're going
5 to a sort of a fully perspective system.

6 DR. CROSSON: Jack.

7 DR. HOADLEY: You talked briefly about this rural
8 add-on, and I saw in the chapter you talk about it expiring
9 and in a sense this has more targeted approaches to limit
10 rural add-on payments to areas with access problems should
11 be pursued. Is that something that we're exploring more,
12 or is it more in the context of if there's a problem with
13 rural then something different than the expiring approach
14 would be the way to go?

15 MR. CHRISTMAN: I think the -- our basic point
16 has been that if you think there's an access problem you
17 should come up with a more targeted policy, you know, as
18 the paper goes through. You know, it's basically a volume-
19 based add-on, so higher-volume areas do better and low-
20 volume areas do much worse, and obviously more targeted
21 policy would seek to flip that. We've talked about it in
22 other settings.

1 I think, you know, from our perspective, 99
2 percent of beneficiaries live in a ZIP served by home
3 health. Generally we think access is pretty high. Again,
4 if people can identify specific locales they want to
5 target, then that's, I think, what we're implying, is
6 that's what the policy should focus on.

7 DR. HOADLEY: But otherwise we're not really
8 identifying a particular access problem in rural areas.
9 So, okay. Good.

10 DR. CROSSON: Questions?

11 Seeing none, we will move ahead with the
12 discussion of the recommendation. Could we have the
13 recommendation slide, Evan?

14 The recommendation is before you. It has several
15 pieces.

16 Discussion. Craig.

17 DR. SAMITT: So I support the Chairman's
18 recommendation, although I have to admit, I don't know
19 about the rest of you, I'm having déjà vu as we have this
20 discussion. So I guess I ask, you know, we've made these
21 recommendations, it feels like it's the fifth year in a
22 row, but they don't get adopted. So I'm just wondering if

1 we're missing something that we should be discussing that
2 we're not discussing.

3 DR. CROSSON: Well, I don't know that we're
4 missing anything --

5 DR. SAMITT: It's a rhetorical question.

6 DR. CROSSON: -- in terms of the thoroughness of
7 the analysis or the rightness of the recommendations. I
8 think what's missing is pressure outside to implement the
9 recommendations and save money for the program and for
10 beneficiaries. That's one of the reasons I agree with you,
11 not just here, but having sat and read through all of
12 these, one who has been on the Commission for a while, as
13 you have, comes to the conclusion that, well, maybe we need
14 to step up the volume or something, which is in part why
15 we're proposing to create this additional pre-chapter,
16 which draws together the impact of our recommendations,
17 what they could have been, what they could be in the
18 future, and it kind of sums it all up in terms of the
19 impact on the Federal Treasury and the impact on
20 beneficiaries over time.

21 Having said that, we still exist in a political
22 process, and with respect to CMS, the situation where I

1 think, in many ways, they struggle with all the priorities
2 that they've been given and the time and resources that
3 they have available to do the work. But our notion so far
4 here is to just be a little louder than we've been.

5 MR. CHRISTMAN: I guess the one point I would
6 just say, Craig, sometimes it is a game of inches. I guess
7 the point I would just make is the latter part about
8 eliminating the therapy visits. We've been recommending
9 that for five years, and the good news is that literally
10 this week, CMS released a draft payment system for review
11 that in fact does that, and while it's not always
12 encouraging to bring the same recommendation back every
13 year, they're in a better position to implement this
14 recommendation than they've ever been, so that's some
15 progress.

16 DR. CROSSON: Rita.

17 DR. REDBERG: I just would note, as you showed on
18 Slide 15, CMS obviously gets impact from industry on all of
19 these recommendations, and industry's projections were
20 wildly off, as compared to ours, which were not, but I'm
21 sure that's part of the pressure on CMS, recommendations
22 from industry which clearly has financial interest in their

1 own projections on the impact of rebasing. But they were
2 really off.

3 DR. CROSSON: Yeah. We have noticed over the
4 years some occasional difference of opinion between various
5 parts of the industry and the Commission in terms of both
6 facts and policy.

7 Pat.

8 MS. WANG: I'm good with the recommendation.
9 Just a small thing with the awareness, this is a deja vu
10 scenario, so maybe it doesn't make that much difference. I
11 liked the specificity and the way that this recommendation
12 was worded about the timing and would encourage us to think
13 about doing something similar for the SNF recommendation
14 about the timing of implementing PPS, whether or not people
15 listen. But I liked that this was very specific that
16 rebasing should start in 2019, et cetera.

17 DR. CROSSON: Jack.

18 DR. HOADLEY: I support the recommendation, and I
19 just wanted to reemphasize one point you made in talking
20 about the mini chapter, pre-chapter, or whatever. Each
21 time you've said it, I think you've been very careful to
22 say there's potential lack of savings or uncaptured savings

1 for the program, the taxpayer, as well as the
2 beneficiaries. Now, it's not as relevant in this
3 particular sector as the others, but I do think that's an
4 important point that doesn't always get heard in these
5 discussions. It feels like this is all about the program
6 versus the providers, but there's a beneficiary piece to it
7 too.

8 DR. CROSSON: David.

9 DR. NERENZ: I guess I'm going to express the
10 same concerns I had just the last time about this as a
11 blunt instrument, the recommendation. I will support it,
12 but I feel much more comfortable as it applies to the
13 freestandings than I do as it applies to the hospital-
14 based.

15 In the chapter, although I don't think you had it
16 in one of the slides, we have margins right now of negative
17 15 percent for the hospital-based home health agencies, and
18 the text goes on to say, well, that's because they have
19 higher costs, and it's because the hospitals allocate
20 costs. So all the questions I had last time, I think,
21 really apply here in spades.

22 I'd really like to see that laid out because the

1 implication is, well, the hospital home health agencies are
2 perhaps wasteful, they're inefficient, they're just a way
3 of allocating cost, so they don't show up someplace else.
4 But I'm not sure I really believe that or I'm comfortable
5 with that, and particularly, what we saw last time about
6 the case mix, I'd at least like to see the case made in
7 more detail that these folks are really doing the same
8 work, but they're not doing it as well, and so it's okay to
9 hit them with a 5 percent cut as well. I really do worry
10 about that because I think we saw some signals in the prior
11 section that maybe they're not doing the same work. Maybe
12 they're not taking care of the same patients, and maybe
13 this cost allocation thing is not as clear an explanation
14 for the difference.

15 So if we're going to hit everybody with 5
16 percent, I really, really would like to make sure that
17 we're not hitting the hospital-based programs too hard
18 because I'm afraid we are.

19 DR. MILLER: So it's been a while since I've
20 thought about it. The change in PPS does move money in
21 direction of the hospital-based. So I would amend -- not
22 that you would want me to, but I would amend your comment.

1 I think there are two things always going on. We
2 do think there is some difference in the patients, and if
3 they would undertake the PPS, that would move dollars in
4 the direction of the hospital-based, and when you look at
5 the cost structure, the cost structure is higher there.
6 And we can try and drill down on that and be more precise
7 about it.

8 DR. NERENZ: And I do appreciate that because
9 also we've seen this in a couple other places, where this
10 is one thing, but then there are a couple of things that
11 are not in the recommendation, like about a rebasing or
12 about a shift of PPS that has the effect of countering an
13 adverse effect I'm concerned about. And I think as long as
14 that's articulated very clearly in the report and maybe
15 just go on to say yes, this 5 percent cut really is going
16 to hit these hospital-based programs where they're already
17 negative, but this other help is coming in this form or
18 this form. I'd like that a little better.

19 DR. MILLER: Okay. And we do mention the PPS
20 thing in the recommendation, right? Should direct the
21 Secretary to --

22 MR. CHRISTMAN: Right. It's the second clause.

1 Yep.

2 DR. MILLER: Yeah.

3 MR. CHRISTMAN: I think we can outline a little
4 bit more explicitly, the shift in payments that occurs
5 under some of the revised PPSs. The shift of dollars to
6 the facility-based providers is quite significant.

7 DR. NERENZ: And maybe it's just the fine point
8 connection that that's a fairly generic wording, but to say
9 if this was actually done as recommended, it would have
10 this effect of shifting some dollars to the hospital
11 programs.

12 DR. CROSSON: We can make that clearer.

13 DR. NERENZ: That's the connection.

14 DR. MILLER: Absolutely.

15 DR. CROSSON: Pat.

16 MS. WANG: This is related to David's comment,
17 and maybe it's for the mini chapter. I don't really see
18 this as just about saving the program money. I think that
19 the other very important thing that's being discussed here
20 is ensuring that payment is targeted appropriately and is
21 providing proper incentives particularly for people to take
22 care of folks who are more complex, because that is a theme

1 that has run throughout, whether it's the IRF or the SNF or
2 home health, that there is some confluence of I'm a type of
3 provider or I'm whatever that is taking care of a more
4 complex patient, and my payments are somehow not matching
5 costs.

6 So I would just urge us in the mini chapter to
7 stress that it's not just about saving green dollars, but
8 it's also the recommendations are intended to really ensure
9 that the proper incentives are in place to take care of
10 people who really have needs.

11 DR. CROSSON: That's a good point, Pat. Somehow
12 we're focusing on payment, and so we tend to spend a lot of
13 time on that. You have done this before, each time
14 correctly, which is to remind us that there is more at
15 stake here. And to the extent that the payment system is
16 having an unintended negative effect on quality for
17 beneficiaries, that's at least as important.

18 DR. MILLER: And to the comments that Craig was
19 making, like why doesn't it happen -- and this comment has
20 no rational endpoint -- I've always been frustrated by the
21 fact that why that portion of the industry that would, in
22 fact, benefit from these changes and are taking these

1 patients doesn't peel off from their associations and say
2 why isn't this happening, but that was worth all you paid
3 for it, so I'll stop.

4 DR. CROSSON: Okay. Seeing no further comments,
5 again, I'm assuming that we have support for the
6 recommendation. Therefore, in January, we'll come forward
7 with an expedited presentation and vote.

8 Thank you to Commissioners for what has been a 9-
9 hour activity here. Everybody has done a fabulous job from
10 my perspective of staying on point and helping us get to
11 where we need to get to.

12 Now, before we leave, we have time for the public
13 comment session. If there are those of you in the audience
14 who would like to make a public comment, please come to the
15 microphone now, so we can see who you are, how many there
16 are.

17 [No response.]

18 DR. CROSSON: Seeing none, thank you. We are
19 adjourned until 8:30 tomorrow morning.

20 [Whereupon, at 4:57 p.m., the meeting was
21 adjourned, to reconvene at 8:30 a.m., Friday, December 9,
22 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
SUSAN THOMPSON, MS, RN
PAT WANG, JD

B&B Reporters
4520 Church Road
Hampstead, Maryland 21074
410-374-3340

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P R O C E E D I N G S

[8:30 a.m.]

1
2
3 DR. CROSSON: Okay. We're going to begin on time
4 this morning. Welcome, everyone. We're going to resume
5 our discussion of payment updates this morning. We'll have
6 three presentations.

7 For our guests from the public, I just want to
8 make a couple of comments. Many of you I can see are
9 veterans. Some of you are not. By law, once a year -- in
10 this case in December and January -- the Commission makes
11 payment recommendations, generally to the Congress, for
12 areas in which Medicare is the payer. We do that two
13 months in a row, make the recommendations, submit the
14 recommendations for discussion in December and then again
15 in January. That's to give the Commission time for due
16 consideration as well as information for the public so that
17 they're aware of what we're doing and provide feedback as
18 appropriate.

19 It has been the custom over the last few years --
20 I think the recognition has been that in some cases the
21 discussion may lead the Commission to a general consensus
22 here at this meeting in December -- that's not uncommon,

1 has not been uncommon so far in this meeting -- in which
2 case we will not repeat the whole presentation, the whole
3 discussion prior to the vote in January, but we'll have an
4 expedited presentation and an expedited vote in January if
5 at the end of the discussion it is evident that the
6 Commission is in agreement with the recommendation that
7 comes at the end of the presentation.

8 So the other point I'd like to make, because
9 sometimes questions come up, is with respect to the
10 recommendations in what way do we consider the sequester
11 which is currently in place, and the sequester, for your
12 information, is already under consideration and is built
13 into the recommendations that you will see.

14 So, with that, we will begin the first
15 presentation. We're going to be discussing payment updates
16 for outpatient dialysis services, Nancy Ray and Andrew
17 Johnson. Who is going begin? Nancy, take it away.

18 MS. RAY: Good morning. Outpatient dialysis
19 services are used to treat most patients with end-stage
20 renal disease. In 2015, there were about 388,000 Medicare
21 fee-for-service dialysis beneficiaries treated at roughly
22 6,500 facilities. Total Medicare spending was about \$11.2

1 billion for dialysis services.

2 During today's session, we will be providing you
3 information about the adequacy of Medicare's payments for
4 outpatient dialysis services. To examine payment adequacy,
5 we use a common framework across all sectors. When data
6 are available, we look at the factors listed on this slide,
7 which include examining beneficiaries' access to care,
8 changes in the quality of care, providers' access to
9 capital, and an analysis of Medicare's payments and
10 providers' costs.

11 We look at beneficiaries' access to care in this
12 sector by examining industry's capacity to furnish care as
13 measured by the growth in dialysis treatment stations.
14 Between 2014 and 2015, growth in dialysis treatment
15 stations grew slightly faster than beneficiary growth.
16 Between 2014 and 2015, more facilities opened than closed;
17 there was a net increase of roughly 150 facilities. This
18 net increase included for-profit facilities, freestanding,
19 as well as facilities located in rural and urban areas.
20 Few facilities closed. The roughly 70 facilities -- about
21 1 percent -- that closed were more likely to be hospital-
22 based and nonprofit compared to all other facilities. Few

1 patients -- less than 1 percent -- were affected by these
2 closures. There is no indication that affected patients
3 were unable to obtain care elsewhere.

4 Another indicator of access to care is the growth
5 in the volume of services. We track volume growth by
6 assessing trends in the number of dialysis fee-for-service
7 treatments and dialysis beneficiaries. Between 2014 and
8 2015, the total number of dialysis beneficiaries grew by 1
9 percent while total treatments grew by 0.4 percent.
10 Between 2014 and 2015, we do see a slight decline in the
11 non-annualized number of treatments per beneficiary.
12 However, the number treatments per beneficiary steadily
13 increased between 2009 through 2014, and the rate in 2015
14 is greater than the rate in earlier years -- between 2009
15 through 2011. We will reexamine this measure in next
16 year's analysis to see how it trends. And as I'll show you
17 in a moment, quality indicators for 2015 are trending in
18 the positive direction.

19 We also look at volume changes by measuring
20 growth in the volume of dialysis drugs furnished. Dialysis
21 drugs are an important component of care. Since the PPS
22 was implemented in 2011, dialysis drugs have been included

1 in the payment bundle. Consequently, providers' incentive
2 to furnish them -- in particular, erythropoietin
3 stimulating agents -- has changed. ESAs are the leading
4 dialysis drug class in terms of utilization. Before
5 implementing the dialysis PPS in 2011, there were both
6 clinical reasons and financial ones for their overuse. As
7 anticipated, after the PPS, ESA use went down
8 significantly. Between 2010 and 2014, use of ESAs declined
9 by 45 percent per treatment. This outcome was expected and
10 desired and has occurred according to researchers with some
11 positive changes to beneficiaries' health status. Most of
12 the decline occurred during the initial years -- 2011 and
13 2012 -- of the PPS. Between 2014 and 2015, ESA use
14 declined. In addition, in recent years we are seeing a
15 shift in beneficiaries being switched to lower-cost
16 products.

17 Next, we look at quality by examining changes
18 between 2011, the first year of the PPS, and 2015.
19 Mortality, admissions, and readmissions are trending down.
20 The percent of dialysis beneficiaries using home dialysis,
21 which is associated with improved quality of life and
22 patient satisfaction, has modestly increased from a monthly

1 average of 9 percent in 2011 to nearly 11 percent in 2015.

2 However, the rate of growth between 2014 and 2015
3 has slowed. Your mailing materials discuss a shortage that
4 began in the fall of 2014 and continued through 2015 of the
5 solutions necessary to perform one type of home dialysis.
6 One indicator that measures how well the dialysis treatment
7 removes waste from the blood -- dialysis adequacy --
8 remains high.

9 Regarding access to capital, indicators suggest
10 it is adequate. An increasing number of facilities are
11 for-profit and freestanding. Private capital appears to be
12 available to the large and smaller-sized chains. In 2016,
13 a mid-sized chain went public. Since 2011, the two largest
14 dialysis organizations have had sufficient capital to each
15 purchase a mid-sized dialysis organization as well as
16 physician services organizations.

17 So moving to our analysis of Medicare payments
18 and costs, in 2015 the Medicare margin is 0.4 percent. The
19 biggest difference across freestanding facilities is the
20 difference between rural and urban facilities. The
21 aggregate Medicare margin for rural facilities, which
22 account for about 20 percent of facilities, is negative 5.1

1 percent. The lower Medicare margin for rural facilities is
2 related to their capacity and treatment volume. Rural
3 facilities are on average smaller than urban ones and have
4 fewer stations and provide fewer treatments. And smaller
5 facilities have substantially higher cost per treatment
6 than larger facilities, particularly overhead and capital
7 costs.

8 The 2015 margin does not take into account the
9 revised low-volume payment adjuster and the new adjuster
10 for all rural facilities that CMS implemented in 2016. We
11 think that the revised low-volume adjuster is a step in the
12 right direction although last year we discussed approaches
13 to better target the adjustment.

14 For this year's analysis, we also calculated the
15 rate of marginal profit -- that is, the rate at which
16 Medicare payments exceed providers' marginal cost. It is
17 calculated by subtracting out capital costs from each
18 providers' total cost per treatment. In 2015, the marginal
19 profit is nearly 16.6 percent, suggesting facilities with
20 available capacity have an incentive to treat Medicare
21 beneficiaries. This is a positive indicator of patient
22 access.

1 So the 2017 projected Medicare margin is negative
2 1 percent, a decrease compared to the 2015 margin. This
3 decrease is net of payment and cost factors. So, first,
4 let's review the payment factors that the projection
5 accounts for.

6 The first factor that the projection takes into
7 account is the rebasing of the base payment rate. The
8 Congress rebased the base payment rate to account for the
9 reduced drug utilization -- particularly use of ESAs --
10 that I showed you on Slide 6. Rebasing has been
11 implemented between 2014 and 2018 in two phases. In the
12 first phase, in 2014, rebasing reduced the base payment
13 rate by roughly 3 percent. In 2015 through 2018, rebasing
14 has been carried out by decreasing the update to the base
15 rate.

16 For 2016 and 2017, this rebasing adjustment
17 decreases the update by 1.25 percentage points.

18 Now, in addition to the rebasing adjustment, this
19 projection also accounts for a small positive regulatory
20 change that CMS made in 2017 and a small estimated
21 reduction in total payments due to the ESRD Quality
22 Incentive Program in both years.

1 So now let's discuss cost factors affecting the
2 2017 projection.

3 The first is a regulatory change that began in
4 2016. For 2016, the limit on the medical director
5 compensation that facilities can report on their cost
6 reports was removed. Prior to 2016, Medicare imposed a
7 limit on the amount of compensation that could be reported
8 on facilities' cost reports. So essentially there has been
9 a change in the definition of facilities' cost reports.

10 Keep in mind that medical directors also bill
11 Medicare fee-for-service under the Part B fee schedule for
12 services provided as clinicians. For example, in 2015,
13 Medicare and beneficiary payments to clinicians to manage
14 their dialysis care was \$920 million. Also, some medical
15 directors can enter into joint ventures with dialysis
16 organizations. Commissioners may want to discuss how the
17 2017 projection should treat this change. By recognizing
18 all of the cost, some facilities may not face sufficient
19 pressure to be judicious in the amount they pay medical
20 directors. If the projected 2017 margin used the old cost
21 definition -- which included a limit on medical director
22 compensation -- then the 2015 margin and the 2017

1 projection would be roughly the same.

2 The second cost factor affecting the projection
3 is how costs are reported by providers, which we have had
4 longstanding concerns about. We see, for example, a
5 different cost structure among the larger chains
6 particularly in the reporting of overhead costs. Based on
7 the Commission's recommendation, the Congress directed CMS
8 to audit dialysis facility cost reports, and this audit is
9 currently in progress. Prior ESRD audits -- the last audit
10 was conducted more than 10 years ago -- have found that
11 facilities' allowable costs ranged from 90 to 96 percent of
12 submitted costs. If providers' costs are overstated, then
13 the Medicare margin would be understated and policymakers'
14 willingness to increase payments would be based on faulty
15 data. The use of unaudited cost report data in the margin
16 calculation is another reason to be judicious about
17 recognizing all reported costs.

18 Policy changes to occur in 2018 include the
19 statutory update of the base payment rate which is reduced
20 by the productivity adjustment less 1 percentage point,
21 which is the last of the rebasing adjustments. There is
22 also an estimated small reduction in total payments due to

1 the ESRD Quality Incentive Program.

2 So here is a quick summary of the payment
3 adequacy findings. Access to care indicators are generally
4 favorable. Quality is improving for key measures. The
5 nearly 16.6 percent marginal profit suggests that
6 facilities with available capacity have an incentive to
7 treat Medicare beneficiaries. The 2016 projected Medicare
8 margin is negative 1 percent.

9 So the Chairman's draft recommendation is: The
10 Congress should increase the outpatient dialysis PPS base
11 payment rate by the update specified in current law for
12 calendar year 2018. Under current estimates of the market
13 basket index and productivity adjustment, this would result
14 in an update of 0.7 percent.

15 In terms of spending implications, this draft
16 recommendation has no effect on spending relative to the
17 statutory update.

18 This recommendation should sufficiently cover
19 providers' cost increases and thus not adversely affect
20 providers' ability to furnish care. Given this sector's
21 large marginal profit, this recommendation is not expected
22 to have an adverse effect on beneficiaries' ability to

1 obtain care.

2 DR. CROSSON: Thank you very much, Nancy.

3 We're now open for clarifying questions.

4 MS. BUTO: Nancy, back to Slide 6, if we could.

5 Can you give us a sense of how much of the decline in the
6 use of ESAs in particular is due to changes in price versus
7 changes in utilization? I know the dollars are both, but I
8 just wondered --

9 MS. RAY: No, in this slide, the dollars are all
10 based on 2016 average sales price. So I've held price
11 constant in this slide.

12 MS. BUTO: Okay. So it's really just utilization
13 that's gone down.

14 MS. RAY: Yes.

15 MS. BUTO: Okay. That's very helpful.

16 The other thing is --

17 DR. MILLER: Price has moved around, but the
18 purpose of this --

19 MS. BUTO: I would expect it to have dropped, but
20 I --

21 MS. RAY: Right.

22 DR. MILLER: Yeah, that drop is to show you --

1 MS. BUTO: Just the utilization.

2 DR. MILLER: -- the clean utilization.

3 MS. RAY: Right, right.

4 MS. BUTO: Okay.

5 DR. MILLER: Is that -- you're okay with that?

6 MS. RAY: Right, right, particularly because, to
7 be clear, since 2011, Medicare does not pay separately for
8 these products.

9 MS. BUTO: Right, right. So they are not
10 actually figuring out what the price differences are.

11 MS. RAY: Exactly.

12 MS. BUTO: The other thing is that physicians
13 used to get -- this is ancient memory, but used to get a
14 monthly capitation payment for taking care of ESRD
15 patients, and I remember your slides having to do with the
16 compensation for medical directors. Is it medical
17 directors who typically get the monthly capitation payment?
18 And are you talking about a different payment than that
19 when you talk about their compensation?

20 MS. RAY: So medical -- a clinician managing the
21 patient, the dialysis patient, on a monthly basis is paid
22 the monthly capitated payment. That could be the medical

1 director, or it could be just another physician.

2 MS. BUTO: Okay.

3 MS. RAY: Now, in addition to the dollars that
4 the medical director can bill under the Part B fee-for-
5 service payment system, they are also paid by the dialysis
6 facility to act as the medical director. There's one
7 medical director per facility.

8 MS. BUTO: Okay. So we don't know how much
9 overlap there is between -- because that's additional
10 compensation that the medical director is getting, is kind
11 of what I'm getting at here.

12 MS. RAY: That's correct. Yeah, so on the cost
13 report, they do report who the medical director is. I have
14 not compared --

15 MS. BUTO: Yeah, those two. There's probably
16 some degree of overlap there.

17 MS. RAY: Yeah.

18 MS. BUTO: And then the last question is: I
19 notice that there has been a reduction of payments related
20 to the Quality Improvement Program. Can you give us an
21 insight as to what's behind that reduction in payments for
22 -- are there quality metrics that aren't being met?

1 MS. RAY: Right, so the ESRD Quality Incentive
2 Program, as mandated by the statute -- so it's not a
3 budget-neutral program. So it can pull out dollars, and it
4 can reduce payment by up to 2 percent per facility.

5 MS. BUTO: Right. And what's the reason behind -
6 - do we have a sense -- because it sounds like there is a
7 reduction related to that that you were factoring into
8 margins, right? And so the question is: What aren't they
9 doing, why are they not getting --

10 MS. RAY: Well --

11 MS. BUTO: If it's a net loss or a net reduction.

12 MS. RAY: Right. So a few number of facilities
13 are experiencing a small decrease due to the QIP, the
14 Quality Incentive --

15 MS. BUTO: Because they're just not meeting the
16 adequacy requirements?

17 MS. RAY: Well, it's based on both clinical
18 measures as well as reporting measures. And I can come
19 back to you at the January --

20 MS. BUTO: Just a sense of that, I think it's
21 helpful to know.

22 MS. RAY: Sure.

1 MS. BUTO: Because, you know, if we're talking
2 about whether you stay with the statutory update or not,
3 one question I would have is: Would that contribute to
4 further decline in quality? Unless we think the quality
5 measures that they're not meeting are really more
6 processing than outcome measures.

7 DR. CHRISTIANSON: [Presiding.] Jack, you're
8 next.

9 DR. HOADLEY: So in the chapter you had some
10 additional detail on the ESAs and shifts among some of the
11 different ESAs in the most recent year, and I think you
12 said in your comments that price was a factor. Is price
13 pretty much the primary factor in that, or were there some
14 clinical decisions being made as well, or do we know?

15 MS. RAY: I don't know.

16 DR. HOADLEY: Okay.

17 MS. RAY: But there is a new ESA on the market,
18 and it was -- began being marketed in 2015.

19 DR. HOADLEY: And was that -- do you know if that
20 ESA was coming out at a lower price point than some of the
21 older ones, or --

22 MS. RAY: by my estimates it looks like it, but

1 those are just my estimates.

2 DR. HOADLEY: Yeah. And with the potential for
3 biosimilars for some of these products, is there any sense
4 of incentives within the system to -- that might slow down
5 a shift to biosimilars, or has there been any -- have you
6 looked into that at all?

7 MS. RAY: So I believe that FDA is currently
8 reviewing one application for an ESA biosimilar. You know,
9 one way to anticipate, you know, when that's approved that
10 it would increase competition among the ESAs.

11 DR. HOADLEY: And that would be -- the default
12 assumption would be that it would create some price
13 competition under the incentives in this system --

14 MS. RAY: Yes.

15 DR. HOADLEY: -- and I guess my only question is,
16 is there anything else going on in there that might
17 mitigate against that, but just maybe something to look at
18 --

19 MS. RAY: Okay.

20 DR. HOADLEY: -- once that happen. Obviously
21 that's into the future, yeah, and whether there's potential
22 for rebasing, if that's a -- if that makes a substantial

1 impact on total costs.

2 DR. MILLER: There's no automatic rebasing, like
3 if there were a big drop, if that's what you're asking.
4 You have the pressure of a bundled payment. If they got a
5 big price decrease and had some head room, I think somebody
6 would actively have to go and --

7 DR. HOADLEY: Right, and that's presuming --
8 that's what happened, you know, as a result of this trend,
9 and I'm just --

10 DR. MILLER: [Speaking off microphone.] -- mostly
11 utilization.

12 DR. HOADLEY: Right.

13 DR. MILLER: That might be a price effect, but
14 yeah, somebody actively --

15 DR. HOADLEY: Actively.

16 DR. MILLER: Yeah. Somebody being in the
17 Congress actively went and made an adjustment here.

18 DR. HOADLEY: So just something to look at. If
19 we see that kind of pattern down the road, that could be
20 something to talk --

21 DR. CROSSON: [Presiding.] Rita, I think you're
22 next on the list.

1 DR. REDBERG: Thanks. Thanks for an excellent
2 report.

3 I was gratified to see the increase in home
4 dialysis because, as you noted, it's associated with a
5 better quality of life for the beneficiaries, and that was
6 despite the problems with Dialysite [phonetic] that
7 occurred in 2014, which was unfortunate.

8 Do you have any insights into what was
9 responsible for the increase in home dialysis, and how we
10 could encourage it -- so the increase from 2011 to 2015 --

11 MS. RAY: Right, and --

12 DR. REDBERG: -- what was driving that?

13 MS. RAY: The increase in home dialysis? I think
14 that PPS was driving it. I think the bundled payment has
15 encouraged the use of -- I think the PPS is partly a reason
16 for the increased use of home dialysis. It was trending up
17 even before the implementation, before 2011.

18 DR. MILLER: Yeah, and the thing I hate to ask
19 when I'm not quite sure, there's also a payment that goes
20 along to educate and train the beneficiary as well --

21 MS. RAY: Yes.

22 DR. MILLER: -- that was created as part of the

1 PPS, or adjusted in some significant way as part of the
2 PPS. Am I remembering this right?

3 MS. RAY: Yes. Medicare does make a separate
4 payment for the dialysis training sessions.

5 DR. REDBERG: And my other question was actually
6 on -- do you happen to know, in the cost reports, do the
7 medical directors include how many hours a week the medical
8 directorship takes and the salary range that you see in
9 cost reports?

10 MS. RAY: So under the cost reporting rules, the
11 medical director's time can be billed up to 25 percent. So
12 they basically take their estimated compensation and then
13 you can multiply up to 25 percent of that to get what that
14 allowable cost is entered into the cost report.

15 With respect to the -- what the medical directors
16 are making, the cost report information is kind of -- what
17 do I want to say? -- a little bit squirrely on that. To
18 give you a sense, though, however, MGMA average
19 compensation for a nephrologist was roughly \$360,000 in
20 2015.

21 DR. REDBERG: And my last question was -- I have
22 one more question.

1 DR. CROSSON: Sorry, Rita. Go ahead.

2 DR. REDBERG: It's on the increased use of the
3 dialysis drugs that are outside the bundle, the
4 calcimimetics and the phosphate binders, because, you know,
5 obviously we learned from ESA, I think very painfully, that
6 we were spending billions of dollars on drugs that were
7 not, you know, given way higher doses than were good for
8 the dialysis, and it's nice to see the trends otherwise.
9 But I notice now that these drugs outside the bundle have
10 increased 22 percent per year, and that the intent of the -
11 - was to include all the drugs in the bundle but the
12 achieving of better life experience delayed including those
13 drugs in the bundle, and I'm wondering if you have any
14 insight, again, why they were taken out. It certainly
15 seems like it may not be in our beneficiaries' interests to
16 see this increase and that it's related to being outside
17 the bundle. Any further information?

18 MS. RAY: So when CMS implemented the bundle in
19 2011, the agency proposed to include the Part D drugs but
20 decided to delay it until 2014, just so they could iron out
21 the, you know, exactly how to put them in, and to, you
22 know, and how to set the base rate accordingly.

1 After the CMS delay, Congress then stepped in
2 and, you know, and through various -- three times delayed
3 the inclusion of the Part D drugs into the oral -- into the
4 bundle.

5 DR. CROSSON: I've got David, Bruce, Craig, and
6 Alice. David is -- and Brian.

7 Let me just as one --

8 DR. CHRISTIANSON: Paul.

9 DR. CROSSON: Sorry, Paul. Let me just ask one
10 question myself, because I thought I understood the medical
11 director thing and now I'm not so sure.

12 So previously -- tell me where I'm wrong here,
13 immediately -- previously the medical director salary, if
14 that's the right term, was -- there was a cap on that, and
15 then you -- then they accounted 25 percent of that towards
16 their cost. The change -- is the change that the entire
17 salary is now accounted for, or that the cap has no limit?
18 Which of those two things?

19 MS. RAY: So before 2016, facilities could report
20 up to 25 percent of the -- what they called the reasonable
21 compensation equivalent, and that was roughly \$196,000.
22 That \$196,000 has been lifted.

1 DR. CROSSON: But it's still 25 percent.

2 MS. RAY: Yes. It's still 25 percent --

3 DR. CROSSON: Okay.

4 MS. RAY: -- up to 25 percent.

5 DR. CROSSON: Right.

6 MS. RAY: If you bill more than 25 percent you
7 have to justify that.

8 DR. CROSSON: Thank you. I understand. Sorry.
9 Bruce.

10 MR. PYENSON: Nancy, thank you very much for a
11 great report.

12 In other reports we looked at yesterday we were
13 able to compare patients covered under Medicare Advantage
14 to the fee-for-service program, and that's perhaps
15 difficult to do, given the coverage rules. But there are a
16 significant number of patients in ACOs who have end-stage
17 renal disease and are covered under that program, perhaps
18 due to the attribution methodology.

19 If we were going to compare patients and
20 outcomes, how would -- do you think that would be a useful
21 -- that that analysis would provide useful information?

22 MS. RAY: Yeah, I think it would. The ESRD ESCO

1 program, which is the -- what I would say the equivalent of
2 ACOs for ESRD organizations, that began in 2015. So 2016
3 is the -- we don't really have data for that yet. But I
4 think in the future that would be one promising area to
5 look at.

6 DR. JOHNSON: Bruce, can you say a little bit
7 more about which outcomes in particular that you're
8 thinking of taking a look at?

9 MR. PYENSON: It's, of course, hard to compare
10 cost outcomes because of the way payment is made, so other
11 outcomes might be the other Part A and Part B costs
12 associated with patients.

13 DR. CROSSON: Craig.

14 DR. SAMITT: So back to Slide 11, I have a couple
15 of questions about the cost factor.

16 Just to clarify the medical director cap shift,
17 are you saying that the total compensation per full-time
18 medical director could be as much as \$196,000, and the cost
19 report could include 25 percent of that number, which means
20 that if the new threshold is somewhat higher, because
21 that's the market demand for that role, it would then be 25
22 percent of that higher number? Okay.

1 MS. RAY: That is correct, and to be clear, in
2 2016 and beyond, there is no threshold. It's whatever the
3 market --

4 DR. SAMITT: Whatever the market will bear.

5 MS. RAY: Yes.

6 DR. SAMITT: So my question is about the
7 materiality of that. So do we have a sense of what the
8 potential impact will be on the marginal profit as a result
9 of that, plus what we think the materiality would be about
10 the cost report audit? You talked about, it sounded like
11 anywhere between a 4 to 8 percent potential impact. So I'm
12 just wondering, in terms of marginal profit, what would we
13 estimate those two factors would have on the dialysis
14 centers?

15 DR. MILLER: So, Nancy, for -- projecting forward
16 to 2017, we did make an assumption about the effect of the
17 change in the threshold?

18 MS. RAY: Yes.

19 DR. MILLER: So here's what I'm going to say.
20 Okay? Ready? You've got about a 2 percent -- let's just
21 call it, in round numbers, 1-1/2 to 2 percentage adjustment
22 in your margin from 2015 to 2017. All other things equal,

1 the marginal profit goes down two points too, but you can
2 see the tentativeness and the guessing in my voice, Craig.
3 Is that kind of what you were asking?

4 DR. SAMITT: For just the medical director piece,
5 or both parts?

6 DR. MILLER: Well, whatever -- no. You're right.
7 The total effect, factors between '15 and '17, is the 2
8 percent. I don't know that we could quantify, or whether
9 we have specifically quantified the medical director
10 component of that.

11 DR. CROSSON: Wait, wait. Let me see if I
12 understand this. So let's assume, for the moment, that the
13 salaries -- the market is not, in the short term, going to
14 push the salaries up.

15 DR. MILLER: Yeah, but just before you go on --

16 DR. CROSSON: Yeah.

17 DR. MILLER: -- Nancy, immediately a higher cost
18 enters the --

19 DR. CROSSON: I know that, but what I'm saying is
20 -- the way I'm thinking about this is that this is
21 primarily an accounting change, right, because the dialysis
22 center has been paying the medical director the amount.

1 The accounting for what -- based on the cap changing, what
2 the 25 percent would amount to in terms of the cost report
3 changes, but the actual money out the door for the dialysis
4 center to the medical director hasn't changed. And so the
5 -- so, in other words, the margin will appear artificially
6 lower --

7 DR. MILLER: Yes. Correct.

8 DR. CROSSON: -- as a result of this.

9 DR. MILLER: Yeah, and in our methodology -- all
10 I was trying to say, in our methodology, you know, both the
11 average and the marginal profit would be affected by this
12 change, because we're getting the information from the cost
13 report.

14 DR. CROSSON: Right, but that's different from --

15 DR. MILLER: What's really --

16 DR. CROSSON: -- what's really happening.

17 DR. DeBUSK: [Speaking off microphone.]

18 DR. CROSSON: Right. No comments about that.

19 Alice.

20 DR. COOMBS: Thank you, Nancy. I look forward to
21 your report every year.

22 I want to talk a little bit about something that

1 I've asked before, and this is the packaged dialysis
2 patient, in terms of the total cost, including the \$900
3 million. MA has patients that develop renal failure while
4 they are MA patients. Do we have any information about
5 what the total cost is, either from the MA population or
6 Kaiser, a closed system, like Kaiser, or some system like
7 that, where you can actually attribute it -- you have the
8 whole cost calculated and then you have attribution of cost
9 within the bundle or within the global cost of care of the
10 patient?

11 DR. JOHNSON: We haven't started to dig into the
12 cost side of that as much, but the MA payments are based
13 off a fee-for-service population and their total costs. So
14 at least the cost to the Medicare program is roughly
15 equivalent on both sides. I know that isn't quite your
16 question.

17 DR. COOMBS: Right, because I've heard quotes
18 from the ASN about the total cost of the end-stage dialysis
19 patient requiring standard dialysis is X number of dollars.
20 And so how do we carry that out to the next level of
21 substantiating it within that packet? I'm really curious
22 because every time I go to one of these presentations

1 there's a quote, and I'm figuring out how they get to that
2 quote.

3 DR. JOHNSON: That's a good question. That's
4 something we'll be sure to look into for next year.

5 DR. COOMBS: Because going forward with --
6 especially with the ESCO, it would be a very important
7 piece of that.

8 And then, secondly, about the kidney -- I was
9 very interested in the education piece and when it's
10 implemented. And it seemed like it was implemented already
11 when you're CKD 4 instead of when you're earlier. And were
12 there any plans to kind of implement that earlier, because
13 if you can avert the onset of Stage 4, I mean, that's where
14 money savings is.

15 MS. RAY: Right. So the Chronic Kidney Education
16 Initiative that is included in your mailing materials is
17 for Stage 4, chronic kidney.

18 DR. COOMBS: Right.

19 MS. RAY: That's correct.

20 DR. COOMBS: Right.

21 MS. RAY: You know, let me get back to you in
22 January to just review Medicare's other education

1 initiative before I -- so I can better answer your
2 question.

3 DR. COOMBS: And lastly, the whole notion of
4 transplant -- and I looked at the wonderful chart that you
5 had -- very good stuff, in terms of reflecting how
6 transplant -- African Americans, Asian Americans are less
7 likely to receive kidney transplants. I was curious as to
8 if you were to project if someone gets a kidney, how much
9 savings that is as a result of the transplantation. It
10 might be something worthwhile looking into, because long-
11 term, I've taken care of patients in the ICU who have had
12 transplants, and it's an amazing turnaround for their life,
13 and, in addition, you know, costs and comorbid conditions,
14 management, everything becomes so much easier to manage,
15 and the global cost goes down as a consequence of quality
16 of life improves dramatically.

17 MS. RAY: Right, and for the next version of this
18 paper we can include the total cost from the USRDS, and
19 they itemize out spending for patients who have gotten a
20 kidney transplant versus dialysis patients. So we can put
21 that in there for you.

22 DR. CROSSON: Okay. I have Brian and Paul, and

1 then we're going to move -- and Kathy -- and then we're
2 going to move on to the discussion here.

3 Brian.

4 DR. DeBUSK: If we could go back to Chart 6,
5 please.

6 That is obviously a very impressive trend in
7 utilization of those drugs, presumably through the
8 introduction of the prospective payment, or the bundled
9 payment. Do we track, or have we tracked the unit prices
10 of those drugs over time and compared their unit prices,
11 say, to drugs overall?

12 MS. RAY: I do track the ASPs for the drugs that
13 are in the bundle.

14 DR. DeBUSK: Have they mirrored the price
15 increases that we've seen of other drugs?

16 MS. RAY: I'd have to get back to you on that.
17 What I can tell you is that within the Vitamin D group, for
18 a couple of years there was some price competition going on
19 between those two products after the implementation of the
20 PPS.

21 DR. DeBUSK: There is something -- when we had
22 our Part B drug discussion, I remember Kathy pointing

1 something out about not necessarily bundling codes,
2 combining codes, but maybe combining the code with the
3 procedure, you know, more of a bundled approach. And to me
4 this seems like that would be an interesting test to see
5 how drug companies responded to the bundling. Did their
6 unit price for that basket of drugs, when sold to a
7 dialysis clinic, did that basket track the overall prices
8 of drugs in general? Or did they respond differently with
9 the change in their unit price?

10 DR. CROSSON: That's a good point. I just think
11 one of the complexities is what do you compare it to,
12 because there's going to be so many things moving around.
13 But there might be a cohort of pharmaceuticals that would
14 represent a comparator. I'm not sure.

15 DR. DeBUSK: And could we find the ones that were
16 sold specifically to dialysis clinics? Can we tease that
17 apart?

18 DR. REDBERG: Compare it to the Part D dialysis
19 drugs outside the bundle.

20 DR. MILLER: Okay. So a few things here, and
21 then some of the drug folks, I'm going to say something, so
22 pay attention.

1 One thing to keep in mind is the other thing that
2 happened here -- now, I still think that the large effect
3 you saw here is PPS, but also remember there was an FDA
4 black box that came out at the same time. So there was a
5 clinical indication here that also changed. But, still,
6 when you watch the data -- and I'm doing this by memory,
7 Nancy -- there was sort of a black box effect, and then
8 there was a PPS effect. And, you know, we thought a lot of
9 that utilization was affected by PPS. So your point
10 stands, Brian, is what I'm trying to get at.

11 Then I have one other thing to say about his
12 point, but you seem to want to say something right now --
13 okay. Well, the other thing I was going to say is that I
14 could imagine this being fairly complex depending on
15 whether the drug can be used in other channels and for
16 other purposes about what the price effect would be. So if
17 you put it in a bundle -- and this is pretty much your
18 dominant population, your dominant payer -- you could be
19 really affecting, you know, prices, utilization very
20 strongly. But if those drugs can travel to other types of
21 patients and other types of channels -- I'm trying to use a
22 drug term to sound like I know what I'm doing over there,

1 Amy -- you know, does that mean that the price effect might
2 not be quite the same thing? So this is not no, but it may
3 be more complex than --

4 DR. DeBUSK: As a corollary, could we pull
5 invoices, say, to dialysis clinics versus where those drugs
6 are sold in other settings and just look and see if there's
7 a difference?

8 DR. MILLER: I'm not sure we have that
9 granularity. I think what we have is, you know, cost
10 report data and then ASP information in other sources, and
11 we'd be trying walk some -- I'm not sure we know the unit
12 price that the dialysis facilities are purchasing at,
13 right?

14 MS. RAY: Right. So the way it's reported on --
15 so the way that dialysis drugs costs are reported on the
16 cost reports, you have a category for the ESAs, and then
17 you have a category for the other Part B drugs that are
18 included in the bundle. So you really can't tease out, for
19 example, under the Vitamin D's, you can't tease out Zemplar
20 versus Hectorol, the two dominant Vitamin D agents.

21 MS. BRICKER: Brian, are you trying to understand
22 if the pricing from the manufacturer is different because

1 of the doctors that are affiliated with ESRD versus someone
2 that's buying the same drug not in relation to dialysis?
3 Is that what you're trying to determine?

4 DR. DeBUSK: I'm trying to see the impact that
5 the bundled payment would have on the overall ASP of the
6 drugs that follow to the dialysis center to see how the
7 manufacturers would respond. Would they price under
8 business as usual policies and just accept the fact that
9 fewer drugs are going to be used? Which is what that chart
10 shows. Or would there be a reduction in the price of those
11 drugs as well, presumably to compete? Because essentially
12 what this has created -- what I'm seeing here is a
13 shrinking market, because the market has -- utilization has
14 decreased more quickly than the number of ESRD patients
15 has.

16 MS. BUTO: I think ESRD is so peculiarly Medicare
17 that a better bundle to look at might be the cancer
18 oncology bundle that CMS is now trying to put in a
19 demonstration, because cancer drugs can be used in
20 populations outside of Medicare. But ESRD is so strongly
21 Medicare, and the other uses of ESAs for cancer and other
22 things wouldn't be comparable. So I'm not sure it's a good

1 case example, but I think probably the behavior you're
2 talking about did happen.

3 MS. BRICKER: To finish my thought, it would be
4 more or less -- I don't know if there's a different class
5 of trade, so class of trade going to drive really pricing
6 around product, and there's not a different class of trade
7 associated with purchasers for ESRD versus non, and so I
8 don't know that -- and you're not going to buy direct from
9 a manufacturer, right? So I don't know that -- we should
10 definitely consider it, but I don't know that you're going
11 to really see manufacturers acting differently because of
12 bundled payment, because the class of trade associated with
13 you as a purchaser isn't going to be different if you're
14 associated with dialysis procedure versus some other
15 physician service. I don't know if that makes sense.

16 DR. CROSSON: Okay. Jack, on this point?

17 DR. HOADLEY: I was just going to say that my
18 question earlier about the multiple products within the ESA
19 class sort of goes to -- you know, there's three -- there
20 was a shift from two of the products to a third one
21 particularly, or it's a little more complicated than that,
22 and I guess part of the problem is we don't see the sort of

1 price points that are going on in the centers amongst
2 those. And so whether there's any maneuvering within the
3 class because they're in this context, but if we could get
4 into that, that would also be potentially interesting to
5 see what's going on, how they're responding, when there are
6 multiple choices within that particular class.

7 DR. CROSSON: Okay. I've got Paul and then
8 Kathy, and then we do need to move forward.

9 DR. GINSBURG: Yeah, just a question on the
10 quality measurements, and what I started thinking about is
11 that, of course, these quality measures are influenced by
12 the service in question, but also other things. And I was
13 wondering if there was less of a relationship between the
14 services in question and quality here than we're running
15 into in many of the other areas. Or I'm just kind of
16 probing, and there may not be anything there. But I just
17 wanted to raise it.

18 I don't think I've been clear. I'm just thinking
19 about these patients have other medical conditions not
20 related to their ESRD, and also the physician payment is
21 not part of this facility payment to the dialysis facility.
22 That's probably very important in, you know, whether there

1 are admissions or readmissions, not just the quality of the
2 dialysis they receive. So that's what I was getting at.

3 MS. RAY: Right. So I'm not a clinician, but,
4 yes, these patients have a lot of comorbidities --
5 congestive heart failure, diabetes, hypertension. That
6 being said, you know, there are -- I think that the
7 treatment dialysis facilities furnish these patients does
8 play a big role in their outcomes. And I guess I could use
9 a little bit of clinical help here.

10 DR. COOMBS: I just want to say something. The
11 point that he's making is a good point, but you're assuming
12 that the prevalence of comorbid disease is fairly constant
13 within this population. What might be more interesting is
14 the number of patients that are admitted from dialysis who
15 are either extremely dehydrated, meaning you overdialyzed
16 them or you haven't done the job to get them to the point
17 where their volume status is adequate and they may have
18 congestive heart failure. So that might be more
19 interesting, is how many patients are admitted from
20 dialysis into the hospital, where during dialysis or
21 sometime around dialysis they have a complication? That's
22 probably a better indicator of quality.

1 DR. CROSSON: On this point?

2 DR. NERENZ: Exactly on this point. I thought,
3 Paul, what you were raising is an example of the signal,
4 the noise question; I used that expression a couple months
5 ago. And, Nancy, I guess this is just an example, not
6 today but as we get into deeper discussion of quality
7 measures. You said it has a big effect. I'd be interested
8 in knowing how big, exactly how big. And that was the
9 point I was making a couple months ago.

10 DR. CROSSON: Okay. Kathy, last question.

11 MS. BUTO: This should be fairly quick. So I
12 just wanted to be clear. We were talking about home
13 dialysis and facility dialysis. Nancy, under home
14 dialysis, is there a payment rate exactly -- is it a PPS
15 rate that gets paid? And is it the same amount that the
16 facility gets?

17 MS. RAY: Yes, there is --

18 MS. BUTO: Okay. There's no reduction for home
19 dialysis.

20 MS. RAY: For adults, the home rate and the in-
21 center rate is the same.

22 MS. BUTO: Okay, good. Because at one point the

1 program was paying a lot more for home dialysis, and there
2 was a spike, and that was due to a reimbursement glitch, so
3 to speak. Thanks.

4 DR. MILLER: The rates are the same, but then
5 there is an additional payment for the education --

6 MS. RAY: For the training.

7 DR. MILLER: For the training.

8 MS. RAY: For the training.

9 DR. MILLER: So depending on what your question
10 was asking, there is another block of dollars that goes
11 along with the home --

12 MS. BUTO: But I think that's a one-shot deal,
13 right?

14 MS. RAY: Right. So --

15 MS. BUTO: It's not every treatment.

16 MS. RAY: Right. They get up to -- what is it? -
17 - 15 training treatments for one kind of home dialysis and
18 25 for the other kind of home dialysis.

19 DR. CROSSON: Okay. Nancy, could you put up the
20 recommendation slide?

21 So this is the order of business. I'd like to
22 hear from the Commissioners about support for the

1 recommendation or not, or other issues related to the
2 recommendation. I'm seeing the appearance of thumbs. A
3 lot of thumbs are in the air.

4 Bruce, you want to make a comment? Go ahead.
5 Alternative view.

6 MR. PYENSON: I would like to see an estimate of
7 the impact of biosimilars for 2018 to see whether we should
8 recommend a split or a time difference, that is one action
9 if biosimilars are not approved and the different action if
10 biosimilars are approved. We're talking about 2018, and
11 the world with respect to some of the major expenditure
12 items could be different then. I'm not sure if that is
13 practical from a recommendation standpoint for MedPAC, but
14 that's my thought.

15 DR. CROSSON: So let me see if I understand. I
16 think what you're saying, Bruce, is the support for this
17 recommendation might vary if we were in possession of
18 information about certain biosimilars and the likelihood of
19 those being approved and marketed and used within the time
20 frame that we're talking about, which is fiscal year 2018.
21 So I guess the question is: Is such an analysis feasible
22 or not?

1 DR. MILLER: No.

2 [Laughter.]

3 DR. MILLER: And I don't mean to be so cavalier
4 about it, but this gets approved, it gets on the market,
5 the price will be X. And I imagine there's a lot of people
6 in the marketplace who would like to know the answer to
7 that, and I don't feel particularly and I don't know that
8 we're particularly equipped to do that. So I would have a
9 very hard time kind of coming back with an analysis that
10 says I think it's two points, you know, on the margin if
11 the biosimilar exists and they use it.

12 Also, you know, I hear -- and, again, I defer to
13 a whole set of drug folks down here -- you know, back and
14 forth on how deep discounts you should be expecting when a
15 biosimilar shows up. And then even if it does hit the
16 market, the price effect I think could take awhile to work
17 through. I'm not sure it would hit in 2018 and, you know,
18 you'd see the thing right off.

19 MS. BUTO: I think the other side of this that
20 I'm a little concerned about is the idea that even if we
21 made an educated guess, the idea that we would recommend
22 payment rates that might actually force a certain price

1 behavior, that really bothers me. So I think the issue of
2 letting that price fall naturally through the use of
3 biosimilars is appropriate and then maybe come back and
4 recommend some rebasing. But to anticipate and in some
5 sense force certain pricing -- I don't think that's -- I
6 would think that's not a good role for the Commission.

7 DR. HOADLEY: I'm not necessarily averse to that
8 notion of sort of putting pressure on, but I think in this
9 instance the chances that this would be on the market and
10 really in wide availability in that short time period seems
11 less likely. But, in addition, as Mark said, the
12 experience in sort of traditional drugs with generics, it
13 can take a full 12 months before you start to see the price
14 effects, and in some ways that gives us the chance to wait
15 until a point when we know that the drug is, in fact,
16 approved, what's the clinical reception to it, and so
17 forth.

18 I mean, there are concerns that you could see
19 price behavior in anticipation of in terms of some of the
20 other products, and one of the things I do wonder about is
21 whether some of the shifts in the market that we're seeing
22 in the last year could be attempts to move to products that

1 are not the ones where the biosimilar competition would
2 come in. But, again, I don't think we can -- I don't think
3 there's a practical way to figure that into an estimate
4 like this. I agree with Mark on that point.

5 MR. GRADISON: In addition to the variables Mark
6 mentioned, I just would point out there are two dominant
7 purchasers of these products -- two. Now, I don't know
8 what the total significance of that is, but I think it's an
9 important fact, and unusual, actually, when a new product
10 comes along.

11 MS. BRICKER: I think there's great interest in
12 anticipation of what biosimilars made do in the market,
13 right? So we might just want to consider, as we're
14 reviewing topics along the way, that we provide sort of
15 pipeline information. I agree, you can't -- we're not
16 going to be able, to Mark's point, to say that will result
17 in a 2 percent reduction. But I think it seems as though
18 because of -- we are hoping that biosimilars will allow
19 some new behaviors in market to just have for all of us, as
20 we're debating, just pipeline drugs that are expected to
21 have a biosimilar into the market, and when and maybe how
22 many, just so then we could have that dialogue. But I

1 don't think there's any way for us to say and that,
2 therefore, will reduce pricing by X.

3 DR. MILLER: I could see us even more broadly
4 than just the -- and I think that's your point more
5 broadly. I think we could try and assemble here's what's
6 at FDA, here's what's -- that actually is a good point.
7 Once again, I want to say to Bruce and to the rest of the
8 Commissioners, I wasn't trying -- the policy, take it in
9 advance, take it behind, that's all for you guys to decide.
10 For me, I just didn't feel like I could deliver that in,
11 you know, in three weeks. That's really what I was
12 reacting to.

13

14 DR. REDBERG: So like other things we've talked
15 about, you know, it's not just how to do a better
16 experience, but also was it needed in the first place? And
17 you will be surprised to know there appears to be overuse
18 of dialysis. And I'm not talking just about inpatients,
19 you know, whose lives probably won't be benefitted or
20 extended. I mean, we know that we dialyze many more
21 patients in the United States than anywhere in the Western
22 world, and our outcomes are poorer, our mortality rates are

1 higher. But there's also been a trend to starting dialysis
2 earlier in this country, which I think probably was
3 initially thought, you know, that would be better. But
4 there has been clear data from randomized controlled trials
5 as well as observational studies in the last five and ten
6 years that we're starting dialysis much, much earlier and
7 are just -- this is from an editorial from a nephrologist
8 in the Archives of Internal Medicine, "Time to rethink the
9 timing of dialysis initiation." So from 1995 to 2007, the
10 average serum creatinine, which is a reflection of your
11 kidney function, the level at which we start dialysis has
12 dropped. So it went from 8.7 to 6.3, meaning that people
13 still had a lot more kidney function. And the glomerular
14 filtration rate, which is another indicator of when to
15 start dialysis, has increased. So we're starting people on
16 dialysis who have much better kidney function, and studies
17 have shown -- this was a study by Rozanski -- that people
18 who are started on dialysis with better kidney function do
19 worse. They have higher mortality rates than the people
20 that we wait. And I think part of this is related to the
21 fact that there's a lot more checking of kidney function
22 and people are getting staged; you know, they're told they

1 have Stage 1 and 2 and 3 and 4 kidney disease. It's
2 basically an asymptomatic, pre-disease that's based on your
3 kidney function. But I think if we are able to sort of tie
4 glomerular filtration rates somehow into the whole bundle
5 as well, it could -- as we saw positive effects and better
6 quality of life for decreasing ESA use, I think this is not
7 a good trend for beneficiaries to be starting dialysis,
8 which clearly has a decrement in quality of life once we
9 initiate dialysis at glomerular filtration rates that are
10 way higher than people need to be started on and, in fact,
11 they will have worse outcomes.

12 DR. CROSSON: Thank you.

13 DR. GINSBURG: I thought that Kathy and Jack and
14 Amy's comments were along the lines of what I was going to
15 say. I just want to go back to the general principle that
16 came up -- I brought it up yesterday -- with the hospital
17 market basket projection, that it's not a good idea for
18 this Commission to become forecasters. And I think our
19 system works quite well by quickly monitoring data, seeing
20 what's happening, and adjusting our recommendations to that
21 when we see it. But I think we just undermine our own
22 credibility if we're going to go and forecast hospital

1 trends or if we're going to go and forecast what's going to
2 be the price, you know, if a biosimilar is approved, and
3 how is that going to affect a lot of other things? So I
4 just wanted to say that on general principle.

5 DR. CROSSON: Thank you.

6 DR. HALL: Another related cost we haven't looked
7 at -- and I'm not suggesting we do right now -- is that the
8 cost of transportation to dialysis units is something that
9 medical directors have to approve. And as I recall, the
10 last time we looked at the ambulance cost, there seemed to
11 be something wrong there, because very highly sophisticated
12 ambulances similar to a space capsule were being used for
13 people that could take a bus. And it was very, very high.
14 So sometime we ought to make an asterisk there, take a look
15 at that, as long as we're looking at costs and what happens
16 when there's a relative monopoly in the marketplace.

17 DR. MILLER: And my quick recollection is -- and
18 we could take another look at this, looking at various
19 victims -- I mean, yeah, not for this next thing in
20 January. We did look at it. I thought was actually some
21 shift in that trend, so we did see some impact on the
22 ambulance stuff because it got highlighted in many ways,

1 including our work, and it hit the newspapers and that type
2 of thing, and there has been some shift. But I don't think
3 we've looked back at it as of late.

4 MR. GLASS: There was a prior rule on that [off
5 microphone].

6 DR. MILLER: Right. So we'll look back at it for
7 you, Bill. You're right.

8 MS. RAY: So U.S. Renal Data System, the last
9 time we looked at it, ESRD spending for ambulance services
10 in 2011-2013 was trending up. Between 2013 and 2014,
11 according to the USRDS data, it's going down a bit. And
12 our preliminary estimate for 2015 is that it is declining
13 relative to 2013.

14 DR. CROSSON: Okay. So, Bruce -- David, do you
15 have a point?

16 DR. NERENZ: Well, in just listening to the last
17 couple comments, I'm afraid Rita's excellent comment is
18 going to get lost. I just want to make sure that we don't
19 -- because it seemed like that leads fairly directly to a
20 possible recommendation to say that payment is different or
21 even non-existent for dialysis procedures in a certain set
22 of clinical conditions. And that's an interesting track to

1 follow. We've been on the cusp of that many times. This
2 may be a place to take it up, and I just didn't want that
3 comment to be in the air and then dropped. We ought to end
4 it thoughtfully somewhere.

5 DR. CROSSON: Well, I mean, I think that's fair
6 enough, and I guess my thought here again, though, is this
7 is basically a payment update, and to take on in the course
8 of this process in December and January a question like
9 should CMS or someone else be setting and enforcing through
10 the payment system clinical guidelines as to who receives
11 dialysis is something that we could take on, but it's a bit
12 larger question, I believe.

13 DR. NERENZ: And that's okay. I don't actually
14 disagree with that. I want it explicit so that it just
15 doesn't fade off into the ether and we don't know where it
16 ended --

17 DR. CROSSON: Yeah, fair enough.

18 DR. HOADLEY: To this point, maybe that's
19 something to look at as a quality indicator or some kind of
20 thing, at least, whether it's literally a quality indicator
21 or something to track, is what are the trends at the stage
22 of disease, and then we'd have better information.

1 DR. SAMITT: I would expand on that further. I
2 also don't want to lose Rita's good point, and, you know, I
3 was going to go where Jack was, which is should we be
4 expanding our notion of quality measurement when we talk
5 about quality dialysis -- you know, we've talked before,
6 and I don't remember if I had seen it, you know, the
7 transfusion rates. We just talked about the start of
8 dialysis and the GFR at the start. And then we also talked
9 about the costs of drugs that are not in the bundle. So it
10 feels like perhaps there are other things at a minimum we
11 should be measuring and tracking, with a discussion at a
12 later date about whether we would recommend any policy
13 changes as a result of the new things that we would begin
14 to measure.

15 DR. CROSSON: Right, so -- and I think we've had
16 similar experience yesterday as well, that in the course of
17 making this determination, which is what we're going to do
18 about the update, it allows us to focus on the broader
19 question of the quality of care in many cases or other
20 aspects of the policy appropriateness in this particular
21 payment area and identify those for future work. And I
22 think that's what I'm hearing, and I agree with that.

1 Okay. So, Bruce, having heard this discussion,
2 will you allow the Gladiator to live or not?

3 MR. PYENSON: I think I'm the Gladiator, so yes.

4 [Laughter.]

5 DR. CROSSON: Okay. So I'm hearing a general
6 consensus for the update here, and so we will handle this
7 in January in the expedited presentation and voting mode.

8 One historical note. If we are going to be doing
9 thumbs, there is a controversy about whether or not in the
10 history of Rome and the gladiatorial games, thumbs up
11 actually represented, "Let the Gladiator live," which is
12 the common wisdom. Or, in fact, it was the opposite. So
13 before January -- well, before next December, before we do
14 this again, I think we need a MedPAC historical analysis so
15 that we're properly employing our thumbs. Thank you.

16 DR. MILLER: No, we won't be. Not before
17 January.

18 [Laughter.]

19 DR. MILLER: I'll bring you in that biosimilar
20 thing then.

21 [Laughter.]

22 DR. CROSSON: Nancy and Andrew, thank you.

1 [Pause.]

2 DR. CROSSON: Okay. We're going to move to our
3 next presentation, which is adequacy of payments for
4 hospice services. Kim Neuman is here. Kim, you have the
5 floor.

6 MS. NEUMAN: Good morning.

7 So first a few facts about hospice in 2015. In
8 2015, more than 1.3 million Medicare beneficiaries used
9 hospice, including nearly half of all decedents. About
10 4,200 hospice providers furnished care to these Medicare
11 beneficiaries, and Medicare paid them nearly \$16 billion.

12 The Medicare hospice benefit offers beneficiaries
13 a choice in the type of end-of-life care they'd like to
14 receive. For beneficiaries that choose to enroll in
15 hospice, hospice provides palliative and supportive
16 services focused on symptom management, psychosocial
17 supports, and quality of life. To be eligible, a
18 beneficiary must have a life expectancy of six months or
19 less if the disease runs its normal course.

20 At the start of each hospice benefit period, a
21 physician must certify that the beneficiary's life
22 expectancy meets this criteria. There is no limit on how

1 long a beneficiary can be in hospice, as long as he or she
2 continues to meet this criteria.

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

6 Before we go through our indicators of payment
7 adequacy, I'll quickly touch on issues with the hospice
8 payment system that the Commission identified in 2009, and
9 remind you of some changes that are underway related to the
10 payment system and other initiative starting in 2016.

11 First, back in 2009, the Commission observed that
12 there had been substantial entry of for-profit hospices,
13 increases in length of stay for patients with the longest
14 stays, and particularly among for-profit providers.

15 Looking at the payment system, we found it was
16 misaligned with providers' costs, making long stays very
17 profitable. So in March 2009, the Commission recommended
18 that the payment system be changed from a flat payment per
19 day to one that's higher in the beginning of the stay and
20 at the end of the stay, near the time of the patient's
21 death, and lower in the middle.

22 Congress gave CMS the authority to revise the

1 payment system as the Secretary determined appropriate, and
2 beginning in January 2016, CMS implemented changes to the
3 hospice payment rates for routine home care, in a manner
4 that's consistent with the spirit of the Commission's
5 recommendation. So beginning in 2016, there are two base
6 rates for routine home care -- a higher rate for the first
7 60 days and a lower rate for days 61 and beyond. In the
8 last seven days of life, hospices receive additional
9 payments for registered nurse and social worker visits on
10 top of the regular per diem rate.

11 CMS projected the new payment rates would be
12 budget neutral in the aggregate but they would redistribute
13 revenues across providers, meaning more revenue for
14 provider-based, nonprofit, and rural hospices, and less
15 revenue for other providers.

16 There are at least two other notable initiative
17 related to end-of-life care that began in 2016. First, in
18 2016, CMS's innovation center launched a five-year
19 demonstration to test concurrent palliative and curative
20 care for certain hospice-eligible beneficiaries who are not
21 enrolled in hospice. The idea is that this might lead
22 these beneficiaries to receive palliative care earlier in

1 the disease trajectory.

2 Second, beginning in 2016, Medicare covers
3 advanced care planning conversations between interested
4 beneficiaries and their physicians or other practitioners.
5 These services are payable under the Physician Fee
6 Schedule.

7 Just one other note, all of the Medicare data
8 that we're going to be seeing today predates these 2016
9 changes.

10 So here we have our update framework, and you've
11 seen this in the other sectors. First we'll look at growth
12 in the number of hospice providers.

13 The green line in this chart shows that the total
14 number of hospice providers serving Medicare beneficiaries
15 has been increasing for more than a decade. Each year on
16 net, the program has been gaining 100 to 200 providers. In
17 2015, the number of hospice providers grew about 2.6
18 percent, a net increase of about 100 providers.

19 Looking at the other three lines in the chart,
20 which show the number of providers by type of ownership, we
21 see growth in the supply of providers is almost entirely
22 due to growth in for-profits. The number of nonprofits and

1 government providers have been on a slight downward trend.

2 The next chart shows the growth in hospice use
3 among Medicare decedents. Between 2014 and 2015, the share
4 of Medicare decedents who used hospice increased from 47.8
5 percent to 48.6 percent. Over the years, hospice use has
6 grown most rapidly for beneficiaries age 85 and over. In
7 2015, 57 percent of decedents in this age group used
8 hospice at the end of life. Minorities and beneficiaries
9 in rural areas continue to have lower hospice use than
10 other beneficiaries, although hospice use rates have been
11 increasing for these groups too.

12 Here we have more detailed utilization data. The
13 number of hospice users grew about 4.3 percent in 2015, to
14 more than 1,380,000 beneficiaries. Average length of stay
15 among decedents declined slightly in 2015, because of a
16 decrease in length of stay for patients with the longest
17 stays, and you can see that the last line of the chart.
18 Hospice length of stay at the 90th percentile decreased
19 from 247 days in 2014 to 240 days in 2015. Hospice length
20 of stay for shorter stays changed little.

21 And as you can see here, in this next chart, the
22 length of stay varies by absorbable patient

1 characteristics, like diagnosis and patient location, so
2 that providers that wish to do so have had an opportunity
3 to focus on more profitable patients. Consistent with
4 that, we see for-profit providers having substantially
5 longer lengths of stay than nonprofits, 105 days versus 65
6 days, on average, and when we look at the margin figures
7 later, embedded in those margins will be the effects of
8 length-of-stay differences on providers' financial
9 performance.

10 Next we have quality. Since July 2014, hospices
11 have been required to submit quality data for seven process
12 measures. A couple of examples of measures include
13 documentation of treatment preferences and screening and
14 assessment of pain. A report from a CMS contractor, RTI
15 International, provides an initial look at performance on
16 these measures. On six of seven measures, most hospices
17 scored very high -- three-quarters or more hospices scored
18 91 percent or higher. Scores on the seventh measure were
19 lower and more varied. That seventh measure relates to
20 whether the hospice performed a comprehensive pain
21 assessment within one day after a patient screened positive
22 for pain.

1 As far as what to make of these seven measures,
2 they are process measures and it is uncertain how much they
3 affect quality from the perspective of the patient, and the
4 high scores suggest some measures may be topped out.

5 There are some additional quality measures on the
6 horizon. Hospice CAHPS, which surveys the family members
7 of deceased hospice patients, has been underway since 2015.
8 Data are not yet available but some aggregate data are
9 expected soon. Also, CMS has added, for 2017, a pair of
10 measures gauging the share of a provider's patients who
11 receive certain types of visits in the last days of life.

12 With quality measurement in general, it has been
13 the Commission's view that outcomes measures would be
14 preferable to process measures. With hospice, clearly
15 outcome measures are challenging, but it is noteworthy that
16 CMS has expressed interest in developing a patient-reported
17 pain measure.

18 Another measure that in some ways could be seen
19 as an outcomes measure is live discharges. An unusually
20 high rate of live discharge for a hospice provider may be a
21 signal of poor quality or program integrity issues. Some
22 live discharges from hospice are expected because sometimes

1 patients improve and no longer meet the eligibility
2 criteria, or because a patient may change their mind about
3 the type of care they would like to receive. But if a
4 provider has a live discharge rate that's substantially
5 higher than its peers, it may be a signal that the provider
6 is not meeting patients' needs or that the hospice is
7 admitting patients that do not meet the eligibility
8 criteria.

9 Across the entire hospice population, we have
10 seen a decrease in the live discharge rate over the last
11 few years, from 18.4 percent in 2013 to 16.7 percent in
12 2015. However, some hospices appear to have outlier live
13 discharge rates. In 2015, 10 percent of hospices had a
14 live discharge rate exceeding 50 percent.

15 So next we have access to capital. Hospice is
16 less intensive than some other sectors in terms of its
17 capital needs. Overall, capital access appears adequate
18 for hospice providers. We continue to see growth in the
19 number of for-profit providers with an increase of about 5
20 percent in 2015, which suggests that capital is accessible
21 to these providers.

22 Reports from publicly traded companies and

1 private equity analysts also suggest that the hospice
2 sector is viewed favorably by the investment community. In
3 particular, some analysts report that post-acute care
4 providers and hospitals are interested in acquiring or
5 developing joint ventures with hospice providers.

6 We have less information on access to capital for
7 nonprofit, freestanding providers, which may be limited,
8 and provider-based hospices have access to capital through
9 their parent providers, and as we have heard, home health
10 agencies and hospitals appear to have adequate access to
11 capital.

12 So this brings us to Medicare margins. Different
13 from other sectors, we have historical margin data through
14 2014, because 2015 margin data are incomplete. So for
15 2014, we estimate the aggregate margin at 8.2 percent, down
16 from 8.5 percent in 2013.

17 One thing to note, as all is, we exclude non-
18 reimbursable costs from our margin calculations, which
19 means we exclude bereavement costs and the non-reimbursable
20 portion of volunteer costs. If those costs were included,
21 it would reduce our margin estimates by, at most, 1.7
22 percentage points.

1 Next we have margins by category of hospice
2 provider. Freestanding hospices continue to have strong
3 margins, 11.5 percent in 2014. Provider-based hospices
4 have lower margins than freestanding hospices. This is
5 partly due to the higher indirect costs of hospital-based
6 and home health-based hospices, which is likely due, in
7 part, to the allocation of overhead from the parent
8 provider, and I can provide more details on that point on
9 question, if you'd like.

10 If provider-based hospices had the same level of
11 overhead as freestanding hospices, their margins would be 9
12 to 14 percentage points higher, and this would cause the
13 overall Medicare margin across types of provider to
14 increase about 2 percentage points.

15 The chart also shows margins by type of
16 ownership. For-profit hospices have very strong margins,
17 at 14.5 percent. The overall margin for nonprofits this
18 year is negative, at -0.7 percent, but when we look at just
19 freestanding nonprofit providers, the margin is positive,
20 at 3.4 percent.

21 One other point to note here, like other sectors
22 we have calculated the marginal profit, and we estimate

1 that that is 11 percent for hospices in 2014.

2 Next we show what's underlying some of the margin
3 differences, as we've talked about before. In the left of
4 this chart you see confirmation of the relationship between
5 length of stay and profit. Providers with longer stays had
6 higher margins. And in the right chart we see how margins
7 increase with percentages of patients in nursing
8 facilities. There may be a number of advantages to the
9 nursing home setting, including access to patients that
10 have conditions associated with long stays, economies of
11 scale from treating patients in one location, and overlap
12 in services provided by the hospice and nursing home.

13 So next we have our 2017 margin projection. To
14 make this projection, we start with the 2014 margin, and we
15 take into account the market basket updates, including
16 productivity adjustments and additional legislated
17 adjustments that occurred between 2015 and 2017. We also
18 take into account the phase-out of the wage index budget
19 neutrality adjustment and other wage index changes.

20 In addition, we make assumptions about cost
21 growth. We assume a higher than historical rate of cost
22 growth in 2015 through 2017, because we anticipate hospices

1 may face additional costs related to new requirements for
2 more detailed claims reporting, new quality initiatives,
3 and revised cost reports.

4 So taking that all together, we project a margin
5 in 2017 of 7.7 percent.

6 To summarize, indicators of access to care are
7 favorable. The supply of providers continues to grow due
8 to entry of for-profits. The number of hospice users
9 increased and average length of stay declined slightly due
10 to a decrease in the longest stays. Limited quality data
11 are now available. Access to capital appears adequate.
12 The 2014 aggregate margin is 8.2 percent, and the 2014
13 marginal profit is 11 percent, and the 2017 projected
14 margin is 7.7 percent.

15 So this brings us to the Chairman's draft
16 recommendation. It reads: The Congress should eliminate
17 the update to the hospice payment rates for fiscal year
18 2018.

19 Given the margin in the industry and our other
20 payment adequacy indicators, we anticipate that providers
21 can cover cost increases in 2018, without any increase in
22 their payment rates. So this recommendation is expected to

1 have no adverse impact on beneficiaries nor providers'
2 willingness or ability to care for them.

3 And that concludes my presentation.

4 DR. CROSSON: Thank you, Kim. We will now do
5 clarifying questions.

6 I have one. With respect to the mandatory
7 bereavement services and the attendant costs that are not
8 allowed, I know we've talked about this before but I can't
9 remember. Can you tell me the rationale for that, (a), and
10 (b) have we in the past made a recommendation that that
11 should be allowed as a cost, or not?

12 MS. NEUMAN: We haven't opined on whether the
13 cost should be considered allowed or not. The origin of it
14 is that the statute says specifically that hospices are
15 required to perform bereavement services, or to offer them,
16 but it also says specifically that Medicare is not allowed
17 to pay for them. And I'm not -- it's hard to know for sure
18 the rationale, but Medicare coverage stems, you know, with
19 the beneficiary, and when the beneficiary has passed, the
20 provision of services outside of that -- you know, I don't
21 know if that was one reason.

22 But regardless, we have, you know, every year,

1 looked at the costs associated with bereavement and we have
2 reported it in our report. So this year -- and it's been
3 very solid, unchanged throughout the last few years. It's
4 about 1.3 percent is that cost. And if you wanted to take
5 it out in your mind, that's how much you would subtract out
6 of our margin.

7 DR. CROSSON: All right. Thank you.

8 MR. GRADISON: I think I can help with that
9 question.

10 DR. CROSSON: Yeah.

11 MR. GRADISON: Having been involved in writing
12 that legislation, what we tried to do was to mirror in
13 statute what the practice was at the time in hospices that
14 had been created in the United States, starting in
15 Connecticut. And this particular aspect of it, that we're
16 talking about, that you asked about, was out there. And so
17 the idea was to design it in a way which would encourage --
18 you can say "require" but there's no real test. There's no
19 inspectors going in there to see how much bereavement
20 services you're doing. It was a sense, this is part of
21 what you ought to do, but that it should be -- have a
22 strong volunteer base, which was consistent with the fact

1 that all the hospices at the time, to the best of my
2 knowledge, were not-for-profit too.

3 So it's just the environment at that time. It
4 doesn't mean it has to be true in the future but that was
5 pretty much the reason. I hope that's helpful.

6 DR. CROSSON: Thank you. Very helpful.

7 Okay. So we've got Amy, Jack, Rita, Bruce, and
8 Paul -- and Craig.

9 DR. MILLER: And Sue.

10 DR. CROSSON: I'm sorry. I missed Sue.

11 All right. Let's try it again. Amy, Jack, Sue,
12 Bruce, Craig, Paul, and Rita. Yeah.

13 MS. BRICKER: Okay. If we could go back to Slide
14 15, I just had a question about specifically -- and then
15 also in the reading material -- on the hospital base, and
16 the negative margins associated, and that it's
17 accelerating. Any insight as to what's driving the
18 acceleration of the loss in margin, and your perspective of
19 will we see hospitals get out of the hospice business
20 because of this, or what's driving that?

21 MS. NEUMAN: We've had -- it's dropped a bit. I
22 think it was minus --

1 MS. BRICKER: Seventeen.

2 MS. NEUMAN: -- yeah, so it's gone down a little
3 bit from last year to this year.

4 I -- there's a couple of components to that
5 margin being negative. One, one piece of it is that we
6 see, in the hospital-based as well as the home health-based
7 hospices, higher administrative costs, and so if -- so some
8 of that may just be an artifact of the fact that it is
9 within a hospital and some of the infrastructure of the
10 hospital cost is getting put on the hospice.

11 We also do see some higher -- we do see some
12 higher costs for patient care as well. It's a smaller
13 component of the cost differences but we do see that, and
14 there's a few things about hospital-based hospices that are
15 different from freestanding, and that is that they have
16 much shorter lengths of stay. So -- and as we've said
17 before, the payment system, as it's currently in this data,
18 favors long stays strongly. So there's probably some of
19 that going on. Also, economies of scale, they tend to be
20 smaller. So those are a couple of reasons, I think, that
21 you see the negative margins, beyond the fact that they
22 have some substantially higher administrative costs.

1 MS. BRICKER: And do you think -- it doesn't
2 show, you know, percent of hospice by type over time,
3 right? It's just 13 percent as of 2014. Do you foresee
4 that number decreasing? Page 41 in the reading material.

5 MS. NEUMAN: Yeah. So I'm going to go back, I'm
6 going to flip back to a slide. Where is it? Here. No, we
7 don't have that. I was thinking we had it by provider type
8 there, but we do not.

9 MS. BRICKER: Just curious.

10 MS. NEUMAN: That first table, let me grab it.
11 So we have seen the number of hospital-based providers
12 going from about 700, near 800, to around a little over
13 500. In the last few years, we've been losing 10 to 20 a
14 year, I would say. So, I mean, it is possible that it
15 could continue to go down a bit. I think that hospitals
16 also, though, see a benefit from having a hospice
17 affiliated with them in terms of the continuum of care and
18 so forth, and we did hear from analysts that hospitals are
19 looking at hospices in an attractive way in terms of joint
20 ventures and mergers and things of that sort. So I think
21 there's a sort of mixed environment.

22 MS. BRICKER: Thanks.

1 DR. MILLER: And there has been a real shift in
2 the structure of the industry over this period, I mean
3 moved a lot from not-for-profit to for-profit, and lots of
4 growth in freestanding hospices. So, you know, outside of
5 the hospital, a lot of things are changing as well.

6 DR. HOADLEY: So my first question is deals with
7 the demonstration you highlighted on Slide 5, and I know
8 it's too early to know anything about that, but I'm
9 wondering when we would first expect to see some results.
10 I assume CMS has some kind of evaluation in place, and I
11 guess, in particular, I'm wondering if they're doing both
12 sort of quantitative stuff and qualitative, because it
13 seems like you would want to know sort of how this has had
14 an effect on the people who use these benefits.

15 MS. NEUMAN: So CMS will be doing an evaluation.
16 We don't have the time frame for sort of when that will
17 happen and when results will first be released. But my
18 sense is that they're anxious to, you know, learn from this
19 as well.

20 So as far as qualitative and quantitative, I
21 believe both, but I can double-check that for you.

22 DR. HOADLEY: Okay. Thank you.

1 My other question had to do with the margin
2 projection and the impact of the 2016 revisions to the
3 payment system, and I'm assuming, from trying to read
4 between the lines, that because that's budget neutral, that
5 would have no effect overall on the average margin. Is
6 that your expectation?

7 MS. NEUMAN: It would not, if there were no
8 utilization changes.

9 DR. HOADLEY: Okay.

10 MS. NEUMAN: If there is a response, you could
11 see an aggregate increase. We just don't know at this
12 point.

13 DR. HOADLEY: But we would presume there would be
14 some impact on the distribution of margins in the sense
15 that you're expecting that sort of differential effect by
16 different categories of providers. Is that right?

17 MS. NEUMAN: That's correct. And, you know, CMS
18 in their rule for the 2016 payment system did estimate by
19 broad categories how much money would be shifting, and, I
20 mean, it's modest. You know, it's a few points between
21 some of the big categories that we're talking about. And
22 individual providers might be affected differently, but

1 categories as a whole, for-profit versus nonprofit, we're
2 talking about a few points as to what they initially
3 projected.

4 DR. HOADLEY: Okay. It might be useful to have a
5 little bit more of that flavor included in what we report
6 on. Thank you.

7 MS. THOMPSON: And my question really is
8 underscoring Jack's question about when that data might be
9 available, because even anecdotally in the Pioneer and our
10 NextGen work, in terms of the high risk, rising risk, and
11 certainly the patients with multiple chronic disease that
12 became cared for by the palliative care program, separate
13 from hospice, but as part of the continuum, when we began
14 to think about palliative care in a continuum to hospice, a
15 couple of really remarkable things happened. I'm thinking
16 there should be good data from the folks who worked within
17 the Pioneer and certainly those who are in NextGen now who
18 are seeing patients wanting to stay in the palliative
19 program much longer. The quality scores in terms of
20 patient perception have gone up, and hospice days have
21 definitely decreased.

22 So, again, I think there's something about a

1 continuum here between a palliative program and then
2 hospice which has some value. So I'm really excited about
3 this demonstration because I'm pretty hopeful, based upon
4 anecdote and experience, but I think there's some good work
5 for us to keep our eye on.

6 MR. PYENSON: Well, thank you very much, Kim.
7 You noted in the report that the portion of decedents
8 coming from Medicare Advantage plans is somewhat higher who
9 use hospice than fee-for-service. Do you have -- I may
10 have missed it in the report, whether the lengths of stay
11 are different.

12 MS. NEUMAN: I don't think we have it in this
13 report. We have looked at it before, and I would need to
14 go back and look for the most recent year. But in the
15 past, what we found was that they were relatively similar.
16 There was slightly lower lengths of stay for Medicare
17 Advantage people on the tail, so on the high end, but not
18 by much. So it was relatively similar. We can put in here
19 for 2015 what it looks like.

20 MR. PYENSON: Thank you. And I guess I've noted
21 that MedPAC has recommended that Medicare Advantage pay for
22 hospice, I think in the past.

1 Another question on the long-term care -- I'm
2 sorry, nursing home patients, and you noted a high margin
3 for patients in nursing home. To what extent do you think
4 that is Medicare absorbing costs from Medicaid-eligible
5 nursing home patients for their hospice stay?

6 MS. NEUMAN: Can you say a little bit more about
7 sort of the mechanics you're thinking there?

8 DR. CROSSON: I think Bruce is asking, as the
9 length of stay is increased -- correct me if I'm wrong --
10 what proportion of that is a consequence of patients, you
11 know, who have conditions that would otherwise be cared for
12 by Medicaid?

13 MR. PYENSON: That's perhaps an aspect of it, but
14 at --

15 DR. CROSSON: I'm sorry. Go ahead.

16 MR. PYENSON: At least in the past, Medicaid-
17 eligible nursing home patients who are covered by Medicaid
18 would have their Medicaid daily rate in effect paid by
19 Medicare as part of their care.

20 MS. NEUMAN: So I think, if I'm following, you're
21 referring to the -- there's a sort of peculiar structure to
22 how the room and board payments work when a beneficiary is

1 in hospice via Medicare and is in a nursing home and the NF
2 part paid for by Medicaid. It's an artifact of Medicaid
3 law, and the way it works is the room and board payments
4 that the state normally makes to the nursing home now gets
5 paid to the hospice, and then the hospice then pays the
6 nursing home for that room and board. And the states often
7 pay 95 percent of the room and board rate, and we hear
8 anecdotally from hospices that then the nursing homes want
9 100 percent of the rate, and so it's common for the
10 hospices to give the nursing home the full rate.

11 And so there is this weird thing -- it doesn't
12 happen in all circumstances, but there is this weird thing
13 where effectively the hospices are kind of subsidizing that
14 5 percent -- voluntarily, but they're choosing to subsidize
15 it for Medicaid patients in nursing homes. And it's an
16 artifact of Medicaid law.

17 MR. PYENSON: Thank you.

18 DR. SAMITT: So thanks for the great report.

19 Slide 16, on the left, I'm curious to see if we've modeled
20 the impact on margins in these groups by average length of
21 stay given the CMS revised payment system in terms of the
22 increase for shorter length and decrease for longer length.

1 What will this mean either by the average length of stay
2 quintile in terms of margins or by types of organization
3 for margins?

4 MS. NEUMAN: Right, so we have not taken the CMS
5 current payment rates and imposed it on this chart and said
6 here's what the margins would look like with the same
7 utilization in 2014 but these different payment rates. We
8 have not done that.

9 What I can tell you is that CMS, when they did
10 their rule, they estimated sort of how margins -- or not
11 margins, revenues would change for various provider groups,
12 and so, for example, the nonprofits -- which, again, it's
13 going to not be broken out exactly like this, but it gives
14 you a sense -- they were going to go up between 1 and 1.5
15 percent, and the for-profits were going to go down by about
16 a little bit under 1 percent. So you can see as categories
17 the magnitude of the shifts. And then within, you know,
18 providers and different ends of the spectrum, you could see
19 it be a little bit more than that. But it's not going to
20 be really, really big in general. It's going to be more
21 modest.

22 DR. SAMITT: Thank you.

1 DR. REDBERG: Thanks for an excellent chapter.
2 My question is just on the live discharge rate, because,
3 you know, certainly 10 to -- I mean, it's hard to say the
4 right number, but 10 to 20 percent sounds about right. So
5 the higher numbers like 29 and 50 percent do sound high.
6 I'm wondering if there is any data on how many hospice days
7 there were on average before the live discharges.

8 MS. NEUMAN: So we've looked at that before, and
9 there's kind of two scenarios. Some of the live discharges
10 happen after people have been in hospice for a very long
11 time, and then others of them are after much shorter stays,
12 sometimes with the patient coming right back, sometimes
13 not. And so we have not -- we don't have it for 2015, but
14 we could certainly recall back to what we've done before
15 and see whether we have the ability to update or not at
16 this point.

17 DR. REDBERG: And I'm also wondering, was there
18 any association with the type of hospice facility, like
19 for-profit or nonprofit, and live discharge rate?

20 MS. NEUMAN: So we do see higher live discharge
21 rates among for-profit providers. We also see it true of
22 newer providers who've entered more recently. And hospices

1 that are above the cap or approaching the cap tend to have
2 much higher live discharge rates than others.

3 DR. GINSBURG: Yes, my question is really not
4 specific to hospices. It applies, I think, to a lot of the
5 areas we've looked at, but I just thought of it now so
6 that's why it's coming up now.

7 We've looked at operating margins in all of the
8 segments, but operating margin is probably not the most
9 relevant information about profitability, which would be
10 return on equity. And, you know, particularly with some of
11 these segments like hospices, like home health care, where
12 the capital needs are very low, there's a possibility that
13 we could have returns on equity that are very high numbers.
14 I guess the problem is that except for when there's a
15 publicly traded company that is a major provider and does
16 mostly one segment, we probably just don't have the
17 information. I don't know if the staff has ever, you know,
18 run into this issue and seen if there's anything that can
19 inform us to be able to say these hospice operating margins
20 probably are really high given the low capital
21 requirements.

22 DR. MILLER: Yeah, I don't think we've looked at

1 it that way, but I'll tell you what, we can go back and
2 huddle and kind of ask ourselves whether there's
3 information like that to bring to bear. I would think it
4 would be particularly hard here because a lot of these are
5 for-profit, freestanding, and often small operations -- I'm
6 looking at Kim as I'm saying this -- although there are a
7 couple of large, you know, companies where maybe you could
8 get at that information. But it certainly wouldn't be
9 global across the industry. Am I getting a nod out of you?

10 DR. DeBUSK: On a related note, you may have a
11 problem there, too, because the capital structure -- you
12 know, for example, in a hospice or home health, you would
13 assume automobiles would be a significant portion of their
14 assets. Well, depending on how you structured that, say
15 leasing versus owning, that could dramatically distort the
16 denominator that you'd use, too. But I do completely
17 understand where you're coming from, because the returns on
18 some of these companies could be incredible.

19 DR. CHRISTIANSON: Just a quick confirm. These
20 are raw data, right? These are not incremental effective
21 length of stay on margin. This is just without adjusting
22 for anything, right?

1 MS. NEUMAN: No adjustment.

2 DR. CROSSON: Okay. Seeing no more questions,
3 we'll put up the recommendation. The recommendation is the
4 order of business. Comments on support for the
5 recommendation or other issues related to the
6 recommendation?

7 Seeing a small outbreak of thumbs, one finger.

8 DR. HOADLEY: I keep looking at this sector and
9 the huge differential between the for-profit and the not-
10 for-profit that we see in terms of margins, and obviously
11 the evolution of the industry, in some ways it feels like
12 it calls out for differential updates by profit status. I
13 know that's not something we typically do. You know,
14 initially I was going to say, well, you know, the 2016
15 changes would purport to make some movement in that
16 direction and potentially change it, but it sounds like
17 that movement is likely to be fairly small. So I'm not
18 going to formally suggest that we modify the
19 recommendation, but I did want to just sort of raise that
20 issue.

21 You know, maybe it just calls for in the future
22 looking harder at sort of what are the factors that are

1 more -- I mean, I know we've looked at this, but even more
2 at what are the factors that are differentiating those
3 categories of providers? And are there other policy levers
4 that we can use -- it isn't as blunt as just going on the
5 profit status -- to try to, you know, address the fact that
6 the margins are so high in the for-profit part of this
7 industry?

8 So, you know, having said that, I'm fine with
9 supporting this recommendation, but I did want to sort of
10 put that on the record.

11 DR. MILLER: Yeah, and the two -- I do think
12 there is some caution to attaching updates to the specific
13 label on a door, because that's kind of -- you know,
14 whether we want to reverse, but generally I've tried to go
15 in the direction of we pay for something for the
16 beneficiary, and we're more agnostic about how that
17 happens, although these here, there are big distortions,
18 and, you know, both Jim, who did a lot of this work early
19 on, and then Kim will remember how years ago people came to
20 us and said, you know, this industry is changing overnight.

21 I'd be more inclined to go after your point on
22 returning to the payment structure and saying maybe it was

1 too shallow, it wasn't deep enough, and thinking of things
2 that were raised like the live discharge and saying is this
3 -- or some other sets of measures, and if you see an
4 association, which you will, with your point and saying now
5 the payment ends up getting adjusted on these factors and
6 try and drive change that way, as opposed to not-for-
7 profit/for-profit.

8 DR. HOADLEY: I'm certainly comfortable with that
9 kind of approach. One of the questions might be -- and I
10 don't remember how -- whether there was much
11 differentiation between what CMS did in their 2016
12 revisions versus what we recommended. If our
13 recommendations were for a bigger shift in terms of that
14 pattern, you know, maybe that's something to go back and
15 say, you know, what was done in 2016 was great but didn't
16 go far enough, if that's an accurate characterization of --

17 DR. MILLER: It is.

18 DR. HOADLEY: I thought it was. yeah.

19 DR. MILLER: I hate to get in line in front of
20 Kim, but I almost think we said that in like a comment
21 letter or something somewhere. It's like you definitely
22 took a step in our direction, but you didn't take the whole

1 way. And my sense is they were more shallow in terms of
2 their adjustments than the way we were thinking about it.

3 DR. HOADLEY: And maybe a descriptive -- you
4 know, some reference to that comment or some repeat of that
5 comment in this chapter would be just a way to continue to
6 keep that theme alive.

7 DR. MILLER: I agree. I just want to make sure,
8 Kim, that was right in your recollection?

9 MS. NEUMAN: Yeah. I agree.

10 DR. NERENZ: I was just going to hold this until
11 the last just because the comment relates to all these
12 segments, but since Jack put it on the table, I'll say it
13 now. I will support the recommendation. I think on our
14 future agenda I would really love to see a focused section
15 on this issue of freestanding/for-profit on the one hand
16 and then not-for-profit hospital-based. We're just seeing
17 it over and over again, and there's growth, and there seem
18 to be positive margins on the one hand. There's lack of
19 growth, negative margins, or at least zero margins on the
20 other hand. And I'd really like us to dig in and see what
21 does it really mean.

22 I don't know whether we could actually do

1 conditional update recommendations. It's not part of
2 today's discussion, I think, but as a focused issue. And
3 the reason I was going to bring it up is that there's at
4 least some risk of us getting into a penny-wise, pound-
5 foolish kind of orientation where, when we look at specific
6 units of service and specific silos, we see that certain
7 kind of entities are low cost. The counter -- and, you
8 know, we can keep doing that separately.

9 The counter view -- and it's typically brought up
10 by proponents of organized system integration -- is that
11 when you put the pieces structurally together you get
12 efficiencies that you only see at the episode level or the
13 per capita level. There's precious little empirical
14 evidence for that, but it seems like that's something that
15 we ought to try to take up.

16 Now, whether we can reach any kind of conclusion,
17 I don't know, but it just seems every single time we walk
18 through one of these -- and it's not even just this year --
19 we see this phenomenon. And I guess I'd like to have a
20 general sense of do we think these trends are good or bad,
21 if we could inform such an impression. But a separate
22 issue, spring issue, sometime, but I'd like to see it on

1 the agenda.

2 DR. CROSSON: Pat.

3 MS. WANG: Speaking for myself, I would be very
4 cautious about trying to draw lines between hospital-
5 sponsored versus freestanding not-for-profit versus for-
6 profit. There's a lot of reasons that I think some of
7 these services may be better provided by freestanding for-
8 profit providers who are specialized. For example -- and I
9 think that there are examples of not-for-profit health
10 systems in the book -- or I guess it was under the dialysis
11 section -- who are entering into joint ventures because
12 somebody else can do that business more efficiently than
13 them. So I would be a little careful about the labels.

14 That said, given the big shift in all of these
15 sectors, which I also agree is kind of like what's going on
16 here, I think it becomes -- where I would put the leverage
17 or the emphasis for MedPac's examination is on accuracy of
18 payment, ensure that there are not disincentives for taking
19 care of the sickest patients, because there is a little bit
20 of a trend in some of the things that we've discussed that
21 the more complex patients seem to be cared for more in
22 certain sectors than in other sectors.

1 To me, sort of the approach to assess payment
2 adequacy with all these factors -- and I agree with this
3 recommendation -- are very sound in saying there's enough
4 money in the sector. Through this analysis, there's enough
5 money in the sector.

6 But what you're bringing up and what Jack has
7 brought up and everybody has talked about in different ways
8 is there does seem to be a second really big question about
9 is it being distributed appropriately within the sector,
10 and on that, I would really go towards beneficiary
11 characteristics, need, ensuring that there are plenty of
12 incentives in place to take care of the sickest Medicare
13 beneficiaries.

14 This sector bothers me because there are these
15 really disparate statistics around length of stay, live
16 discharges, program integrity issues. So I think there's a
17 really good reason to keep looking at it, but I would
18 really try to stay away from labels of sponsorship and
19 really go after beneficiary characteristics and quality,
20 personally, and make sure that the payment system,
21 regardless of sponsorship, is really paying for what we
22 want it to pay for.

1 DR. CROSSON: And I have to say I agree with that
2 strongly.

3 I think over the last few years, we have seen --
4 and we observed again -- that something is different. The
5 hospice -- the use of the hospice benefit is changing
6 compared to what the expectation was when Bill worked on
7 it.

8 Oftentimes, when we look at sectors and we
9 analyze that and we see the sudden growth of for-profit
10 entities, entrepreneurial entities, it can be an indicator
11 that something with respect to choice of beneficiaries,
12 risk, modes of treatment is askew compared with what it
13 used to be. And to the extent that that's not the right
14 thing for the program, not the right thing for the
15 beneficiaries, then it's at that level, I think, that we
16 would want to be doing a closer look.

17 I think, Kim, at least in the last couple of
18 years, you have focused on some of those issues, but I
19 think you're hearing support for a continuation of that
20 analysis.

21 DR. MILLER: And I would say, too -- and I think
22 you put it extremely well and on point -- that you focus on

1 the patient's characteristics and quality because the
2 organization of the system may be changing, maybe should be
3 changing, and if you start attaching payments to things,
4 then they'll become those things. We're going to see
5 emergency rooms grow because of some of the site-neutral
6 policies that are out there now, and so that's why, in some
7 ways, I think her point is fairly strong.

8 DR. CROSSON: Alice.

9 DR. COOMBS: So something that Jack said
10 resonated with me specifically about the hospitals, and it
11 is a trend, but I was reflecting back to the dialysis
12 piece. And I know for a fact that dialysis in the
13 freestanding dialysis, away from the hospital, they have a
14 different labor criteria. So, when you see the labor units
15 in the dialysis unit, they're very different than the labor
16 units in the ICU. We have ICU nurses that run the dialysis
17 nurses. It's very different. That goes beyond the usual
18 VSRN. Most of them have master's, and they've had years of
19 experience. So that labor unit by itself is
20 extraordinarily expensive.

21 I don't necessarily think it's the capital model
22 that's there, more so the infrastructure and availability

1 of extra resources in that unit. My concern is if there is
2 an isolation, geographic isolation, what does that hospital
3 unit mean for hospice or dialysis? In thinking about it, I
4 think that's the greatest threat to the beneficiary is if
5 that unit proves to be a sanctuary site, where there's not
6 a lot of other units in the same area. I don't think we've
7 heard that, but that would be my greatest concern, and that
8 that unit suddenly disappearing would be a significant
9 change for beneficiaries, whether it's hospice, dialysis,
10 or the like.

11 So while quality is really important, with
12 quality there must be some quantity in your geography. So
13 I think quality is the other piece of it, because a for-
14 profit comes in, in an area where they can actually make a
15 profit, and we've had this scenario where they're not
16 necessarily going to Compton, California. They're going to
17 the place where there is the ZIP code and the average
18 income and the housing market and everything is a robust
19 environment, so that the hospital doesn't have -- you know,
20 a hospital may be in an area where it's been for years, and
21 the area may have changed, but this other issue about what
22 happens when a hospice goes under in an area and the

1 beneficiaries are left to either kind of fend or do they
2 make different decisions when geography becomes a
3 limitation.

4 So I understand, and it did resonate with me.

5 DR. CROSSON: Okay. So I think, again, I have
6 the sense that there is a consensus for the recommendation.
7 Seeing no objections, then we will bring this forward in
8 January through the expedited presentation and voting
9 process.

10 Kim, thank you very much. Nice job.

11 We will move on to the final presentation for the
12 morning.

13 [Pause.]

14 DR. CROSSON: Stephanie Cameron is here, and
15 we're going to talk about the adequacy of payment for long-
16 term care hospitals.

17 Stephanie?

18 MS. CAMERON: Good morning. Today we are here to
19 discuss how payments to LTCHs should be updated for fiscal
20 year 2018. First, I will summarize some of the background
21 information included in your mailing materials.

22 To qualify as an LTCH under Medicare, a facility

1 must meet Medicare's conditions of participation for acute
2 care hospitals and have an average length of stay for
3 certain Medicare cases of greater than 25 days. Care
4 provided in LTCHs is expensive -- the average Medicare
5 payment in 2015 was over \$41,000.

6 Similar to a short-stay acute care hospitals,
7 Medicare pays LTCHs on a per discharge basis with an
8 upwards adjustment for cases with extraordinarily high
9 costs. Unlike the acute care hospitals, LTCHs also have a
10 downward payment adjustment for cases with extremely short
11 lengths of stay.

12 Beginning in fiscal year 2016, an LTCH discharge
13 either needs to have three or more days in the referring
14 hospital's ICU or receive an LTCH principle diagnosis that
15 includes prolonged mechanical ventilation to qualify for
16 the full LTCH standard payment rate. Discharges that don't
17 meet these criteria will receive a site neutral payment
18 equal to the lesser of an IPPS comparable rate or 100% of
19 costs. As you'll recall, the criteria to qualify for the
20 full LTCH standard payment rate are consistent with the
21 direction of Commission's 2014 and 2015 recommendation for
22 chronically critically ill beneficiaries.

1 The Pathway for SGR Reform Act also changes the
2 calculation of the 25-day average length of stay
3 requirement to exclude Medicare fee-for-service cases paid
4 the site neutral rate as well as cases paid by Medicare
5 Advantage. It also created a moratorium on new facilities
6 and additional beds, with some exceptions, through
7 September of 2017.

8 Although the dual-payment policy began in fiscal
9 year 2016, because of the multi-year phase-in and range of
10 hospital cost report periods, we don't expect to see the
11 full effect of implementation until our December 2020
12 analysis.

13 I will now turn to the question of how payments
14 to LTCHs should be updated for fiscal year 2018, using our
15 established framework you've seen throughout the last day
16 and a half.

17 We have no direct indicators of beneficiaries'
18 access to needed LTCH services so we focus on changes in
19 capacity and use. The absence of LTCHs in many areas of
20 the country makes it particularly difficult to assess the
21 adequacy of supply.

22 Even though about 60 percent of fee-for-service

1 beneficiaries live in counties without LTCHs, over 95
2 percent of beneficiaries live in counties with at least
3 some LTCH use. There is quite a bit of variation in the
4 number of LTCH days per fee-for-service beneficiary by
5 county. For example, the median utilization for LTCH care
6 is 6 days per 100 fee-for-service beneficiaries, where the
7 top ten percent of counties use over 21 days and the bottom
8 10 percent use fewer than 2 days. The top 10 percent of
9 counties are concentrated in four states; therefore most
10 beneficiaries receive care in acute care hospitals.
11 Research has shown that outcomes for the most medically
12 complex beneficiaries who receive care in LTCHs are no
13 better than those for similar patients treated in other
14 settings.

15 To gauge access to services, we typically look at
16 available capacity. Here we show the cumulative growth of
17 LTCHs and beds since 2006. A moratorium began in 2007, but
18 took several years to slow the growth of LTCH expansion
19 given the exceptions provided by law. We found a reduction
20 in the rate of the growth of LTCHs starting in 2009.

21 You'll note the second dashed lines between 2012
22 and 2015. This year, similar to the last two years, the

1 number of facilities and beds calculated based on the cost
2 report data is artificially low because of a larger than
3 average number of LTCHs that changed their cost reporting
4 periods and therefore were not included in our analysis
5 based on our long-standing data screens.

6 Because of this, we also analyzed the number of
7 beds and facilities for active LTCHs in Medicare's Provider
8 of Services file. Based on data from this file, we find
9 that the number of facilities increased by about 0.3
10 percent between 2014 and 2015, and further estimate that
11 there was an approximate 1 percent increase in beds during
12 that time period. This file likely overestimates the
13 number of facilities and beds based on a lag between when a
14 facility closes and when it is reported as such. Given
15 this, we estimate that there were likely some small
16 declines in the number of available beds and facilities but
17 not likely to the extent suggested by our analysis of the
18 cost report data.

19 This chart shows what's happening with LTCH cases
20 per 10,000 fee-for-service beneficiaries. After rapid
21 growth through 2005, volume continued to grow but at a
22 slower pace. Controlling for the number of beneficiaries,

1 the number of LTCH cases declined after 2011 when volume
2 peaked at 38.3 cases per 10,000 fee-for-service
3 beneficiaries. Volume further declined 2 percent between
4 2014 and 2015, to equal 34.7 cases per 10,000 fee-for-
5 service beneficiaries. Unlike in prior years, this
6 decrease in volume was not observed across other inpatient
7 settings during 2015.

8 In terms of quality, LTCHs began submitting
9 quality data on a limited number of measures to CMS in
10 fiscal year 2013. CMS has expanded the number of measures
11 required for reporting over the past four years. None of
12 these data are currently available for analysis. We
13 expected CMS to begin releasing some data publicly this
14 fall; however, public reporting on two of the four measures
15 has been delayed until next spring. In the meantime, we
16 continue to rely on claims data to assess gross changes in
17 quality of care in LTCHs.

18 Between 2010 and 2015, mortality and readmission
19 rates were stable or declining for most of the common LTCH
20 diagnoses. The aggregate mortality rate reminds us of how
21 sick some patients in LTCHs are. On average, about one-
22 quarter of LTCH patients die in the facilities or within 30

1 days of discharge. Among the top 25 conditions in LTCHs,
2 this ranges from a high of 46 percent for patients with
3 septicemia and prolonged mechanical ventilation to a low of
4 4 percent for patients treated for aftercare with
5 complication or comorbidity. During this same time
6 period, the unadjusted aggregate 30-day readmission rate
7 was just under 10 percent.

8 Access to capital allows LTCHs to maintain and
9 modernize their facilities. If LTCHs were unable to access
10 capital, it might reflect problems with the adequacy of
11 Medicare payments since Medicare accounts for about half of
12 LTCHs' total revenues. Historically, however, the
13 availability of capital said more about the uncertainty
14 regarding the regulations governing LTCHs as well as the
15 effect of the prior moratorium, than it did about payment
16 rates.

17 Since the phase-in of the payment criteria began
18 in October of 2015, LTCHs have been working toward adapting
19 their admission patterns, costs, and case mix to mitigate
20 the effect of the payment reduction for cases that don't
21 meet the new criteria.

22 While the increased certainty of the rules

1 governing LTCH payment policy would typically increase the
2 availability of capital, the moratorium significantly
3 reduces opportunities for expansion and, thus, the need for
4 capital.

5 Turning now to LTCHs' per case payments and
6 costs, you can see why we have reason to believe that LTCHs
7 will adapt to the upcoming regulatory changes. LTCHs
8 historically have been very responsive to changes in
9 payment, adjusting their cost per case when payments per
10 case change. As you can see here, payment per case
11 increased rapidly after the PPS was implemented.

12 After 2007, the growth in cost per case
13 stabilized to less than 3 percent per year. Between 2014
14 and 2015, the average cost per case increased by 2.1
15 percent. Starting in 2012, Medicare payments increased
16 more slowly than the rate of increase of provider costs and
17 beginning in 2013, cost growth exceeded payment growth.

18 Increase in cost growth relative to payment
19 growth between 2014 and 2015, resulted in a 2015 aggregate
20 Medicare margin of 4.6 percent, and a 6.8 percent margin
21 for Medicare qualifying cases that I will discuss
22 momentarily. The marginal profit assesses whether

1 providers have a financial incentive to expand the number
2 of Medicare beneficiaries they serve. Because the average
3 LTCH marginal profit was close 20 percent in both 2014 and
4 2015, we contend that LTCHs have a financial incentive to
5 increase their occupancy rates with Medicare beneficiaries.

6 As you can see, there is a wide variation in the
7 Medicare margins, similar to what we see in other settings,
8 with the bottom quarter of LTCHs having an average margin
9 of minus 14.6 percent and the top quarter having an average
10 margin of 17.8 percent. The margins shown here of 4.6
11 percent for urban facilities and 2.8 percent for rural
12 facilities deviate from the historical trends of similar
13 LTCH margins across geographic area. This year's variation
14 is from technical changes to the definition of CBSA based
15 on new data -- based on the 2010 Census.

16 Consistent with other sectors, the for-profit
17 facilities, accounting for 84 percent of cases, have the
18 highest average margin at 6.4 percent while the nonprofit
19 facilities have the lowest margin at negative 6.0 percent.
20 There are a number of reasons why LTCHs have lower costs
21 and higher margins that we will discuss on the next slide.

22 This slide compares LTCHs in the top quartile for

1 2015 margins with those in the bottom quartile. As you can
2 see in the top line, high-margin LTCHs tend to be larger
3 and to have higher occupancy rates, so they likely benefit
4 more from economies of scale. Low-margin LTCHs had
5 standardized costs per discharge that were 35 percent
6 higher than high margin LTCHs.

7 High margin LTCHs have fewer high cost outlier
8 cases and fewer short stay cases. As you remember, these
9 short cases are paid differently from the standard PPS
10 rate, given their comparability in length of stay with
11 similar cases in acute care hospitals. Lastly, high-margin
12 LTCHs are more likely to be for-profit based on their
13 demonstrated ability to restrain costs in this sector and
14 across other provider types we've discussed over the past
15 two days.

16 Turning to the margin calculation that only
17 includes only cases that would qualify to receive the full
18 LTCH standard payment rate. To calculate a margin for
19 these qualifying cases, we used the most recently available
20 claims data, combined with revenue center-specific cost-to-
21 charge ratios for each LTCH. Using this methodology, we
22 calculated a pro forma 2015 margin of 6.8 percent. We

1 project that this margin will decline in 2017. Updates to
2 payments in 2016 and 2017 were reduced by PPACA-mandated
3 adjustments.

4 We expect cost growth to be higher than current
5 law payments for the qualifying cases as the LTCH dual
6 payment structure is implemented. Using the projected
7 growth in the LTCH market basket, we project that LTCHs'
8 Medicare margin for qualifying cases paid under the LTCH
9 PPS will be 5.4 percent in 2017. While we expect
10 significant changes to admission patterns and per case cost
11 associated with the implementation of the new patient-
12 specific criteria, the extent of these changes is less
13 certain. If we assume the relationship between costs and
14 payments for the cases that qualify to receive the LTCH
15 standard payment amount change to reflect the current
16 overall book of business, a conservative margin estimate
17 for 2017 would be closer to 3.2 percent.

18 The extent that LTCHs continue to provide care to
19 beneficiaries who do not qualify to receive the full LTCH
20 standard payment rate will determine the aggregate total
21 margin in 2016 and beyond.

22 In sum, growth in the volume of LTCH services per

1 fee-for-service beneficiary declined about two percent. We
2 have little information about quality in LTCHs but
3 unadjusted mortality and readmission rates appear to be
4 stable or improving. The effect of the current moratorium,
5 combined with adjustments to meet the patient-specified
6 criteria, will likely limit growth at this time. Our
7 projected margin for qualifying cases paid under the LTCH
8 PPS in 2017 will equal 5.4 percent assuming the current
9 underlying cost structure for these cases.

10 CMS historically has used the market basket as a
11 starting point for establishing updates to LTCH payments;
12 however MACRA requires a 1 percent payment update for LTCHs
13 in fiscal year 2018. Therefore, this year, we are making
14 our recommendation to the Congress. With that, the
15 Chairman's draft recommendation reads, The Congress should
16 eliminate the update to the payment rates for long-term
17 care hospitals for fiscal year 2018.

18 Eliminating this update for 2018 will decrease
19 federal program spending relative to the MACRA-specified 1
20 percent payment update.

21 We anticipate that LTCHs will continue to provide
22 Medicare beneficiaries with access to safe and effective

1 care and accommodate changes in costs with no update to the
2 payment rates for qualifying cases in LTCHs in fiscal year
3 2018.

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

5 DR. CROSSON: Thank you very much, Stephanie.
6 Very clear.

7 We're open for clarifying questions. Bruce.

8 Sorry. Bruce, Kathy, Jack.

9 MR. PYENSON: Yeah. Thank you very much,
10 Stephanie. On page 15 of the report you note that some of
11 the decline in LTCH use is consistent with the growth of
12 Medicare Advantage plans, which seems to suggest Medicare
13 Advantage plans don't use LTCH services very much. In the
14 section on inpatient rehab, we did have a comparison of
15 patient use for Medicare Advantage patients compared to
16 fee-for-service patients. I thought that was very useful.

17 Is it possible to do the same for LTCH, or are
18 there simply not enough Medicare Advantage patients going
19 to LTCH?

20 MS. CAMERON: That's actually not the issue at
21 all. I believe the IRF data came from the IRF PAI, which
22 is the assessment instrument which is required for IRF

1 patients, not just Medicare fee-for-service beneficiaries
2 but all of IRF patients.

3 The LTCH care data set, assessment data, is not
4 yet available for analysis in the LTCH, so we, at this
5 point, don't have access to that level of data. Perhaps in
6 the future we will, and I will be happy to report it at
7 that time. It's not an issue with not having the data or
8 few beneficiaries using the service, although I think we do
9 expect a fewer number of Medicare Advantage beneficiaries
10 currently use LTCH services relative to, say, Medicare
11 Advantage use of the inpatient acute short-stay hospitals,
12 but it's more of a matter of data availability at this
13 time.

14 MR. PYENSON: Thank you.

15 DR. CROSSON: Kathy.

16 MS. BUTO: Several questions. Stephanie, on page
17 18 of the mailing materials there is a really helpful table
18 that lists some of the -- I guess the top 25 MS-LTCH DRGs.
19 So two questions about this chart. One is, these are
20 unique to the LTCH system of categorizing patients, but I
21 assume that some of these, or all of them, track back to an
22 acute care DRG. Do we have a sense of how those are

1 distributed? For example, pulmonary edema, you know,
2 related to CHF admission in the acute care hospital. Do we
3 have any sense of which are the predominant acute care DRGs
4 that track to LTCH? Or maybe it's all over the map. I
5 don't know.

6 MS. CAMERON: It is a bit all over the map. The
7 LTCH MS-DRGs are the exact same in terms of the number and
8 the description as the DRG, MS-DRGs that are used in the
9 acute care hospital setting. So there an exact crosswalk.

10 MS. BUTO: Okay.

11 MS. CAMERON: The difference is the weights that
12 are assigned to the LTCH MS-DRGs, and then, obviously, the
13 standardized payment amount is different in this setting.

14 MS. BUTO: Right, right.

15 MS. CAMERON: The difficult part in doing
16 comparisons with acute care hospitals is there's a sheer
17 volume differential. I believe there are upwards of 10
18 million short-term acute care hospital claims --

19 MS. BUTO: Right.

20 MS. CAMERON: -- where LTCHs have about 130,000.

21 MS. BUTO: Yeah.

22 MS. CAMERON: So doing comparisons is somewhat

1 difficult because we don't know if we're comparing just on
2 looking at DRGs, kind of on this aggregate level, who is
3 getting mixed in.

4 MS. BUTO: Right. Okay.

5 The second question about these DRGs or these
6 diagnoses or categories is, in areas that don't have LTCHs,
7 where do these folks go? Do we have a sense of that? I
8 assume SNFs. I assume some stay in the hospital. But I'd
9 be curious to know what you know about that.

10 MS. CAMERON: That's exactly right.

11 So our understanding is that some do, in fact,
12 stay in the hospital. Perhaps they stay in the hospital
13 longer and then receive SNF care, and that is their course
14 of action.

15 Areas that don't have LTCHs, as I mentioned in
16 the presentation, there are many areas of the country where
17 people do travel for some LTCH use, and when we looked at
18 the data, we found that beneficiaries who come from areas
19 without LTCHs use certain services and LTCHs more than
20 others. So vent services, for example, are used more by
21 beneficiaries in areas without LTCHs, who travel for LTCHs,
22 than beneficiaries in areas who have existing LTCHs.

1 MS. BUTO: Okay. Another question, are most of
2 these patients coming directly out of an acute care stay,
3 or all of these patients, or do any of them come from the
4 community?

5 MS. CAMERON: So, at this juncture -- I'm going
6 to answer your question in two parts because I think the
7 data here reflect data from 2015, which was before the dual
8 payments, the criteria was implemented. And I believe our
9 latest estimates were about 85 percent of beneficiaries are
10 admitted to an LTCH directly from an acute care hospital
11 discharge.

12 MS. BUTO: Okay.

13 MS. CAMERON: The criteria that was effective
14 starting in fiscal year 2016, which we will start to see in
15 next year's data, in order for an LTCH beneficiary to
16 qualify for the higher payment rate, they have to meet
17 certain criteria, and one of those criteria is a three-day-
18 or-longer prior stay --

19 MS. BUTO: In an ICU?

20 MS. CAMERON: -- in an ICU in an acute care
21 hospital.

22 MS. BUTO: Okay.

1 MS. CAMERON: So one would expect -- although we
2 don't have data yet, one would expect that 85 percent will
3 in fact increase.

4 MS. BUTO: Thank you.

5 DR. CROSSON: Jack.

6 DR. HOADLEY: So I have a question about the
7 margin calculation, and I want to make sure I'm
8 understanding correctly the difference between the 5.4 and
9 the 3.2. As I hear it, 5.4 is assuming a behavioral
10 response from the industry. It sort of parallels the
11 historic kind of response pattern that you've seen, and the
12 3.2 essentially would assume less behavior response, more
13 sort of just continuing the current patterns? Is that it?
14 Or correct me.

15 MS. CAMERON: Absolutely. So the 5.4 percent
16 was looking only at the cases that currently would have
17 qualified, so taking the 2015 cases, and in last year's
18 analysis, as you'll remember, we also did a similar
19 exercise. And we only looked at cases that would have
20 qualified if the criteria had been in effect at the time of
21 discharge. Based on the available cost and payment
22 information on a claim-by-claim basis for only those cases

1 that would have qualified, we project out the 5.4 percent
2 margin.

3 The 3.2 percent conservative margin is based on
4 the other cases that LTCHs currently see. So LTCHs' entire
5 book of business right now actually has a lower margin than
6 just the qualifying cases, and knowing their current cost
7 structure across all the cases does, in fact, have a lower
8 margin. If we apply that cost structure to the qualifying
9 cases, that's where we get the 3.2. However, the data to
10 date has shown the higher margin, and that's why we
11 projected it out to the 5.4.

12 DR. HOADLEY: And in projecting further or at
13 least in thinking about the effect of the 2016 changes, are
14 we assuming that there will be some changes in the
15 distribution of margins -- urban, rural, for-profit, not-
16 for-profit, et cetera?

17 MS. CAMERON: We did not do that level of
18 analysis because --

19 DR. HOADLEY: Has CMS given you anything on that?

20 MS. CAMERON: Not at this juncture.

21 When we look at the cases that would qualify,
22 there's not a lot of difference, for example, in the

1 percentage of cases that quality in the for-profits versus
2 the not-for-profits. So different facilities are
3 approaching this legislation and these policies
4 differently. So really only time will tell.

5 To the extent that length of stay for cases that
6 don't meet the criteria will shorten, we don't know the
7 extent to that. We expect it will happen. We just don't
8 know.

9 DR. HOADLEY: Thank you. Very helpful.

10 DR. CROSSON: Rita.

11 DR. REDBERG: Thanks.

12 Very informative chapter, Stephanie.

13 My question is on the quality measures because
14 you listed a lot of them in Text Box 4. Do we have data --
15 and they started in 2014. Do we have data on any of them?

16 MS. CAMERON: We do not. CMS was expecting to
17 release data on four of the measures publicly this fall.
18 Two of the measures, those collected by the CDC, have been
19 delayed until next spring, and two measures -- one is for a
20 pressure ulcer measure, and the other is for readmission --
21 is still slated to be released this fall, using, I guess,
22 the meteorological definition. We are hopeful, based on a

1 call I listened to last week, that in the next couple
2 weeks, the data will be released, and we will analyze that
3 as soon as it becomes available.

4 DR. REDBERG: I know that's what you've said, but
5 then when I thought it's been reported since October 2013,
6 so I'm a little puzzled why it's still -- we've been
7 talking about this for years now. I look forward to that,
8 before December 21st.

9 Do we have any data on how many people get off
10 the ventilator who are admitted to LTCHs?

11 MS. CAMERON: I don't have that offhand. I can
12 certainly look to see what studies have been done to date,
13 but that's not a number I have at my fingertips.

14 DR. REDBERG: To me, that would be an interesting
15 quality measure because I think that's sort of the main
16 driving reason people would go to LTCHs, and it's not clear
17 to me what that data shows.

18 DR. CROSSON: Okay. So let me see who I've got.
19 Pat.

20 MS. WANG: Stephanie, going back to the chart on
21 page 12, the slide, I am not sure I am understanding this,
22 particularly the difference between the high-margin and

1 low-margin LTCHs and what might be driving differences in
2 performance.

3 I see that for the low margin, for example,
4 occupancy rate is lower, cost is higher, payment is lower.
5 Case-mix index is lower, but high-cost outlier payments are
6 require a bit higher. I don't understand this profile.
7 What's going on here?

8 MS. CAMERON: I'll start by saying that this
9 chart actually looks oddly similar to the charts that we
10 provided back when we started doing the analysis almost a
11 decade ago, and historically, this has really been the
12 pattern.

13 We think that a lot of the difference, for
14 example, in the standardized cost per discharge stems from
15 the smaller facilities, the slightly longer length of stay,
16 and the increase in outlier payments, when you sum up the
17 Medicare payment per discharge with the outlier payments,
18 the payments do actually come out a little bit closer
19 together.

20 The low-margin LTCHs have had many more
21 historically high-cost outlier cases and short-stay outlier
22 cases. So it is tough to tease out, but then you look at

1 the occupancy rates, and the low-margin LTCHs clearly have
2 a lot more empty beds.

3 MS. WANG: Okay. I don't understand it, but it's
4 a strange profile.

5 Where do most people upon discharge from LTCH go?

6 MS. CAMERON: So some go to skilled nursing
7 facilities. Some also use -- are discharged home with home
8 health, but of those survivors, many do go to skilled
9 nursing facilities.

10 MS. WANG: And just the final question, do you
11 see any interaction here between -- especially after the
12 three-day ICU stay is put in place, between LTCH stay and
13 hospital outlier, high-cost outlier pool? Do you think
14 there's going to be an interaction there, a reduction in
15 outlier claims? Because it's not available, right?

16 MS. CAMERON: That's right.

17 MS. WANG: But where it is and especially where
18 there might be an affiliation discharge from hospital,
19 which will increase, do you think there's going to be an
20 impact on the other sector?

21 MS. CAMERON: It is tough to say. About 15
22 percent of current LTCH cases were outliers from an acute

1 care hospital. That is under kind of our prior law 2015
2 data. We, again, don't have data on what's happened since
3 criteria was put in place; however, when you look at the
4 numbers, we're kind of dealing with a volume issue,
5 because, again, we go back to short-term acute care
6 hospitals have so many cases relative to those that are
7 sent to -- that are in an LTCH, that it's tough to
8 determine. Small changes, which could be big in an LTCH
9 setting, really don't even show up in the acute care
10 hospital setting.

11 We are going to be looking at over time -- we've
12 started tracking the use of some of the more common
13 diagnoses in LTCHs and the more somewhat LTCH-specific
14 diagnoses, like prolonged ventilation use and looking at
15 that in an LTCH versus an acute care hospital, because that
16 may be where we'll see some differences. But within all of
17 these diagnoses, it gets very muddled due to the volume.

18 DR. CROSSON: Kathy.

19 MS. BUTO: One last question about what you know.
20 Are LTCHs a Medicare creature versus -- what percentage of
21 use is really by the private sector or other payers, maybe
22 Medicaid? But I'd be curious to know that.

1 MS. CAMERON: About, I believe, on average, 65
2 percent of discharges in LTCHs are Medicare. So,
3 predominantly, when you look at the entire industry, it is
4 a highly concentrated Medicare industry.

5 There are facilities, however, that do quite a
6 bit of work in the Medicaid sector. So I think it does
7 vary based on when the LTCH was created, for example, and
8 what its original mission was.

9 MR. GRADISON: On that point?

10 DR. CROSSON: Bill.

11 MR. GRADISON: My recollection is that, in a
12 discussion of this with Peter Butler -- said that in
13 Chicago, a number of the hospitals recognized that each of
14 the acute care hospitals -- they each recognize they had a
15 handful of cases like this, and they might be better off to
16 concentrate them in a new facility. I don't know how
17 general that was, but that stuck in my mind because it
18 might explain some of the things that have happened in
19 urban areas, which, in a sense, that's Medicare-specific,
20 but, in a sense, it really isn't.

21 DR. CROSSON: Brian.

22 DR. DeBUSK: Back to Table 3 on page 18, where

1 you list the common LTCH MS-DRGs, I understand there's a
2 one-to-one relationship, obviously, with the acute care DRG
3 with the LTCH DRG, but I would assume that you are
4 discharged from the acute care hospital under a variety --
5 there are a number of DRGs that would then map to a
6 different LTCH DRG. My primary diagnosis in the acute care
7 setting would be different, say, than the LTCH. Do we
8 track or do we even have a way to track the acute care DRGs
9 that are mapping into the LTCH DRGs?

10 MS. CAMERON: We certainly could do an analysis
11 such as that using claims data. I haven't specifically
12 looked at that during my time here, but that is something
13 we could do in the future, if there was interest in that.

14 DR. DeBUSK: Could there be -- and I guess where
15 I'm leaning to is, could there be a handful, a subset of
16 inpatient DRGs that are really driving this? And back to
17 this idea, is this a creation of Medicare? I mean, is this
18 something that could be addressed?

19 MS. CAMERON: I think, again, while that -- yes,
20 we could certainly map beneficiaries from an acute care
21 hospitals -- discharge DRG in the acute care hospital to
22 their discharge DRG in the LTCH. I am very concerned that

1 you're going to be dealing with a volume issue because,
2 again, 10 million discharges in an acute care hospital
3 translating to 130, at best, discharges from the LTCH, I
4 mean, it's really difficult to tease out what's going on.

5 DR. DeBUSK: Okay. So, for example, this
6 septicemia without ventilator support, it's not just going
7 to map back to two or three or four MS-DRGs. You're saying
8 there's going to be this huge variety that's going to
9 funnel into that one LTCH DRG?

10 MS. CAMERON: That's true, yes.

11 DR. DeBUSK: Okay.

12 MS. KELLEY: That is right. When we looked at
13 this a few years ago, when we first made our recommendation
14 for LTCH criteria, we did do a fair bit of work that
15 matched LTCH claims with their previous acute care hospital
16 claims, and what we found was that there was a wide variety
17 of DRGs that led to LTCH stays. A lot of them were sort of
18 major surgical DRGs, and my sort of nonclinical thinking
19 about it was that these were surgeries that had gone badly
20 wrong, patients ending up on the -- I'm sure Alice could
21 tell us about this -- patients ending up on a ventilator or
22 with sepsis, and then they would be admitted to the LTCH

1 with a sepsis DRG or a ventilator DRG.

2 DR. CROSSON: Okay. Thank you very much.

3 I see no further clarifying questions, so we'll
4 move to the recommendation slide. The recommendation is
5 before you, so I'd like to get an indication of support or
6 lack thereof, other items related to the recommendation. I
7 see Kathy's hand, and I see Alice's hand.

8 Kathy.

9 MS. BUTO: I support the recommendation. I have
10 serious questions about this category of provider in the
11 sense that, number one, there are very few -- as you say,
12 only 130,000 or patients. I wonder, if this category
13 didn't exist, whether -- I believe these individuals would
14 be taken care of either through the outlier policy in the
15 acute-care hospital, and actually the hospital would then
16 be accountable for these issues, which are surgeries gone
17 badly wrong or whatever. So it strikes me as something
18 that it's a creature in a way of Medicare, of an
19 opportunity to create this category, or SNFs, and where
20 appropriately much of this care could go on.

21 So I just raise that. It's a broader question.
22 Obviously, Congress has questions about it, or they

1 wouldn't have put a moratorium on it. And I think this is
2 the second time. When I was at the agency, we tried to
3 actually eliminate the category altogether. So I don't see
4 a compelling reason for the provider category. I do think
5 it provides a valuable service. But I also think there's
6 some accountability of acute-care hospitals to manage some
7 of these issues.

8 So I support the recommendation, but that's my
9 concern.

10 DR. COOMBS: Thank you, Kathy. That sounds
11 vaguely familiar. I've heard that before.

12 So I think as an ICU doctor, in certain regions
13 your hospital may be able to accommodate these type of
14 patients for longer periods of time. But in our regions,
15 an LTCH is very valuable to me as an ICU doctor because if
16 you have a patient who's on a vent, who requires a VAC, and
17 maybe needs even dialysis, you can house them in your ICU,
18 and you can house them in your ICU for an extended period
19 of time. But that means that the ICU beneficiary who rolls
20 up in the ED, they don't get an ICU bed, and they sit in
21 the ED until an ICU bed becomes available. So in certain
22 regions, the LTCH is an incredible way to decompress the

1 ICU, but not just decompress the ICU; their weaning
2 protocols are actually better than many acute-care
3 hospitals, and they know how to wean the chronic vents
4 because they have protocolized therapy, and they have some
5 robust strategies in terms of the right personnel at the
6 right time for follow-up.

7 That's not everywhere, but in certain regions of
8 the country, LTCHes are very valuable for what they do.
9 And you're not going to find -- most SNFs are not going to
10 be, oh, I want the wound VACs, I want the dialysis
11 patients, and I want all the vents. They're not coming in.
12 Those are really high resource patients, and they require a
13 lot of input from respiratory therapists. You have
14 dialysis. I mean, those patients are very complex.

15 So I would say that before we say the LTCHs have
16 no role in our lives, the LTCHs have a definite role. And
17 in certain regions, they can be the rate-limiting step for
18 why a patient who's a Medicare beneficiary has access into
19 the ICU. I've had this conversation before, and I would
20 say that for me it's very important. Our unit is majority
21 Medicare and Medicaid beneficiaries, and so it becomes
22 important for me to be able to treat the next septic

1 patient who arrives in the ED quickly and get them stored
2 away in terms of what we need to do for them in the ICU.

3 MS. WANG: I really appreciate Alice's comment.
4 I support the recommendation. I think the thing that's
5 vexing about the LTCH and the thing that I mainly see as
6 the benefit is the -- without being a clinician, is the
7 capacity for ventilator-dependent patients. There really
8 is no place for a lot of people to go, and, you know, Alice
9 just painted a picture of folks who are even more complex
10 than that. But, you know, they really should not be
11 staying in the hospital for 25, 30 days just because they
12 need -- they're vent-dependent. Many SNFs do not offer
13 this service.

14 So, you know, my main issue with LTCHs is that I
15 think that they provide an important service in this
16 particular area. I don't know about all of the other
17 conditions that they treat. But the fact that they're so
18 uneven in their distribution and availability is sort of if
19 it's an important resource, then is there a better way to
20 make it more broadly available, because I think that the
21 situation that Alice just described is probably a need
22 that's felt uniformly in many, many parts of the country

1 that are not served by LTCHs.

2 MS. BUTO: I guess my question would be: How are
3 those other parts of the country dealing with it? Because
4 they have the need, too, for ventilator-dependent care. So
5 I just feel like we don't know enough about that, but it's
6 something we ought to look into.

7 DR. HALL: I support the recommendation. I look
8 on LTCHs -- I don't use an LTCH because we don't happen to
9 have one, but I think of them as a place for what might be
10 called the diseases of medical progress. In the course of
11 treating people for other more conventional disease, like
12 pneumonia or bad congestive heart failure or a botched
13 surgical procedure, long-term antibiotic therapy, these are
14 not sort of typical diseases. They're diseases that have
15 been caused by -- not by malpractice, but by just the
16 limits of technology. To the extent that this occurs
17 everywhere in the United States, people who have access to
18 an LTCH, such as Alice mentioned, it's very useful. But I
19 don't think it's applicable in a way to every part of the
20 country, and I think the outlier program is one way --
21 upgrading SNFs and having them have special ability to
22 handle this would be a much better model for the entire

1 country.

2 So I think for now we need to make these
3 recommendations, but for the long term, I have serious
4 doubts as to whether this is something that should spread
5 around the country. And the data suggests that that
6 opinion is shared pretty much universally, or otherwise,
7 we'd have many more LTCHs and no moratorium.

8 MS. THOMPSON: I can speak to a part of the
9 country where we don't have a good number of LTCHs, and for
10 patients who do require long-term ventilator care, which
11 does include younger patients, too, with head injuries,
12 which would make up some of that 35 percent non-Medicare,
13 these patients are traveling two and three areas for an
14 LTCH bed, and waiting a long time to even have one of these
15 beds open up. So I also want to just emphasize the
16 comments that Alice made. This is a highly skilled, very
17 intensive set of services that this LTCH setting offers.

18 However, I'm going back to our chapter on
19 inpatient and reflecting on the fact we have an overall 62
20 percent occupancy of our inpatient beds across this
21 country, 41 percent in the rural areas. So were there not
22 this designation and were we to propose these patients be

1 cared for in an outlier status, I suspect inpatient
2 settings would dedicate beds and appropriate staff with the
3 skill sets to care for these patients on a long-term basis.

4 So I think the beds are available. Obviously,
5 it's a matter of the right skill sets. And from a therapy,
6 respiratory, physical, occupational, not to mention just
7 overall intensive nursing care, these are a very special
8 set of patients that do require special services.

9 DR. REDBERG: I still think we need the quality
10 measures and to understand how well we're doing on these
11 ventilator-dependent and if they're coming off or not.

12 MS. THOMPSON: I agree.

13 DR. HOADLEY: This last round of discussion is
14 reminding me of some work I did with the Commission well
15 before I was a Commissioner where we did interviews around
16 the country in both communities that had LTCHs and
17 communities that didn't, and I think, you know, you've
18 captured some of the things in some of the answers you
19 gave, and others have -- you know, SNFs would provide care
20 in some places, but it did require a community to have a
21 sort of very well equipped SNF that was designed to deal
22 with ventilators or so forth.

1 The one thing that hasn't come up that I remember
2 -- and it was one particular interview, so, again, I don't
3 want to overgeneralize from it, but it was one place that
4 did not have an LTCH where the person we talked to really
5 felt like it was encouraging them to have more end-of-life
6 discussions with some of the patients, and that at least in
7 this one person's perception, you know, the fact that an
8 LTCH might have been available might have said, well,
9 that's something we can do, rather than really have that
10 talk with the family about whether -- you know, what's the
11 long-term quality of life for this person who's on the
12 ventilator? And, again, be wary of overgeneralizing from a
13 single person's response, but I think that's just another
14 potential element, and it sort of goes to that question of
15 quality. There are many cases, clearly, where the LTCH is
16 doing the right thing for people, but there may be others
17 where it's just allowing a delay of other kinds of
18 decisions.

19 DR. MILLER: And I did recall that, and it's one
20 of the rare occasions I was allowed to leave the office --
21 I don't know how I slipped through -- and went on some of
22 those trips. And I also had the hospice discussion -- it

1 was in Louisiana, and this is, I think, different than
2 yours, and basically the medical director said there's a
3 number of the people who are here who really should be in
4 hospice, but, you know, they aren't. And exactly how that
5 decision set was made was very peculiar to both the
6 patients and the presence of the LTCH. And my recollection
7 is similar to yours. You would go into the communities
8 that didn't have them, and they had more souped-up SNFs
9 and/or, you know, a setting in the hospital where this was
10 being taken. You know, maybe we should revisit that
11 exercise to sort of see what's going on out there.

12 I think Kathy's point is does the delivery
13 system, you know, respond to the presence of the LTCH, is I
14 think her basis point here. Or to Alice's point, is this
15 created because there is a unique need? I think we could
16 get back out into the field and ask those questions.

17 DR. CROSSON: Okay. Good discussion there.

18 Again, I think I saw -- and I'll ask to be sure --
19 - consensus support for the recommendation before us.
20 Seeing no objections, we'll, therefore, carry this forward
21 into January for the expedited discussion -- presentation,
22 rather, and voting process. Stephanie, thank you very

1 much. This concludes our discussion period, and we are now
2 at the point where we will invite comments from the public.
3 If you have a comment that you wish to make about items
4 that have been discussed here, please come to the
5 microphone so we can see who you are.

6 So I will ask you to identify yourself and your
7 organization, if there is one.

8 Please keep your comments to about two minutes.
9 When this light comes back on, that is an indication that
10 the time is up, and we will ask you to conclude.

11 I will point out, as we often do, that there are
12 other avenues for individuals and organizations to provide
13 input to the Commission and staff, particularly through the
14 website or through direct communication with Mark and his
15 staff.

16 Please go ahead.

17 MS. GRIFFITH: Thank you. I think we're
18 together, so can we have four minutes? He gets two, I get
19 two?

20 DR. CROSSON: I think if you're representing an
21 organization and you have an organizational perspective to
22 provide, then that should be done by one person.

1 MS. GRIFFITH: Okay. Well, I'm Ellen Griffith,
2 and I am a kidney patient, and I am on the advisory board
3 of Home Dialyzors United, and he is not with -- okay.

4 Basically, this is our first time coming to
5 MedPAC. I am -- myself, I have never been on dialysis, by
6 the grace of God. I was given a transplant in January of
7 this year, and so I managed to skip the dialysis process.

8 Going real quickly, our concerns about the way
9 the reports -- the way the data has been analyzed -- and it
10 may be too late to do this for this year -- first of all,
11 there is no one-size-fits-all dialysis. There are about
12 five or six different kinds of dialysis. They each have
13 individual cost structure, which are not right now being
14 identified when payment rates are developed. Their payment
15 rates are developed across the line without regard to
16 modality. That creates incentives to provide one kind of
17 dialysis versus another. They all have different clinical
18 outcomes for patients, and they have different impacts on
19 patient lifestyle.

20 I'm with Home Dialyzors United because we believe
21 that home dialysis, and particularly home hemodialysis is
22 underutilized in this country, and that there are

1 substantial reasons for that, including payment
2 implications.

3 We would recommend, in this study or in future
4 years, to separate out PD and home hemo. They are very,
5 very different. Not all patients can do PD because they
6 are, for instance, diabetes -- dialysis is very, very
7 sugary, and so patients with diabetes really can't do PD.

8 The training payment, which came up in the
9 discussion, most PD is not covered by the training payment
10 -- for the training for PD, because most PD patients are
11 new patients. And so there is a new patient adjustment
12 that is paid -- that supersedes all other payment
13 adjustments. So your PD training generally is built into
14 that new payment adjustment. It doesn't show up in the
15 data for home training.

16 The home hemo patient --

17 DR. CROSSON: Please conclude your remarks.
18 Thank you.

19 MS. GRIFFITH: Okay. I'll submit something to
20 you through the website.

21 DR. CROSSON: Thank you very much.

22 MS. GRIFFITH: Thank you.

1 MR. WHITE: Hi. My name is David White. I did
2 dialysis for six years locally, within walking distance
3 from here, and I'm a kidney transplant recipient, about 17
4 months out.

5 I'm a full-time advocate. I advocate for more
6 organizations than I can count, so I don't play favorites.
7 The two that I'll mention are the American Association of
8 Kidney Patients -- I'm a member of the board of directors -
9 - and I am the acting chair of the Kidney Health
10 Initiative's Patient Family Partnership Council.

11 One remark I have is that the quality of life
12 measures that were mentioned in the dialysis payment
13 recommendation presentation, mortality, hospital admissions
14 and readmissions, paradoxically patients don't care about
15 those. It sound weird, but we care about how we feel and
16 how we're treated.

17 CMS is aware of this, and they're adding an ICH
18 CAHPS in-center hemodialysis consumer assessment of health
19 care provider systems measure for the payment year 2019,
20 and that survey is given by third-party vendors.

21 Ms. Buto -- I hope I'm saying your name correctly
22 -- you had a question about do QIP reductions lower the

1 quality of care. QIP scores are posted in dialysis clinics
2 and they're reported publicly on a website called Dialysis
3 Facility Compare, so probably not.

4 And finally, Ms. Coombs, you had a question about
5 the difference between annual cost of dialysis versus
6 transplant. When I advocate on Capitol Hill, I always
7 point out that the difference is \$50,000 to \$55,000 a year.
8 Transplant is about \$35,000 a year, whereas dialysis is
9 \$85,000 to \$90,000 a year.

10 Thank you very much for your time.

11 DR. CROSSON: Thank you.

12 MR. KOENIG: Hi there. I'm Lane Koenig,
13 President of KNG Health Consulting, also Director of Policy
14 and Research for the National Association of Long Term Care
15 Hospitals.

16 I wanted to make just a couple of points. One,
17 in the slide there was a statement that outcomes -- or
18 research indicates outcomes are the same for patients who
19 go to long-term care hospitals and those that go to other
20 settings. I just want to make the Commission aware that
21 there was a peer-reviewed study, and there are very few
22 peer-reviewed studies on outcomes for long-term care

1 hospitals, published in Medical Care, that showed for the
2 most critically ill -- so those with three or more days in
3 ICU or on multiple organ failure -- outcomes are pretty
4 positive for long-term care hospitals. So I encourage you
5 all to take a look at that study.

6 The other point I wanted to make was on the
7 margin projection, and I know it's been talked about before
8 but just to make clear that for the site-neutral cases, the
9 payment for those cases, starting in 2018, is going to be
10 the lower of the IPPS amount or the cost. So for the site-
11 neutral cases, starting in 2018, there is no margin that
12 can be made, and so the conservative margin that was
13 presented, which included sort of all of those -- all
14 patients qualifying and non-qualifying, that the non-
15 qualifying, unlike in the past where an LTCH could make a
16 margin on those cases, starting in 2018 they will not be
17 able to make a margin, and that's going to have an effect
18 on what our expectations will be, in terms of the margins
19 going forward.

20 Thank you.

21 DR. CROSSON: Thank you. Seeing no further
22 individuals at the microphone, the meeting is concluded.

1 We will reconvene in our January meeting.

2 Thank you very much. Happy holidays to everyone.

3 Safe travels.

4 [Whereupon, at 11:31 a.m., the meeting was
5 adjourned.]

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