

## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

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

## COMMISSIONERS PRESENT:

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

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

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

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

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

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

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

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

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

22 This highlights a difference between what we do

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

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

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

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

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

22           The last thing I would say about the challenge of

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

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

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

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

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

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

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

16           Physicians and other health professionals bill  
17 Medicare using a fee schedule. In total, fee schedule  
18 spending was around \$70 billion in 2012, 12 percent of  
19 Medicare fee-for-service spending. There are about 850,000  
20 practitioners billing Medicare, 500,000 physicians and  
21 350,000 nurse practitioners, physician assistants,  
22 therapists, and other providers. Nearly every beneficiary



1 receives at least one fee schedule service.

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

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

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

1 than for the privately insured.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 outpatient departments went up by 13.5 percent, but the  
2 number furnished in professional offices went down by nine  
3 percent. Over the same time frame, cardiac nuclear medicine  
4 studies per beneficiary as furnished in hospital outpatient  
5 departments went up by 9.4 percent, while the number  
6 furnished in professional offices went down by 15.9 percent.  
7 Much of the decrease in imaging volume is due to this shift  
8 in setting for cardiac imaging. If cardiac imaging is  
9 excluded from the calculations, the imaging decrease from  
10 2011 to 2012 would be 1.9 percent instead of 3.2 percent.  
11 You will hear more about the shift in setting during this  
12 meeting's next session on hospital services.

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

1 Medicare.

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

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

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

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

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

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

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



1 ASCs have some degree of physician ownership.

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

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

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

22 In our assessment of payment adequacy, we use the

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

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

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

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

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

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

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

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

1 performing ones.

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

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

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

22 In addition, CMS uses the Consumer Price Index to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 MS. BLONJARZ: No. As Glenn described, we only  
20 have --

21 MR. GEORGE MILLER: The national average, okay.

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



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

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

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

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

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

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

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

8 MR. GRADISON: Thank you.

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

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

1 response.

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

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

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

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

1 2011. So stay tuned. We are trying hard to find out when  
2 that will be available.

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

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

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

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

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

13 MS. BLONIARZ: That's right.

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

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

19 MR. HACKBARTH: Right.

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

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

5 MR. HACKBARTH: Clarifying questions?

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

16 DR. BAICKER: And prices.

17 DR. CHERNEW: Right.

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

1 occur.

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

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

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

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

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

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

18 DR. HAYES: Right.

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

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

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

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

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

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



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

8           DR. ZABINSKI: For 2014?

9           MR. BUTLER: For 2014.

10          DR. ZABINSKI: 1.2.

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

14          DR. ZABINSKI: Sure, yeah.

15          MR. BUTLER: Is that about right?

16          DR. ZABINSKI: Yeah.

17          MR. BUTLER: Okay.

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

20          MS. BLONJARZ: Through 2015.

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

1 different bases. So I just want to make sure we can't  
2 compare sort of the magnitude. Do we have a sense of the  
3 size of the volume in the two columns so that we know sort  
4 of -- as opposed to just rates of increase what's the actual  
5 --

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

9 DR. HOADLEY: Yeah, net effect.

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

13 DR. HOADLEY: Okay.

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

16 DR. HOADLEY: Okay.

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

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

4 Jack, do you want to begin Round 2?

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

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

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

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

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

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

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

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

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

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

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

1 demand.

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

17           DR. COOMBS: So, I'll start with the last  
18 recommendation first and then talk a little bit about Slide  
19 16.

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

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

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

1 update over the next ensuing years.

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

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

1 in a smaller group, might be more beneficial.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16           MR. GRADISON: I support the recommendations.

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



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

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

22           MR. GEORGE MILLER: Yes. On the recommendations

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

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

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

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

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

15           MR. HACKBARTH:  Okay.

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

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

5 MR. HACKBARTH: Jon.

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

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

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

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

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

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

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

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

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

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

3           [Pause.]

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

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

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

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

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

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

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

8           In most markets we find an excess supply --

9           DR. MARK MILLER: Craig?

10          MR. LISK: Yes?

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

12          MR. LISK: Access to care.

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

15          MR. LISK: Sorry. I misspoke.

16          DR. MARK MILLER: No problem.

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

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



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

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

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

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

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

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

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

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

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

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

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

14           From 2011 to 2012, Medicare inpatient and  
15 outpatient margins both declined, but the overall Medicare  
16 margin remained steady at minus 5.4 percent due to increases  
17 in Medicare HIT payments hospitals received from 2011 to  
18 2012.

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

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

1 points above the margin for urban hospitals.

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

8 Next we are going to move on and discuss our  
9 forecast of the overall Medicare margin for fiscal year  
10 2014, the current policy year. We estimate that the overall  
11 Medicare margin will decline slightly, going from minus 5.4  
12 percent in 2012 to minus 6 percent in 2014.

13 So why do we expect margins to decline slightly?

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

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

22 Finally, increases in HIT payments will mostly

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

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

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

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

13 Now Jeff will move on.

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

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

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

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

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

14 Here are the results. We ended up with a group of  
15 302 hospitals that have historically been relatively  
16 efficient providers for three straight years prior to 2012.  
17 This group of 302 hospitals represents about 14 percent of  
18 all IPPS hospitals that had usable data.

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

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

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

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

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

1 to improve incentives in the system.

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

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

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

22 First, for the less severely ill patients, LTCH



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

9 I will now turn it over to Dan.

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

14 In a previous presentation, we had this slide, or  
15 a similar one, anyway, that shows that volume of E&M office  
16 visits, echocardiograms, and nuclear cardiology services  
17 that are provided in free-standing offices all decreased in  
18 2011 and 2012, while the volume increased in OPDs for the  
19 same services.

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

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

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

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

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

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

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

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

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

19           We have also identified 42 APCs that meet four of  
20 the criteria, but they have greater packaging under the  
21 outpatient PPS than the physician fee schedule. For these  
22 42 APCs, the payment rate differences between offices and

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

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

9 Most hospital categories would be affected by  
10 about the same amount as the overall average of 0.6  
11 percent, except that rural hospitals and hospitals that have  
12 100 or fewer beds would be affected more.

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

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

22 Now Dana will talk about payment reform in long-

1 term care hospitals.

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

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

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

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

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

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

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

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

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

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

13           Now Jeff will wrap things up for us.

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

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

1 billion per year.

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

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

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

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

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



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

3           The Congress should direct the Secretary of HHS  
4 to:

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

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

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

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

1 2015 under current law. And as I stated earlier, this is  
2 expected to bring the margins of even relatively efficient  
3 providers to a negative level in 2015 if current law holds.

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

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

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

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

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

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

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

22           In addition, the Chairman's recommendation is

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

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

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

20           Now we open it for questions.

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

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

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

6 MR. HACKBARTH: Mm-hmm.

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

11 MR. HACKBARTH: Uh-huh.

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

14 MR. HACKBARTH: Uh-huh.

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

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

21 DR. STENSLAND: Correct.

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

1 remember?

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

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

7 DR. STENSLAND: Yes.

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

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

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

21 DR. SAMITT: Great. Thank you.

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

1 Peter, before --

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

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

11 DR. NAYLOR: Yes.

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

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

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

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



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

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

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

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

1 1.3 percent --

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

5 MR. HACKBARTH: Clarifying questions? Dave. No?

6 DR. NERENZ: Already answered.

7 MR. HACKBARTH: Already got it. Bill.

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

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

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

13 MR. GRADISON: Thank you.

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

21 MR. GRADISON: Thank you.

22 MR. HACKBARTH: George, and then Jon.

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

7           DR. ZABINSKI: Well --

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

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

16          MR. GEORGE MILLER: So access equates to cost?

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

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

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

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

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

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

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

13 MR. GEORGE MILLER: [Off microphone.]

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

17 MR. GEORGE MILLER: Okay.

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

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

3 MR. GEORGE MILLER: All right.

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

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

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

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

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

17 MR. GEORGE MILLER: Yes.

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

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

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

1 MR. GEORGE MILLER: Never mind.

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

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

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

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

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

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

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

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

7 DR. STENSLAND: You mean --

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

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

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



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

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

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

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

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

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

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

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

1 include that.

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

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

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

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

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

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

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

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

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

1 transitioned.

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

14 DR. STENSLAND: Right.

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

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

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

1 zero.

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

3 MR. HACKBARTH: Okay.

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

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

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

16 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

1 thanks for raising that.

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

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

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

22 I do believe this puts into perspective the very

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

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

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

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



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

4 MR. HACKBARTH: We made it as a recommendation.

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

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

7 MR. HACKBARTH: Oh, it didn't?

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

12 DR. HOADLEY: Earlier.

13 DR. MARK MILLER: -- you could be saying that.

14 Then we said, you know, it's on the right track, but here  
15 are some refinements. It was stated very much as, "You  
16 should do this," but we didn't say, "Here is a bold-faced  
17 recommendation."

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

21 DR. MARK MILLER: Decidedly statutory.

22 MR. HACKBARTH: Okay.

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

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

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

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

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

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

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

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

1           Could we go back to the recommendation slide?

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

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

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

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

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

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

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

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

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

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

21           Over to you guys if you want to add.

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

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

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



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

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

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

22 So I don't know the definition of "appropriate

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

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

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

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

4 Thank you.

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

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

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

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

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

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

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

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

1 very different.

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

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

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

18 DR. COOMBS: Yes.

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

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

1 you're looking at is going to change in terms of the  
2 percentage of CCI patients, so you've just shifted what you  
3 thought was going to be 36 percent, maybe now will be 45 or  
4 50 percent, and then the realized savings in terms of  
5 shifting it to the IPPS system is not there anymore, so that  
6 \$2 billion that you're looking at for savings to be able to  
7 redistribute to the acute-case hospital is not realized.  
8 And so that's one of the behavioral things that would change  
9 drastically, and as an ICU doctor, I would be less apt to do  
10 something that would actually fail in the LTCH for fear of  
11 readmission from the LTCH, so you might just say, well, I'm  
12 going to leave this patient in the current state. And I  
13 only say that in lieu of what we've seen in the chart that  
14 comes later in terms of the diagnosis that drives you into  
15 the LTCH, which predominantly are respiratory. Even though  
16 the top two diagnoses are respiratory, when you look at  
17 those other diagnoses way down there, they actually are  
18 respiratory, too. They're trach patients, they're  
19 pneumonia. You could throw them in with the respiratory and  
20 the number one diagnosis for LTCH admissions.

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

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

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

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



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

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

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

21 DR. COOMBS: That's it.

22 DR. NERENZ: So the numbers look significant. So

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           What makes this circumstance unique is this is the

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

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

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

20 MR. HACKBARTH: Please do.

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

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

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

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



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

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

22           So I think the goal -- my overarching goal,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 MR. HACKBARTH: Right.



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

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

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

3 [Laughter.]

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

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

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

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

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

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

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

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

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

21           MR. ARMSTRONG: Yeah, and it's kind of an  
22 interesting question, and the hard part about this is that

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Please begin by introducing yourself and your organization.

2 Limit your comments to two minutes. When the red light

3 comes back on, that signifies the end of your two minutes.

4 As always, I would remind people this isn't your

5 only, or even your best, opportunity to influence the work

6 of the Commission. Talking to the staff is the best way.

7 Also, please be assured that we read our mail and, in

8 addition to that, we do have an opportunity on our website

9 to lodge comments, as well.

10 So two minutes.

11 MR. LIND: Keith Lind, AARP.

12 Just a comment about the LTCHs. You might want to

13 explicitly consider what Congress is considering now because

14 my understanding was that there was an LTCH proposal in the

15 SGR 30-day patch which they may pass. And I thought it had

16 a three-day ICU stay, not an eight-day stay. You might just

17 want to address that if you're going to talk about it.

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

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

20 The question that I have is in hospital inpatient

21 and outpatient margins and payment, did you consider the

22 impact of SGR? And if not, why not? What is the impact of



1 SGR?

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

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

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

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

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

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

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

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

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

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

22 MR. KALMAN: Good afternoon. My name is Ed

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

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

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

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

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

22 Thirdly, I want to make you aware that you are

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

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

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

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

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

1 the IPPS equivalent is a distortion of that.

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

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

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

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

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

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

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

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

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

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

9           Following implementation of the LTCH PPS in fiscal  
10 year 2003, Medicare spending for LTCH services grew rapidly,  
11 climbing an average of 29 percent per year between 2003 and  
12 2005. At that point, CMS implemented a number of  
13 regulations that stemmed this growth. Between 2005 and  
14 2008, growth in spending slowed to less than one percent per  
15 year. After Congress rolled back or delayed implementation  
16 of some of these regulations, spending for LTCH services  
17 began to climb again, rising 12 percent between 2008 and  
18 2010. Since 2010, small updates to payments, including an  
19 actual reduction in the payment rate in 2011, have slowed  
20 spending growth once more.

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



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

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

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

1 can see the very tail end of that growth here. Beginning in  
2 2005, as CMS began to regulate LTCH payments more closely,  
3 facility growth slowed markedly. Although Congress  
4 temporarily eased some of those regulations between 2008 and  
5 2012, facility growth remained low due to a moratorium on  
6 these facilities --on new facilities. The moratorium  
7 expired in December 2012, but as we will see, uncertainty  
8 about future LTCH policy continues to have an effect on  
9 facility growth.

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

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

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

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

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

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

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

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

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

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

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

16           Between 2005 and 2007, payment per case grew an  
17 average of 1.3 percent per year. Growth in cost per case  
18 slowed, as well. Since 2007, LTCHs have held cost growth  
19 well below the market basket. Cost per case increased less  
20 than one percent per year between 2009 and 2011, and grew  
21 1.6 percent between 2011 and 2012.

22           Margins have, of course, tracked the trends you

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

6 This slide shows 2012 Medicare margins for all  
7 LTCHs combined and for different LTCH groups, as well as the  
8 share each represents of total providers and total cases.  
9 As you can see in the top row, the aggregate Medicare margin  
10 for 2012 was 7.1 percent. There is wide spread in the  
11 margins, similar to what we see in other settings, with the  
12 bottom quarter of LTCHs having an average margin of minus-  
13 12.8 percent and the top quarter having an average margin of  
14 20.5 percent.

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

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

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

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

22           Note, however, that high cost outlier payments

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

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

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



1           So, to sum --

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

4           MS. KELLEY: Yes, if the --

5           DR. MARK MILLER: -- two points less.

6           MS. KELLEY: Exactly. Yes.

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

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

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

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

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

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

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

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

15           MR. HACKBARTH: Thank you very much.

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

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

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

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

2 MR. KUHN: Okay.

3 MR. PETTENGILL: For the mix. For the mix of  
4 cases that LTCHs treat, IPPS payments would be around  
5 \$10,000 per case.

6 MR. KUHN: Okay. Thank you.

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

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

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

1 your concern. Kate.

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

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

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

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

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

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

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

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

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

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

15 DR. NERENZ: Okay.

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

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

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

12           DR. NERENZ: Okay. So, just to make it concrete,  
13 so let's just say for a given patient who starts in acute  
14 care who then could either go to --say, stay in acute care  
15 or go to LTCH, and let's say that transfer occurred at day  
16 20 and then the end of the episode was at day 60, when we're  
17 comparing payments in the LTCH, we're talking about day 20  
18 to day 60. We're then comparing that to the payments that  
19 would have occurred 20 to 60 in the acute care?

20           MS. KELLEY: No. When --

21           DR. NERENZ: No?

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

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

8 DR. NERENZ: Which gets rolled in?

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

11 DR. NERENZ: Okay. Okay.

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

14 DR. NERENZ: I understand.

15 MS. KELLEY: Right.

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

18 MS. KELLEY: And that's been --

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

20 MS. KELLEY: -- a historic problem here.

21 DR. NERENZ: Okay.

22 MS. KELLEY: Absolutely.



1 DR. NERENZ: Deep water here. Okay.

2 MS. KELLEY: Yeah.

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

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

22 MR. PETTENGILL: The average stay in an IPPS

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

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

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

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

15 [Laughter.]

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

20 MS. KELLEY: That's exactly right.

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

1 DR. NERENZ: [Off microphone.]

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

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

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

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

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

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

1 specialized settings in the acute care hospital.

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

6 MR. GRADISON: I support the recommendation.

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

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

16 MR. GEORGE MILLER: I got it. Okay.

17 DR. CHRISTIANSON: I support the recommendations.

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

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

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

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

19           MS. KELLEY: That's right.

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

1 MS. KELLEY: Right. That's right.

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

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

8 MR. HACKBARTH: You do.

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

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

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

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

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



1 it, zero update, as for you to consider.

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

7 MR. ARMSTRONG: Oh.

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

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

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

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

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

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

12 MR. GEORGE MILLER: Right.

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

1 MS. KELLEY: We have not done that analysis. My  
2 concern about doing it would still come back to an ability  
3 to risk adjust well. The patients who end up in DRG 209 in  
4 an LTCH may have started out at a different DRG when they  
5 were in the acute-care hospital. So if I were to compare  
6 the DRG 209 patients in the LTCH with patients who had that  
7 same DRG assignment in the acute-care hospital but never  
8 went to the LTCH, they might not be the same patient. Some  
9 of the 209 patients had a major bowel procedure that went  
10 terribly badly, and they ended up on a ventilator. Their  
11 IPPS assignment is going to be the major bowel procedure.  
12 But when they get to the LTCH, then they'll be in 209. That  
13 209 patient may really be different from the patient who  
14 entered the acute-care hospital and got a principal  
15 diagnosis of 209.

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

19 MS. KELLEY: Mm-hmm.

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

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

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

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

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

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

14 DR. NAYLOR: Hopes are dashed.

15 MS. KELLEY: Yes. I'm sorry.

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

18 [Laughter.]

19 MS. UCCELLO: I support the recommendation.

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

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

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

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

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

22           [Laughter.]

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

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

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

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

1 [Laughter.]

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

7 MS. KELLEY: January, is that when --

8 [Laughter.]

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

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

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

15 MR. BUTLER: Round 3.

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

20 [Pause.]

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



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

5 My presentation is composed of three parts.

6 First, I will summarize the new prospective payment system  
7 for dialysis services that began in 2011. Then I will  
8 proceed with the adequacy analysis and provide you with  
9 information for your assessment of the adequacy of  
10 Medicare's payments for dialysis services and the Chairman's  
11 draft recommendation for the 2015 payment rate. Lastly, I  
12 will discuss several concerns that we continue to have about  
13 the new prospective payment system.

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

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

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

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

8 We look at beneficiaries' access to care by  
9 examining the industry's capacity to furnish care. Between  
10 2010 and 2012, growth in dialysis treatment stations and  
11 facilities matched beneficiary growth. In 2011, the latest  
12 year we have closure information, the roughly 70 facilities  
13 that closed were smaller, more likely to be hospital based,  
14 and nonprofit. Few beneficiaries -- about 1 percent -- were  
15 affected by these closures. Affected patients received care  
16 at other facilities. There are few differences in the  
17 characteristics of patients treated at closed facilities  
18 compared to all facilities.

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

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

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

12 Next, we look at quality by examining changes  
13 between 2010, the year prior to the new prospective payment  
14 system, and June 2013. CMS is the source of these data.  
15 Mortality and ED use, while high, have remained steady.  
16 Hospital admissions during this time period are declining.  
17 Home dialysis is associated with improved quality of life  
18 and patient satisfaction. During this time period, the  
19 percent of dialysis beneficiaries using home dialysis has  
20 modestly increased from a monthly average of 8 percent in  
21 2010 to 10 percent in the first six months of 2013.

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

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

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

17           Moving to our analysis of payments and costs, in  
18 2012 the Medicare margin is nearly 4 percent. The Medicare  
19 margin is higher for the two large dialysis organizations  
20 that account for roughly 70 percent of all spending compared  
21 to other facilities.

22           The aggregate Medicare margin for rural

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

8           The 2014 projected Medicare margin is 2.9 percent.  
9 This margin reflects statutory updates in 2013 and 2014. It  
10 includes the estimated reduction due to the ESRD QIP. It  
11 also includes policy changes implemented by CMS that result  
12 in increasing payments in 2013 and 2014. Finally, it  
13 includes the 3.3 percent rebase of the base payment rate in  
14 2014. And, finally, if the sequester is in effect in 2014,  
15 the margin would be about two points less.

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

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

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

10 Here is a quick summary of the payment adequacy  
11 findings. Access-to-care and access-to-capital indicators  
12 are favorable. Quality is improving for some measures. The  
13 2012 Medicare margin is nearly 4 percent.

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

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

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

12 The first issue concerns the design of the low-  
13 volume adjustment. For existing facilities as of the end of  
14 2010, CMS does not factor the distance to the next facility  
15 for determining the adjustment. In 2012, nearly half of all  
16 low-volume facilities were within five miles of another  
17 facility. A low-volume adjustment should focus on  
18 protecting facilities critical to beneficiary access. The  
19 Secretary has the authority to redesign this adjustment by  
20 applying a distance requirement to all facilities.

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

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

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

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



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

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

13 That concludes my presentation.

14 MR. HACKBARTH: Thank you, Nancy.

15 Round 1 clarifying questions?

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

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

1 DR. MARK MILLER: Nice job, Nancy.

2 [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

7 MR. GEORGE MILLER: Okay.

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

9 MR. GEORGE MILLER: Okay.

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

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

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

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

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

6           MR. GEORGE MILLER: Thank you.

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

10          MS. RAY: Okay.

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

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

15          DR. HOADLEY: My question was essentially Cori's  
16 question, but the additional piece that I was going to ask  
17 was because of the reduction of the rebasing is phased in  
18 over a three- to four-year period -- this is on Slide 15 --  
19 is there a sense that there's something left in like 2016 or  
20 '17 if they go four years that will be more negative? Or is  
21 there some way to say what's going to happen further down  
22 the road?

1 DR. MARK MILLER: If you are asking in a margin  
2 sense, we don't -- or haven't, in any case, projected beyond  
3 2014. And I think the other part of our answer would be if  
4 we looked at net costs and we were approaching, you know, a  
5 point that concerned the Commission, without saying what  
6 that point is, we would be saying don't go further if that  
7 was the collective judgment.

8 For the purposes of this conversation, out to  
9 2015, we're pretty much in the same place they are, CMS, in  
10 the rebasing, just by different routes. Does that --

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

15 MR. HACKBARTH: Yeah.

16 DR. MARK MILLER: Oh, I see.

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

20 DR. HOADLEY: Right.

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

1 DR. HOADLEY: Right.

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

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

10 MR. HACKBARTH: Right.

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

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

18 MR. HACKBARTH: Yes.

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

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

1 some --

2 MS. RAY: Right.

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

5 DR. HOADLEY: Okay. That's helpful.

6 DR. MARK MILLER: It sort of goes in even  
7 increments over the four years.

8 MR. HACKBARTH: Yeah, that's what we were looking  
9 for.

10 DR. HOADLEY: That does it.

11 MR. HACKBARTH: So, Rita, was it on this  
12 particular point?

13 DR. REDBERG: It was. I don't remember the  
14 details now, but there was an article in the Times, which I  
15 didn't see in here, that I thought was about the rebasing  
16 because there was some discussion over whether the money was  
17 going to go back to CMS and DaVita was lobbying to have it  
18 get redistributed back to the dialysis centers because the  
19 drop has been more than predicted. Does that sound  
20 familiar? I'll have to find the --

21 MR. HACKBARTH: Yeah, it does ring a bell for me.  
22 So we'll look into that.



1 DR. COOMBS: Thank you very much. I really  
2 enjoyed reading this chapter. On page 36, Appendix A,

3 MS. RAY: [Off microphone.]

4 [Laughter.]

5 DR. COOMBS: Well, I couldn't help but think about  
6 the clinical indicators that have been included here and  
7 outcome-like measures. And one of the areas that I noticed  
8 is the area of renal transplant in African Americans as well  
9 as percent of prevalent dialysis patients waiting for a  
10 kidney transplant in both of those blocks. And I'm just  
11 kind of curious. Are they able to confirm that the wait  
12 list -- the time that you spend on the wait list for African  
13 Americans seems to be proportionately longer for whatever  
14 reasons, just to look at why -- is this something with  
15 shared decisionmaking or is it something that we know as a  
16 true -- we've talked about this as a health care disparity  
17 in the past, that African Americans don't get kidney  
18 transplants as often as other races.

19 MS. RAY: Right, and we have discussed and written  
20 about this in the past. Access to kidney transplantation is  
21 multifaceted, and I know -- well, it -- many different  
22 factors affect it, starting with patients knowing that it is

1 a treatment option, so being informed about the treatment  
2 option from their nephrologist, from their dialysis  
3 facility, and understanding the information, so that is  
4 where shared decisionmaking would be an important role.

5           For those patients that do get on a transplant  
6 wait list, then they're of the transplant center, and their  
7 policies and who they -- you know, at some point they have  
8 their own factors in deciding, in making decisions regarding  
9 kidney transplants. And there are lots of different factors  
10 involved there, including socioeconomic status, including --  
11 I just read a recent article about if you're unemployed,  
12 you're less likely to get on the kidney transplant wait  
13 list, and even if you do get on, you're still less likely to  
14 get a kidney transplant wait list.

15           Of course, there are the biological factors, and I  
16 think that's -- and this is where I'm speaking completely  
17 over my head, where it may affect rates of transplant for  
18 certain groups. And then, of course, there are differences  
19 between donation rates, live donation rates, and those do  
20 tend to be -- the last time I looked at those numbers, they  
21 tend to be lower among African Americans.

22           So it's multifaceted. Yes, outpatient dialysis

1 facilities have a role, but lots of other players also have  
2 a role, is I think the bottom-line message.

3 MR. HACKBARTH: So I say this with admiration,  
4 Alice. You've become very skilled at Round 1 question --

5 MR. GEORGE MILLER: Yeah, that was a Round 2 --

6 MR. HACKBARTH: -- based on a table that raises  
7 big issues.

8 [Laughter.]

9 MR. GEORGE MILLER: She went down my Round 2.  
10 I'll wait until Round 2. She teed it up for me.

11 MR. HACKBARTH: Okay.

12 MR. GEORGE MILLER: She teed

13 DR. CHRISTIANSON: Just a couple quick questions,  
14 Nancy. If you could go back to Slide 10? So the last  
15 bullet point, I guess I would characterize that as maybe not  
16 so modest. A 20 percent increase in a three- or four-year  
17 period seems something to think about. What I was wondering  
18 is were we seeing similar increases prior to 2010. Has this  
19 just been a general big trend upward?

20 MS. RAY: Between 2000 and 2009, it's been  
21 relatively constant. So this decline is since 2010.

22 DR. CHRISTIANSON: Well, it's an increase in home

1 dialysis.

2 MS. RAY: Yeah. Oh, I'm sorry. That's what I  
3 meant to say. Yes.

4 DR. CHRISTIANSON: Is that triggered by something?

5 MS. RAY: I mean, again, you started seeing this  
6 increase beginning in 2010, so that was the year prior to  
7 the prospective payment system, but it certainly has  
8 continued into the new prospective payment system.

9 DR. CHRISTIANSON: Yeah, okay.

10 MS. RAY: The extent to which home dialysis is  
11 more profitable for providers, you know, you would think  
12 that that rate is only going to go up.

13 DR. CHRISTIANSON: So my related question then is:  
14 That's listed as a dialysis quality measure. Can you talk  
15 to me a little bit about home dialysis is higher quality and  
16 so you want more people to get it? Or what's the thinking  
17 on that as a quality measure?

18 MS. RAY: Home dialysis, when surveying patients,  
19 home dialysis versus in-center patients, home dialysis  
20 patients are generally more satisfied with their care.

21 DR. CHRISTIANSON: So it's a patient experience  
22 measure of quality. Okay.

1 MS. RAY: Yes, yes. And they have a higher  
2 quality of life. And they are also more able to work, be  
3 employed.

4 MR. HACKBARTH: It may be helpful just to remind  
5 us about how the payment works. So the prospectively  
6 determined payment to the dialysis facility is the same  
7 whether it's in-center or at home, and the costs may be  
8 lower at home, and that's why it could be more profitable  
9 and thus increase. Is that what you're saying?

10 MS. RAY: That is correct. For adults it is the  
11 same rate. Yes.

12 MR. HACKBARTH: Okay. I think we covered all the  
13 Round 1 clarifying questions and a Round 2 from Alice.  
14 Cori, do you want to go ahead and start Round 2?

15 MS. UCCELLO: Sure. Assuming I understand the  
16 update recommendation correctly, which might be a big  
17 assumption, I am supportive of it. In terms of the  
18 recommendations on Slide 22, I am inclined to support all of  
19 them. Just my one question about the urban-rural thing is  
20 just -- well, one thing I'll say about this. In the text,  
21 not in the presentation, you actually talked about some  
22 facilities that got the adjustment being at the same address

1 as other -- I mean, that's just crazy. And that will make  
2 the newspaper, I'm sure.

3 [Laughter.]

4 MS. UCCELLO: So, I mean, this is definitely  
5 something we need to make a recommendation on. You know,  
6 going back to what five miles is, what is the right mileage  
7 and how that may differ, you know, I don't know what the  
8 exact answer is, but I think this is the right direction.

9 In terms of the anemia undertreatment, I think as  
10 part of this -- and correct me if I'm wrong -- you know, the  
11 issue -- we've raised this in the past about using the  
12 hemoglobin, or whatever, and that's not the right way to do  
13 it because there's not really a scientific -- a clinical  
14 measure here, so that's why we need to look at the blood  
15 transfusions or other things, right?

16 MS. RAY: Right. So when the FDA came out with  
17 the revised label for ESAs in 2011, they did not give a  
18 floor for the hemoglobin level. So there is no official  
19 floor. What the FDA basically -- how I interpreted what the  
20 FDA said is give just enough ESA so the patient avoids blood  
21 transfusions. So that's why CMS -- CMS had a lower-bound  
22 hemoglobin level in the 2012 ESRD QIP, and they removed that

1 beginning in 2013 because of what the FDA did.

2 MS. UCCELLO: Okay. So, yes, I am supportive.

3 DR. NAYLOR: So, I'm going to operate on the same  
4 assumption that Cori has, which is that I understand and  
5 support the direction of the Chairman in terms of the update  
6 and all of the recommendations in terms of improving  
7 redesign measurement and audit.

8 MR. ARMSTRONG: Yeah, same. Nothing more to add.  
9 I do support the direction you're heading in.

10 DR. HOADLEY: Yeah. I support the various  
11 recommendations in this chapter. I guess I'm interested in  
12 along the lines that -- just being asked about whether the -  
13 - how this measure of assessing anemia under-treatments  
14 relates to the FDA recommendations and so forth, but to some  
15 degree, that's up to the Secretary to figure out, I guess.

16 DR. CHRISTIANSON: Yeah. I support the payment  
17 update recommendation and also the two recommendations here  
18 on Slide 22.

19 MR. GEORGE MILLER: Yes. I support the Chairman's  
20 draft recommendation, but I would like the Chairman to  
21 consider on the quality measure adding something that links  
22 improvement, especially for African Americans and for other

1 minorities who fall below the threshold, both for the wait  
2 lists and transplants. As we talk about trying to bundle  
3 payments and bundle quality of care together, I think this  
4 should be one of the measures.

5 African Americans have disproportionately higher  
6 use of renal dialysis but yet have the lowest for the -- on  
7 the list, and the renal transplant, getting the transplant.  
8 While I understand many of the factors -- I understand them  
9 -- it may be more difficult, it may be hard, but it still  
10 should be an incentive to provide a whole continuum of care  
11 and just not do fragmented part of care, and I think this is  
12 one of the quality measures that should be certainly  
13 considered, to especially improve the dialogue and the  
14 education. And there are many reasons why folks don't get  
15 them, get to the list. I'm a little concerned about why  
16 they don't get to the list, but more importantly, why they  
17 don't have -- the lower rate for transplants is a concern.  
18 So, I would like for us to design, make a recommendation on  
19 quality measures to deal with that very issue.

20 MR. HACKBARTH: So, Nancy, has this been --  
21 generally speaking, on this and other sectors, we often draw  
22 our measures or quality measures from work that others have



1 done, and that's certainly been true in the ESRD area. Has  
2 this been considered as a quality measure by other  
3 organizations, and if they haven't adopted it, is it because  
4 of the multi-factorial character of it, or what's the status  
5 of the history?

6 MS. RAY: I mean, it certainly is considered --  
7 the information I provide you on kidney transplantation is  
8 from the U.S. Renal Data System that tracks outcomes of ESRD  
9 patients and, of course, that includes kidney  
10 transplantation.

11 MR. GEORGE MILLER: I appreciate the information.

12 MS. RAY: CMS has not proposed using such a  
13 measure in the ESRD QIP. I would need to go back and  
14 double-check with other quality, you know, like the NQF and  
15 other quality organizations, and I can report back to you  
16 about that.

17 MR. HACKBARTH: Okay. Thank you. Bill.

18 MR. GRADISON: I support the package.

19 MR. HACKBARTH: Alice.

20 DR. COOMBS: So, it was a year ago, I think, we  
21 discussed ambulance and transport of dialysis patients to  
22 dialysis units, and I remember when we discussed that, that

1 that contributed a large portion -- it was a considerable  
2 cost. And what I was wondering, and several people around  
3 the table said, well, could we bundle transportation  
4 services under the general bundle as a whole, and so I don't  
5 know if you could add a fourth bullet, but one would be to  
6 consider those services that were under the umbrella of  
7 getting to dialysis, and maybe -- I don't know if you can  
8 include some of the ancillary services like ambulance  
9 service.

10 I was thinking as George was talking that maybe we  
11 should include something like shared decision making as it  
12 pertains to all of the things with the dialysis patient,  
13 including transplantation.

14 I support the recommendations.

15 DR. NERENZ: I'm generally supportive, a little  
16 nervous, though, and I will commit the error, perhaps, of  
17 being too focused on margin. I'd just like to briefly walk  
18 through a little calculation.

19 If you can go to Slide 14, please, on top here,  
20 we've got 2014 projection, 2.9 percent, and a number of  
21 things in the bullet points feed that. Then sequester takes  
22 two percent from that, right, so now we're down to 0.9. And

1 then we flip to Slide 16, market basket, 2.8, a couple other  
2 things go on. If we don't do an update, does that make the  
3 projection of margin for 2015 negative, on average?

4 DR. MARK MILLER: [Off microphone.] I think we  
5 can answer this more precisely -- it turns on what the --

6 MS. RAY: The sequester.

7 DR. MARK MILLER: Sorry?

8 MS. RAY: No. You go.

9 DR. MARK MILLER: Well, the cost growth that we're  
10 assuming for the period that he's talking about, which I  
11 don't happen to have.

12 MS. RAY: Right, but -- so your question is, if  
13 you do take into account the sequester --

14 DR. NERENZ: Yes.

15 MS. RAY: -- what would the margin -- the margin  
16 would -- well, the margin would come down about two  
17 percentage points in 2014, so that's roughly one percent.

18 MR. HACKBARTH: So, implicit in Dave's question, I  
19 think -- and correct me if I'm wrong, Dave -- is that he was  
20 using, in the absence of other information, that costs would  
21 grow by the rate of the market basket increase.

22 DR. NERENZ: Exactly.

1 MS. RAY: Right.

2 MR. HACKBARTH: Right.

3 MS. RAY: Right. Right.

4 MR. HACKBARTH: And, in fact, that may not be the  
5 case, and --

6 MS. RAY: Right, and if the cost per treatment is  
7 less than the increase in the market basket, then the margin  
8 will be a little bit higher. Yes.

9 MR. HACKBARTH: And remind me what the cost growth  
10 was this year.

11 MS. RAY: The cost growth was roughly two percent  
12 between --

13 MR. HACKBARTH: Okay. And what about the year  
14 before?

15 MS. RAY: Between 2011 and 2012.

16 MR. HACKBARTH: It was two percent.

17 MS. RAY: Yes.

18 MR. HACKBARTH: Yeah. Okay.

19 DR. NERENZ: Okay. And then just the context  
20 around this is that Medicare is such a dominant payer for  
21 this group as opposed to others that can offset a negative  
22 margin elsewhere. That's just -- I'm rolling that all

1 together and being a little nervous, that's all.

2 DR. REDBERG: I support the recommendations.

3 They're correct. I was just trying to find -- there was a  
4 note somewhere in the chapter about the trend towards  
5 earlier dialysis in the U.S. and whether we could in the  
6 future incorporate that, because -- I can't find it now, but  
7 it's definitely been documented in multiple studies that we  
8 have started dialyzing people earlier, and certainly earlier  
9 than in other countries, and there has been no benefit in  
10 outcomes. Obviously, there's considerable, besides cost,  
11 but inconvenience, I mean, decrement in quality of life, and  
12 so whether that would be a future quality measure, I think,  
13 would be worthy of consideration.

14 And I also think the trend, the small increase in  
15 home dialysis with the benefits on quality of life was very  
16 positive and would hope we could encourage that, as well.

17 DR. HALL: I'm in favor of the recommendations.

18 About 25 percent of the Medicare dialysis population is over  
19 age 75 now, and that's probably going to be increasing  
20 because the procedure works. It does keep people alive.  
21 And it's another example where we really need some concrete  
22 measures of function and we need to talk about quality of

1 life, one of five or six areas we've discussed where we  
2 desperately need these scales and I hope that we can keep  
3 our eye on what is available and what's in the pipeline.

4 DR. BAICKER: I'm supportive, and as a side note,  
5 I found the figure in the reading and that you showed of the  
6 change in use of drugs and number of drugs with the payment  
7 reform very striking and telling about how these payment  
8 reforms may have real impacts on utilization and not --  
9 improve patient outcomes or not harm them.

10 DR. CHERNEW: I'm supportive of the  
11 recommendations, but I have two questions. The short  
12 question is, just it looked like in the chapter that they  
13 were doing audits of the cost reports every three to five  
14 years or something, until 2001, and then they stopped. Is  
15 that basically right?

16 MS. RAY: Yeah. You know, the BBA required CMS to  
17 do some audits, and then there has not been --

18 DR. CHERNEW: But there were, like, four or five  
19 regular audits, like every few years, and then they stopped  
20 doing them, like, a decade ago or -- that's what it seemed  
21 to me.

22 MS. RAY: Right. Yes.

1 DR. CHERNEW: I just -- all right. I just wanted  
2 to make it clear that this isn't, like, the first time these  
3 cost reports have been ever audited.

4 The second comment has to do with the quality  
5 measures, and this is really a clinical question that I know  
6 nothing about. There's different types of quality measures,  
7 and some of them look good, in fact, even improving, and  
8 others might be a little more concerning. And I'm curious  
9 clinically how these types of measures are related.

10 So, for example, you might think you take someone  
11 off of a set of drugs and then you solve some problems and  
12 they look better on some quality measures, but other things  
13 might happen more common that look like it was getting  
14 worse. So I'm not sure, clinically, the extent to which a  
15 provider has the ability to move each quality measure sort  
16 of individually, or more to the point, if they try and, say,  
17 get hemoglobin at a certain level, they risk more of some  
18 other complication. I just don't know if that's the case,  
19 but I think in other clinical areas, it is.

20 And so what that means is, or my question is, are  
21 there sort of -- can we think of maybe macro measures that  
22 think they're doing a good job as opposed to looking at a

1 whole slew of them and saying, oh, they're doing great on  
2 these five but not so good on these ones, so -- because it  
3 might be that they're connected in ways clinically that I  
4 don't understand.

5 MS. RAY: Right. I mean, I think your assessment  
6 about the different clinical measures being related is  
7 correct in this area, although I am not a clinician. You  
8 know, the Commission in our comments on the ESRD QIP has  
9 advised the Secretary to move towards fewer outcome  
10 measures, outcome measures including rates of admission,  
11 rates of mortality, and, you know, at least those two  
12 measures do capture -- of course, needless to say, lower  
13 rates capture higher quality care.

14 We've also focused on home dialysis measure  
15 because of the improvement in patient satisfaction and  
16 quality of life, and kidney transplantation.

17 DR. COOMBS: I just want to say, if you can  
18 transplant someone, you've actually eliminated, in terms of  
19 the cost, a great deal of cost. The up-front cost is  
20 expensive. But, over time, you've actually benefitted the  
21 patient both in quality of life and in terms of costs  
22 associated with chronic renal failure.



1 DR. CHERNEW: I understood it to be true. I  
2 gather the limitation on transplantation is the limitation  
3 in the number of organs you have to actually transplant, so  
4 it gets into a whole other set of issues. I was more  
5 interested in things like whether or not the reduction in  
6 stroke, heart failure, and AMIs could reflect -- if those  
7 things were side effects of some other type of treatment, if  
8 you got rid of that other type of treatment, you'd get rid  
9 of those other things, but there's tradeoffs, and I just --  
10 I think -- I still don't understand, but I understand  
11 better.

12 DR. MARK MILLER: [Off microphone.] Well, I think  
13 there is --

14 DR. REDBERG: I think that was the reduction -- I  
15 mean, those were associated with the higher ESA use, so I  
16 think with the reduction in ESA, there was a reduction in  
17 stroke, heart failure, and --

18 DR. CHERNEW: [Off microphone.] Exactly. Right.  
19 But then hemoglobin levels may have declined. And so it's  
20 odd to sort of treat them the same, right, because when you  
21 do one thing -- it's hard for us to look at -- these things  
22 declined, great. But, oh, hemoglobin declined, as well.

1 Oh, that's a problem. Now we want -- you know, because  
2 they're tied together into how they all behave.

3 DR. REDBERG: I don't think the hemoglobin going  
4 down is a problem. And actually, the increase in blood  
5 transfusions, I think, is a problem, because it -- that's  
6 very soft and you don't have to transfuse. But I think  
7 there's somewhat of -- and I don't know everything behind  
8 it, but sometimes there's this reflex to transfuse when you  
9 see a lower hemoglobin even though that may not be  
10 beneficial for the patient.

11 DR. CHERNEW: And so talking to Rita about good  
12 quality measures is really good.

13 DR. HALL: So, we should remember that you don't  
14 just wake up one morning and say, I think I need end stage  
15 renal disease treatment. These people all have very complex  
16 comorbidities, principally diabetes, so that by getting to  
17 this, to the stage of being dialyzed, you already do have a  
18 number of things that would seem to be complications, a high  
19 propensity for myocardial infarction for stroke, and that's  
20 why it's so hard to develop quality measures.

21 There's a subset of older dialysis patients that  
22 are brought to dialysis units, usually by an ambulance

1    staffed for space travel in terms of the technology in the  
2    ambulance, who really don't know where they are, who  
3    wouldn't be able to recognize that they'd been dialyzed, and  
4    go back without much in the way of cognitive function. So,  
5    there are all kinds of issues here and that's, I guess, why  
6    I made an appeal that we need to have other kinds of  
7    measures to really assess what we're doing as this  
8    population ages.

9           MR. HACKBARTH: And I think that this dialogue is  
10   a good illustration of why MedPAC should not be in the  
11   business of specifying quality measures. It really is a  
12   field for expert. I feel comfortable when we make general  
13   directional statements like, you know, so far as possible,  
14   we ought to be using outcomes as opposed to process, things  
15   like that. But actually developing a clinically sensible  
16   set of measures is way beyond our expertise.

17           DR. CHERNEW: I agree completely with that, at  
18   least my and your expertise. But I do think because quality  
19   is one of our criteria, knowing how to interpret the quality  
20   measures that are put in front of us actually does become  
21   important.

22           MR. BUTLER: I support the recommendations.

1           MR. KUHN: I support the recommendations, but I  
2 just have one additional question on this quality measure  
3 recommendation. So, during the presentation, you talked  
4 about the ESAs and the 45 percent drop we've seen, which is  
5 a good thing, because as a result of that, as you mentioned,  
6 a decrease in heart failure, stroke, and AMI. At the same  
7 time, we're seeing a bit of an uptick in transfusions, you  
8 said, from 2.7 to 3.3 percent. So, on that level of  
9 transfusion, is that, basically, are we in a lower bound,  
10 mid-point, high range in terms of concern, or kind of where  
11 are we in that space right now? Any sense of that?

12           DR. MARK MILLER: If I were asked that question,  
13 and fortunately, it's Nancy, so I don't have to answer --

14           [Laughter.]

15           DR. MARK MILLER: -- I'm a little bit unclear.  
16 And we saw an uptick and it was coincident with the move to  
17 the PPS and the drop in the ESAs --

18           MR. KUHN: Right.

19           DR. MARK MILLER: -- and so -- and for the things  
20 that you said, so we're concerned. On the other hand, it's  
21 a fairly low frequency.

22           MR. KUHN: Right.

1 DR. MARK MILLER: When we were having  
2 conversations with -- and this relates to the whole  
3 conversation that you've been having on the quality stuff --  
4 we were talking to CMS and we were saying, you know, we're  
5 concerned about this under-management of anemia, but we  
6 recognize clinically the notion of getting to hemoglobin-  
7 level types of measures, or hematocrit or whatever the right  
8 thing is, is probably not easy to do, and they were saying,  
9 yes, it's not easy to do and so please don't ask us to do  
10 it.

11 And then we said, well, are there other measures  
12 that by proxy you could say, okay, I'm confident that you  
13 must be doing a good job because you're not hitting the  
14 hospital or your mortality rate, and we said, what about the  
15 transfusion rate? And they said, again, because it's so low  
16 and infrequent, it's a pretty noisy measure to use. And  
17 that's where the conversations stand at this point.

18 And so, yeah, there's some concern because it's an  
19 uptick and it does seem related to what's going on, but  
20 exactly how much urgency and what is happening given things  
21 like Rita is saying, I think it's hard for me to say.

22 MR. KUHN: Yeah. And, you know, I, too, have been

1 kind of watching this somewhat from afar because I do know  
2 about the label change in 2011, and so that makes it even a  
3 little bit more difficult here as we go forward.

4           But I think the one thing I like about this  
5 particular recommendation, because I know CMS now has an  
6 active claims surveillance program that's very  
7 sophisticated, to the point where they can almost get real  
8 time information on kind of what's going on, so with that  
9 kind of system in place, if they came in with some better  
10 ways to assess, the actions that they can take are so much  
11 more quick. They don't have to wait a year, 18 months for  
12 that data. They're almost getting it real time, I think as  
13 close as four to six weeks when it's coming in. So I think  
14 this is a very good recommendation and could be very helpful  
15 for the care for these patients.

16           MR. HACKBARTH: Okay. Thank you, Nancy. Well  
17 done.

18           We will now turn to skilled nursing facility  
19 payment.

20           [Pause.]

21           MR. CHRISTMAN: Okay. Next we are going to talk  
22 about PAC reform. This presentation builds on a discussion

1 we had last month about better data for reforming PAC  
2 payments.

3 For many years, the Commission and others have  
4 been concerned about the multiple PAC payment silos in  
5 Medicare. The BBA established separate PPSs for the four  
6 PAC providers, and there has been concern that these  
7 separate systems have discouraged coordination across silos  
8 and led to inefficient payment.

9 These separate silos exist even though these  
10 providers often overlap in the services they provide and the  
11 patients they serve. Medicare payments for similar patients  
12 can vary significantly between settings because each setting  
13 has its own approach to setting base rates and measuring  
14 patient case mix.

15 Medicare's current approach to collecting patient  
16 assessment data is siloed. It mandates unique assessment  
17 tools for the SNF, IRF, and home health and does not collect  
18 patient assessment information from LTCHs. The silos' use  
19 of dissimilar data makes it difficult to compare patient  
20 severity and quality.

21 The lack of common data makes it difficult to  
22 compare the resource use and outcomes across the silos. For

1 many years, the Commission and others have sought to  
2 consolidate some or all of the PAC silos and do a more  
3 uniform system of payment, but the current use of multiple  
4 assessment approaches makes it difficult.

5           MedPAC and others have desired a unified  
6 assessment tool for some time, but progress towards this  
7 goal has been sluggish. In 1999, the Commission recommended  
8 the Secretary select a core set of patient assessment  
9 information across all PAC settings. We have reiterated the  
10 need for this data at many meetings and annual reports since  
11 then. The Deficit Reduction Act of 2005 required the  
12 Secretary to conduct a demonstration to develop and test a  
13 tool. CMS successfully developed, validated, and tested a  
14 uniform tool, the Continuity Assessment Record and  
15 Evaluation, or CARE, tool in the PAC PRD demonstration. CMS  
16 completed the demonstration in 2011 but has not yet  
17 announced plans for replacing the current PAC assessments,  
18 the common tool.

19           The results of the CARE demonstration suggested  
20 that a cross-sector assessment tool could reliably measure  
21 patient severity across settings. The CARE tool developed  
22 and fielded for this demo was tested in each of the four PAC



1 settings and inpatient hospitals. The evaluation of the  
2 statistical reliability of the CARE assessments, such as  
3 inter-rater reliability and cross-sector reliability,  
4 indicated that the data collected were comparable to current  
5 assessment instruments in their accuracy.

6           The demonstration also found that the CARE data on  
7 patient severity could be used to measure resource use and  
8 compare outcomes across the sectors. The evaluation of  
9 quality suggested that the sites achieved similar outcomes  
10 when they served similar patients. There was little  
11 difference among the settings in the rate of readmissions,  
12 and the average functional gains were also comparable.

13           The results of the CARE demo suggest several  
14 elements that a common assessment instrument should include  
15 to facilitate cross-sector analysis. The chart on this  
16 table highlights the assessment items that proved useful for  
17 comparing resource use and outcomes and would be good  
18 candidates to include.

19           Most of these items are collected on the current  
20 siloed assessment tools but not in a standardized way.  
21 Standardized items from CARE or similar assessment tool with  
22 demonstrated utility of cross-sector assessment could be

1 phased in to the current tools, replacing similar items over  
2 time. Not all would necessarily have to be added at once,  
3 and if it minimized the burden, they could start with the  
4 items that had the greatest statistical power for risk  
5 adjustment, and additional items could be added over time.

6 CMS completed the CARE demo over two years ago,  
7 and currently they have two announced follow-on projects.  
8 The first will evaluate the use of CARE assessment items in  
9 place of the siloed assessment items currently used in the  
10 PAC PPSs. Second, it has a project underway to develop  
11 CARE-based functional measures for IRFs and LTCHs. However,  
12 CMS has not announced a timeline for implementing a common  
13 assessment tool.

14 This lack of a path forward for fielding a common  
15 assessment tool is troublesome because many PAC reforms  
16 would benefit from better comparative data. A common  
17 patient assessment tool would permit a better understanding  
18 of cost and outcomes across settings, allowing us to better  
19 understand the overlaps that are suggested by existing  
20 patterns of utilization. This information would be valuable  
21 for beneficiaries in the program. It could be used to guide  
22 beneficiaries and physicians when selecting the PAC site of

1 care.

2 In addition, having a common assessment tool would  
3 leave Medicare better prepared in the future to develop and  
4 implement a refined PAC PPS that combines at least some of  
5 the existing PAC PPSs into a single system.

6 The CARE demonstration suggested that a common  
7 approach to patient assessment is possible in PAC and that a  
8 more unified system of payment may be feasible. However,  
9 there is no clear plan for moving forward with a common  
10 instrument that would enable these further reforms.

11 For these reasons, the Chairman has offered a  
12 draft recommendation for your consideration that would set a  
13 deadline to begin implementation. The draft recommendation  
14 reads: The Commission should direct the Secretary to  
15 implement a common assessment tool for use in home health  
16 agencies, skilled nursing facilities, inpatient  
17 rehabilitation hospitals, and long-term care hospitals by  
18 2016.

19 The recommendation would set 2016 as the deadline,  
20 but the changes to the assessments could be phased in over  
21 time. CMS could start by adding common assessment items as  
22 a supplement to the existing tools in 2016. In 2017, they

1 would retire the items on the original assessment form that  
2 cover the same domains as the new common assessment items  
3 and use the new common assessment items in the existing  
4 payment system when necessary.

5 Through 2019, CMS could continue to replace each  
6 silo's unique assessment items with common assessment items,  
7 eventually establishing a single common tool for the four  
8 PAC silos.

9 The spending implications are that there will be  
10 administrative costs in the short term as Medicare develops  
11 and fields the new common assessment items. These costs may  
12 be lower in the long run if CMS is successful in reducing  
13 the number of silo-unique assessments it has to maintain.  
14 Beneficiaries will have better information about the quality  
15 of providers and for selecting the side of PAC care.  
16 Providers will have better data to improve care transitions  
17 and tie outcomes to core processes, and providers may incur  
18 costs to implement the new tools and train staff.

19 This completes my presentation, and now Carol will  
20 talk about SNFs.

21 DR. CARTER: Before I get started, I wanted to  
22 thank Lauren Metayer for her help with the Medicaid section

1 of this chapter.

2 I'll start with an overview of the industry and  
3 then present information related to the update and end with  
4 a summary of the Medicaid trends we are required to report.

5 Let me start with a brief sketch of the industry.  
6 There are just under 15,000 providers. About 1.7 million or  
7 about 4.5 percent of fee-for-service beneficiaries use SNFs.  
8 Program spending in 2012 was just under \$29 billion. And  
9 Medicare makes up about 12 percent of days but 23 percent of  
10 revenues.

11 We'll be using our standard update framework to  
12 work through the adequacy of Medicare's payments. I'll be  
13 going through this material quickly, but there is more  
14 detail in the chapter.

15 Access is adequate and stable. Supply has been  
16 steady between 2011 and 2012. Three-quarters of  
17 beneficiaries live in counties with at least five SNFs, and  
18 the majority live in counties with ten or more. Bed days  
19 available increased slightly, and occupancy rates were  
20 unchanged from 2011 to '12 at 87 percent.

21 Between 2011 and 2012, covered admissions and days  
22 declined, paralleling the decline in inpatient hospital

1 stays, which is a prerequisite for covered SNF care.

2 Because the decline in days was smaller than the decline in  
3 admissions, the length of increased slightly.

4 Turning to quality, before I go through these  
5 trends, I want to point out that we revised our  
6 rehospitalization measure this year to better reflect  
7 Commission conversations about defining readmissions that  
8 are potentially avoidable. The details of these refinements  
9 are in the paper.

10 The risk-adjusted rates of discharge back to the  
11 community and potentially avoidable rehospitalization show  
12 small improvement between 2011 and 2012. The community  
13 discharge rate increased from 29 percent to 30.8 percent in  
14 2012.

15 We looked separately at rehospitalization rates  
16 during the SNF stay and during the 30 days after discharge,  
17 and both declined slightly. Combined, the potentially  
18 avoidable rehospitalizations declined from 14.7 percent in  
19 2011 to 14 percent in 2012. These declines are likely to  
20 reflect a focus by both hospitals and SNFs to lower their  
21 readmissions.

22 This year we worked with a contractor to develop

1 measures of the changes in functional status of  
2 beneficiaries treated in SNFs. We developed two composite  
3 measures: the average share of a SNF's stays with  
4 improvement across three measures of mobility and the  
5 average share of stays with no declines in mobility, given a  
6 beneficiary's functional status at admission and how much  
7 improvement they would be expected to make. In looking at  
8 risk-adjusted rates between 2011 and 2012, we found  
9 essentially no change in either measure. Although the  
10 average SNF share of stays with improvement did not change,  
11 they were successful at preventing declines in functional  
12 status.

13 We also found large variation in all of the risk-  
14 adjusted quality measures, and here I have listed the 25th  
15 and 75th percentiles for three measures. The amount of  
16 variation represents large opportunities to improve  
17 beneficiary care, realize program savings, and increase the  
18 value of the program's purchases. There were not consistent  
19 patterns and quality by type of facility or location, but  
20 nonprofits had better rates of quality across all five  
21 measures.

22 In terms of access to capital, industry analysts

1 report that capital is generally available and expected to  
2 continue for 2014. Some lenders are reluctant to lend to  
3 nursing homes, but this reflects uncertainties about the  
4 federal budget, not the level of Medicare's payments.

5 In 2012, the average margin for free-standing  
6 facilities was 13.8 percent. This was the 13th year in a  
7 row that the average was above 10 percent. Across  
8 facilities, margins vary more than four-fold. One-quarter  
9 of SNFs had margins of 4.8 percent or lower, and one-quarter  
10 had margins of at least 23 percent. There continue to be  
11 large differences between nonprofit and for-profit  
12 facilities, with nonprofits having considerably lower  
13 margins than their for-profit counterparts. Compared to  
14 SNFs in the lowest quartile of margins, SNFs in the highest  
15 quartile had considerably lower cost per day after adjusting  
16 for differences in wages and case mix, and they had higher  
17 payments per day, in part reflecting their provision of more  
18 intensive therapy.

19 Hospital-based SNFs, which make up 5 percent of  
20 the industry, continue to have very negative margins --  
21 negative 62 percent). However, hospital-based units  
22 contribute to the bottom line of hospitals, allowing them to



1 lower their inpatient lengths of stay. Prior work we've  
2 done found that hospitals with SNFs had lower inpatient  
3 costs per case and higher inpatient Medicare margins than  
4 hospitals without SNFs.

5 We estimated the 2014 margin for free-standing  
6 SNFs to be 12 percent. We assumed that costs grew at the  
7 market basket, revenues would increase at the market basket  
8 minus productivity, and we accounted for changes in bad debt  
9 policy, as required by law. If the sequester is in effect,  
10 the margin would be about two points lower.

11 Each year we look at efficient providers, using  
12 three years' performance to identify SNFs with relatively  
13 low cost and high quality. And we use a very similar  
14 definition that Jeff walked through with the hospitals this  
15 morning. We found 11 percent of SNFs were relatively  
16 efficient. Compared to the average, they had costs that  
17 were 3 percent lower, community discharge rates that were 16  
18 percent higher, and rehospitalization rates that were 11  
19 percent lower, yet they still had average Medicare margins  
20 of 17 percent.

21 In 2012, the Commission made a two-part  
22 recommendation. For the update year, you recommended that

1 the PPS be revised, with no update. Then in the second  
2 year, payments would be lowered by an initial 4 percent,  
3 with subsequent reductions made during a transition until  
4 payments were more closely aligned to costs. For those of  
5 you who were not here, I want to explain the logic of that  
6 recommendation.

7           With margins so high for so long, the Commission  
8 believed that Medicare payments needed to be lowered.  
9 However, we also knew that margins varied widely and  
10 reflected systematic shortcomings with the PPS. More  
11 importantly, payments are driven by the amount of therapy  
12 furnished, and payments are not targeted to patients with  
13 high non-therapy ancillary costs, such as drugs. In  
14 addition the PPS does not have an outlier policy. The  
15 Commission believed that before rebasing began, the PPS  
16 needed to be revised to correct these biases. The  
17 Commission first recommended revising the PPS in 2008.

18           Without raising total spending, the design would  
19 shift payments within the industry. We estimated payments  
20 would decrease 10 percent for SNFs that furnish a lot of  
21 intensive therapy and would increase 17 to 18 percent for  
22 SNFs that treat a high share of medically complex patients.

1 Based on a facility's mix of cases and their therapy  
2 practices, payments would shift from free-standing SNFs to  
3 hospital-based facilities and from for-profit to nonprofit  
4 facilities -- that is, from the highest margin providers to  
5 lowest margin providers.

6 The second part of the recommendation stated that  
7 payments would be rebased, beginning with a 4 percent  
8 reduction. The Commission reviewed many pieces of evidence  
9 that supported this reduction.

10 First, the average Medicare margins for SNFs has  
11 been above 10 percent since 2000. The variation in margins  
12 is related to the amount of therapy and cost per day, not  
13 differences in -- other differences in patient mix. Large  
14 cost differences remain after controlling for wages, case  
15 mix, and beneficiary demographics. Our analysis of  
16 efficient providers shows that it is possible to furnish  
17 relatively low-cost, high-quality care.

18 In addition, we compared fee-for-service payments  
19 to MA payments for four publicly traded companies and found  
20 that fee-for-service payments average 25 percent higher. We  
21 compared the average age, risk scores, and beneficiaries'  
22 ability to perform activities of daily living between MA

1 enrollees and fee-for-service beneficiaries and found small  
2 differences that are unlikely to explain the differences in  
3 payments.

4 Last, the industry has responded to the level of  
5 payments in two ways over time. First, since 2001, cost  
6 growth has outpaced the market basket every year except for  
7 2012. And, second, when payments were lowered, the industry  
8 shifted the mix of days and therapy modalities that  
9 increased their revenues or dampened the impact of the  
10 reductions.

11 The payment adequacy factors indicate that the SNF  
12 landscape has not changed during the past year. The  
13 Chairman proposes to rerun the recommendation with a  
14 discussion about why these changes are still needed. For  
15 2015, this would provide a zero update while the PPS was  
16 revised, and in 2016, rebasing would begin with a 4 percent  
17 reduction in payments.

18 As required by PPACA, we examine Medicaid trends  
19 in spending, utilization, and financial performance for  
20 nursing homes. About 15,000 facilities participated in  
21 Medicaid, and that was a small decrease from 2012. Between  
22 2009 and 2010, the most recent year of data, the number of

1 users decreased slightly to 1.5 million. Spending is  
2 estimated to be \$51 billion in 2013, and that's a 5 percent  
3 increase from 2012. The non-Medicare margin for 2012 was  
4 negative 2 percent, and the total margin was 1.8 percent.  
5 Both of these declined from 2011, reflecting Medicaid rate  
6 freezes in some states, reductions in some states, Medicaid  
7 reductions in some states, the shifts in enrollment in  
8 Medicare from fee-for-service to MA and the associated lower  
9 payments; and in the case of total margins, the corrections  
10 and the lowering of Medicare's rates in 2012.

11 The industry consistently posits that facilities  
12 lose money on Medicaid and they need the high payments from  
13 Medicare to be viable. Using Medicare payments to subsidize  
14 Medicaid payments is poor policy for a number of reasons.  
15 First, it does not target payments to facilities that need  
16 the assistance the most. Second, when Medicare raises or  
17 maintain its high rates, it could encourage states to either  
18 freeze or lower their own rates. And, finally, it diverts  
19 trust fund dollars to subsidize payments from -- subsidize  
20 the payments from Medicaid and -- Medicare's payments to  
21 Medicaid and private payers. If the Congress wishes to help  
22 nursing facilities with high Medicaid payer mix, then a

1 separately financed, targeted program should be established  
2 to do this.

3 And with that, I look forward to your discussion.

4 MR. HACKBARTH: Okay. Thank you, Carol and Evan.

5 So just as a reminder, this is one of the areas  
6 where we do not have a vote on a new recommendation.

7 Physicians, SNFs, and home health we have passed multiyear  
8 recommendations, so we would simply be rerunning those  
9 recommendations in this year's report.

10 Round 1 clarifying questions?

11 MR. ARMSTRONG: Thank you. This is really  
12 interesting. But these are really two different topics we  
13 just talked about, right? One is across post-acute services  
14 how we can rationalize the way in which case is organized  
15 and how we evaluate actually the value we get from different  
16 of those payment silos that we talk about. And then the  
17 second was really much more specifically around SNF and the  
18 SNF payment updates and so forth.

19 What I lost in here was -- I should probably know  
20 this, but what's the status, on the first topic, which  
21 relates to the second topic, of demonstration of bundled  
22 payments and some of the recommendations that we've made in

1 the past around those?

2 DR. CARTER: So the BPCI is ongoing right now. I  
3 think it began -- participants began this year, and I think  
4 it's a three-year demonstration. They have selected an  
5 evaluator, but obviously that's years away from now. It  
6 will be a tricky evaluation because each participant has  
7 designed their program differently. But there are some  
8 common parameters across the programs in terms of the kinds  
9 of waivers that they allowed providers, participants to be  
10 excluded from in terms of current Medicare policies. So  
11 that is ongoing, and we don't have any results per se from  
12 that at this point.

13 MR. ARMSTRONG: And so it's just getting started,  
14 and it will be three years before we expect some result from  
15 that demonstration or those pilots? Three years, you said?

16 DR. CARTER: That's right. Yes.

17 MR. HACKBARTH: Okay. Clarifying questions?

18 MR. BUTLER: So in Evan's presentation, on page 4,  
19 which I think we do vote on a recommendation here, right?

20 MR. HACKBARTH: Yes [off microphone].

21 MR. BUTLER: Which seems like an easy  
22 recommendation. But as efficiently as you did this, I

1 really didn't understand the third point and what you meant  
2 by limited differences in outcomes.

3 MR. CHRISTMAN: Sure. The CARE demo looked at two  
4 types of outcomes across settings, and the novelty here is  
5 that -- they looked at readmissions and they looked at  
6 change in function during the post-acute stay. And the  
7 important thing they had for the CARE demo is they finally  
8 had a common set of risk factors for adjusting across the  
9 settings so that they could accurately compare the patients  
10 in the different settings without, you know, worrying about  
11 whether they truly had comparable data. And readmissions  
12 for SNF, home health, and IRF, there was not any significant  
13 risk-adjusted differences in the rate of readmissions across  
14 the sites.

15 The LTCHs were a little lower, but the LTCHs are  
16 tricky because they are a hospital level of care, and they  
17 may be able to treat patients in the LTCH that the others  
18 can't because they're not hospitals.

19 The second set of outcomes looked at function, and  
20 they looked at mobility and self-care, which you can  
21 essentially kind of think of as upper body and lower body.  
22 And I believe on self-care there was no significant



1 differences among the sites in the average gain in self-care  
2 ability when they risk-adjusted across the sites. On the  
3 mobility one, that was mostly true. The home health was  
4 slightly better than some of the other settings, and I think  
5 IRF was slightly better. But it was really a few points on  
6 a 100-point scale. It wasn't really established that there  
7 was a clinically significant difference in the outcomes.

8 MR. BUTLER: I guess then my question is: You're  
9 really talking about not validating the tool itself, but, in  
10 fact, this addresses the differences for case mix adjusted  
11 patients, and it's already saying, oh, the tool's good,  
12 let's see if there are differences across these settings,  
13 and that's what you're referring to.

14 MR. CHRISTMAN: That's right. And I think -- that  
15 was part of the CARE demo, is they were just sort of seeing  
16 if we could -- you know, if the information collected would  
17 be analytically useful, what would you find? It gives you a  
18 preliminary sense of how, you know, questions we've been  
19 asking for many years, how these sites vary in their ability  
20 and in terms of quality and in resource use.

21 MR. BUTLER: Okay.

22 MR. HACKBARTH: Part of this was to, in fact,

1 validate the tool and all of the things that people who do  
2 such work know how to do that I don't understand.

3 MR. CHRISTMAN: Right. They also did an analysis  
4 that looked at how well the care items could be used to  
5 predict resource use, the idea being that you could use the  
6 functional information and the other information from CARE  
7 to build a common payment system across all of the sites.  
8 And they looked at how well the CARE items would predict  
9 nursing and therapy costs across the four sites, and it  
10 worked, you know, on a level that was comparable to the  
11 existing payment systems. It worked better to group all of  
12 the inpatient settings together kind of in one common system  
13 and keep home health separate. But, you know, the key point  
14 was that if they had -- if a common tool was in place, it  
15 could be used as sort of the engine for building a common  
16 case mix.

17 MR. BUTLER: So one other follow-up. We haven't  
18 really mentioned ICD-10 today and the enormous millions of  
19 dollars it costs to put that in this year. But I realize  
20 functional status is captured I think in a different way,  
21 but we go to almost a 15-fold increase in the number of  
22 codes we're collecting. Is there any value of any of that

1 to this tool?

2 MR. CHRISTMAN: My understanding is that ICD-10 is  
3 principally looking at clinical diagnoses and doesn't really  
4 get into capturing functional severity very well. There are  
5 some different types of codes that sometimes move into this  
6 territory a little bit, but, you know, there is an entirely  
7 -- there is actually the ICF, the International  
8 Classification of Function, which is sort of the functional  
9 analog of ICD, and it's much more complex in terms of what  
10 it captures in terms of function. Nobody has really even  
11 experimented with using it in Medicare. I think it would be  
12 much more complex and burdensome than the types of  
13 functional collection we do in CARE, the existing tools.

14 MR. HACKBARTH: Bill, with a clarifying question?  
15 Anybody else? Okay.

16 DR. HALL: It was mentioned two or three different  
17 places in the materials we had and also in the presentation  
18 here that Medicare Advantage seemed to have been able to  
19 negotiate lower rates in SNFs. It was presented very  
20 qualitatively. Is there any way you can quantitate that a  
21 little bit more? Is this a common phenomenon? And do we  
22 know -- do we have access to any --

1 DR. CARTER: It's interesting you ask that because  
2 we were wondering the same thing. We don't know.

3 DR. HALL: Okay.

4 DR. CARTER: So I just know for the publicly  
5 reported and traded firms. We don't know how widespread  
6 that is.

7 MR. HACKBARTH: So let's shift to Round 2, and so  
8 would you put up the draft recommendation, Evan? So the  
9 draft recommendation we're considering here is not an update  
10 but rather on the implementation of the CARE tool. And,  
11 let's see, Dave, do you want to start Round 2?

12 DR. NERENZ: I'm generally in favor, just maybe a  
13 clarifying question. Would the common assessment tool  
14 replace the current different ones or be in addition to, if  
15 this recommendation were --

16 MR. CHRISTMAN: The thinking is it will ultimately  
17 replace the current assessment tools.

18 DR. NERENZ: How long is "ultimately"?

19 MR. CHRISTMAN: It would take -- I think what --  
20 the way we have talked about doing it is phasing it in over  
21 time. And part of that is driven by the need to, you know --  
22 - the payment systems use items from the current assessment

1 tools, and we would need to collect -- and so to phase out  
2 the old items, we have to -- fully phase them out, we have  
3 to gain experience or gain data of the -- we have to collect  
4 the new items so that we can sort of, you know, when we drop  
5 the old assessment items, we can use -- we have some basis  
6 for forecasting the case mix using the new items. So we're  
7 kind of -- what we've suggested here is that you could start  
8 -- you could phase it in over time to give people some  
9 ability to sort of gradually get used to the new tool.

10 DR. NERENZ: Okay. Just an obvious observation  
11 that there's a cost involved to gathering the data and using  
12 it. So the less duplication for the shorter period of time,  
13 the better.

14 DR. COOMBS: I support the recommendation.

15 MR. GRADISON: As I do.

16 DR. CHRISTIANSON: And I.

17 DR. HOADLEY: Yeah, I support the recommendation,  
18 as well as, you know, going forward on the reprint of the  
19 SNF payment ones. And I guess I had one small question on  
20 the Medicaid discussion, and with some of the states now  
21 going to managed Medicaid long-term care. Has there been  
22 any thought about how that may play in and change the

1 impact? Or that's something obviously you could look at  
2 eventually over time?

3 DR. CARTER: We can look at that over time, yeah.

4 MR. ARMSTRONG: Yes, I support the recommendation  
5 as well. But I do have to express a frustration at how slow  
6 this is. And I think, Dave, your point, there's a cost  
7 associated with redundant reporting tools. My view is  
8 there's a tremendous cost in this taking so long.

9 First of all, there's no disagreement that post-  
10 acute care services need to be better coordinated, and the  
11 kind of tool we're talking about is a basic tool that will  
12 allow us to do that work better than we've done in the past.  
13 And reading the material -- correct me if I'm wrong -- our  
14 first recommendation to do this work was in 1999, which is  
15 basically a 20-year lag before this recommendation would  
16 actually implement this idea that there's very little  
17 disagreement about.

18 So I support this, but I would ask if there's any  
19 way of moving it a little more quickly.

20 DR. NERENZ: [off microphone.]

21 MR. ARMSTRONG: Yeah.

22 DR. NAYLOR: Yes. The answer is yes, we should do

1 this, and I would encourage, as Scott and David have said,  
2 that we rethink the recommended phase-in plan. I honestly -  
3 - I think that this is such an extraordinarily high priority  
4 for us as a Medicare program to understand the experience of  
5 care and transitions in care and use of health services over  
6 time. And I think when you recommend incremental  
7 adjustments to MDS and all of these other systems, you're  
8 talking about real costs in just doing that and when you  
9 could set an aggressive timeline for everybody to convert to  
10 the same system. So I support fully the recommendation and  
11 recommend reconsideration of the phase-in plan to be much  
12 more aggressive.

13 On the SNF, obviously support re-echoing the plan  
14 proposed update, but wonder also -- just a couple of  
15 comments because of the work that's been done on these  
16 measures, readmission measure and functional status, I think  
17 they're so much improved. I do wonder -- I mean, I think  
18 the demonstrated emphasis on functional decline that you  
19 made so clear in the chapter is really important so that we  
20 don't always think about function improving in an 85-year-  
21 old or 90-year-old or 100, et cetera.

22 I also wonder if further analysis around those

1 steps, so when you talked about mobility and transfer -- the  
2 chapter did, I should say -- that might be an  
3 extraordinarily important way to understand, so someone who  
4 moves from two-person transfer to one-person transfer as a  
5 result of this could be, in fact, a very substantial  
6 improvement. Certainly it is for the family caregiver to  
7 whom the person is being transitioned.

8           And the last thing I would mention is on the  
9 Medicare margin I'm wondering if we could pay a little bit  
10 more attention to uncovering the impact of the change that  
11 we're already accepting on the nonprofits, on the very small  
12 SNFs, et cetera, because their margins obviously are 5.4  
13 versus 16 percent for the nonprofit and for-profit. So I  
14 just wonder if we could pay more attention to that. But  
15 really great work.

16           MS. UCCELLO: I, too, support the recommendation  
17 and agree with Scott and Mary that we -- I mean, I'd be very  
18 comfortable with trying to move as aggressively as we can.  
19 I think this is such an important thing to help make sure  
20 that beneficiaries go to the site that makes the most sense  
21 for them, and also to help us as a Commission move forward  
22 on some of the payment reforms that we'd like to do.



1           In terms of the SNF, I agree with repeating our  
2     recommendation, but I just wanted to highlight something  
3     that was in the text but you didn't mention that I just  
4     found very interesting and wanted to say it out loud. The  
5     statement that acuity differences between Medicaid and  
6     Medicare translate to payments that would be 84 percent  
7     higher for Medicare patients, I thought that was just quite  
8     interesting and helps kind of provide some information about  
9     some of the differences in payments there.

10           DR. CARTER: I mean, people often talk about how  
11     low the Medicaid rates are, and Medicaid rates are low, but  
12     the patients are also really different. So that's why I put  
13     that in there.

14           MR. KUHN: I strongly support this recommendation.  
15     I think it's long overdue, and I think this is a good  
16     proposal.

17           One additional thing I'd like to kind of talk a  
18     little bit about on the SNF issue is the Jimmo case. We  
19     talked about it around here before. It's the improvement  
20     standard. It's the settlement that CMS reached on that.  
21     They started the implementation last Friday with the  
22     issuance of instructions for program manual updates as part

1 of the process, and what concerns me a little bit here --  
2 and maybe I'm being oversensitive here -- is that, as we  
3 know, in the SNF benefit it's a 100-day stay. So we also  
4 know that observation days are going up. In order to get  
5 into a SNF, you have to have a three-day prior  
6 hospitalization so they're seeing some decline in terms of  
7 some of their volumes as a result of more observation use  
8 perhaps and triggering -- at least coming in under the  
9 Medicare benefit.

10           What I'm wondering here is at least begin some  
11 surveillance or something here is that when folks move into  
12 the SNF benefit, they're not being kept for longer than  
13 necessary because of now the improvement standard being  
14 changed as a result of that. Could there be some incentives  
15 here that could drive certain providers to want to run up  
16 the full 100 days as part of the process?

17           So I think this is just one that we ought to be  
18 aware of. I don't know if we need to have any kind of text  
19 box or something in the copy there or just something we want  
20 to monitor in the future. But I think this is one that you  
21 could see the opportunity for gaming, and I think we just  
22 need to be very careful and monitor that in the future.

1           MR. BUTLER: I'm in support of the recommendation,  
2 and on the SNF front, I'm afraid these hospital-based units  
3 are an endangered species, maybe at best. We made the  
4 recommendation to revise PPS in MedPAC five years ago, and  
5 it shows, according to your Urban Institute numbers, it  
6 would be a 27 percent increase for hospital SNF units based  
7 on different kinds of patients they're treating. But we're  
8 down to 3 percent of all payments going to hospital-based  
9 SNF units, which is half of what it was, you know, six years  
10 ago. So I don't know what to do, but I would say that when  
11 you comment and say, gee, if you have a SNF, your total  
12 margin is likely higher because you can have a lower length  
13 of stay and that's what the data, in fact, shows, it  
14 suggests that the way you say it is this is a good deal, so,  
15 you know, if you just understood it, even under current  
16 rates, you know, you ought to -- it makes sense, economic  
17 sense. Well, it must not in the ideas of hospitals because  
18 these things are fading away quickly.

19           So I would caution using that as a kind of  
20 language even though I realize that the statistics show that  
21 hospitals that have these are more profitable than ones that  
22 don't.

1 DR. CHERNEW: So I also support this. I would  
2 echo what Herb said, which is even if the -- so I believe in  
3 having a common assessment tool strongly. But even if it's  
4 very predictive now, that doesn't mean that it's necessarily  
5 the right thing to do if people can game different aspects  
6 of it. So having a common tool and then how to use it are  
7 sort of two separate things, and sometimes once you decide  
8 how you want to use it, you might want to change aspects of  
9 the tool. But that's not really what's on the  
10 recommendation here. So we'll stick with I'm supportive of  
11 the idea of having a common tool. I think that's a great  
12 step forward.

13 The only other thing I'd like to say is I don't  
14 want to give the impression, given my earlier comments, that  
15 the driving force behind all the recommendations is simply  
16 the margins were high and we wanted to, therefore, lower the  
17 margins. I think my view of that is it looks like all of  
18 the other measures are fine and there's reason to believe  
19 that there might be room to reduce rates. Note we do it  
20 slowly, we don't go and take the margins down to whatever we  
21 think they are right away, because I think one motivation  
22 for that is you want to, as you go along this process, make

1 sure that the other indicators are not doing too badly. And  
2 so while I'm supportive of the recommendation, I don't want  
3 to give the impression that it's just the idea that we need  
4 to get the margins down.

5 DR. BAICKER: I, too, am very supportive of the  
6 recommendation. One slight note of caution in the  
7 transition period. I'm very sympathetic to not  
8 transitioning too slowly and that it's taken too long  
9 already. But just to echo something that Evan said, there's  
10 a huge return in data quality and measure validation to have  
11 both for a substantial overlap period so that you can make  
12 sure that the new ones map to the old ones the way you  
13 thought they did, that you can continue to use the old  
14 measure as an input into generating the new formulas. So  
15 I'd very much be in favor of starting the new ones right  
16 away, but ensuring -- we don't want any language that  
17 suggests that there shouldn't be both for, you know, at  
18 least a couple of cycles so that that validation and mapping  
19 can proceed with good data.

20 DR. HALL: Very supportive of this. And, Scott,  
21 in answer to your question about why did this take so long,  
22 I think it required a different sort of interactive

1 environment in the hospital for this to catch on. If this  
2 had been an imaging test or a series of lab tests, it would  
3 have been done in two days. But to do these assessments  
4 accurately, everybody on the team has to be talking to each  
5 other in the hospital setting. Sometimes silos exist within  
6 silos, and -- but the world has changed considerably over  
7 these past 15 years, so it's a good idea and its time has  
8 finally come. Kudos to MedPAC for thinking about this in  
9 '99.

10 DR. REDBERG: I heartily support the  
11 recommendation and agree with my fellow Commissioners that  
12 sooner would be better, and even for the goal of getting  
13 people to talk to each other by implementing this tool is a  
14 great unintended consequence.

15 MR. HACKBARTH: I just want to raise again the  
16 point that I raised this morning when we were talking about  
17 LTCHs. I do think of the SNF case mix improvement that is  
18 part of the recommendation that we're rerunning as related  
19 to the issues around LTCH. You know, we want to make sure  
20 that if these patients are going to go to places other than  
21 LTCHs that we are paying appropriately at those new sites,  
22 and we do have a longstanding belief that the current SNF

1 payment system does not pay appropriately for medically  
2 complex patients because of, among other things, how it  
3 handles the non-therapy ancillaries.

4 Now, as I understand it, CMS has done little on  
5 that but not enough, is the bottom line. And so I think we  
6 need to consider how, in addition to having it in this  
7 chapter, we can place this so that it reinforces other  
8 things that we're saying about LTCHs in acute-care  
9 hospitals. We may need to have it a couple places.

10 DR. MARK MILLER: Right. You made the connection  
11 this morning that that helped with having another location  
12 when a person leaves LTCH [off microphone].

13 MR. HACKBARTH: Yeah. Just a way of heightening  
14 its importance and visibility to have it in more than one  
15 place.

16 MR. ARMSTRONG: Just one other comment. I think  
17 particularly as we're looking not just at the SNF payment  
18 but the coordination of post-acute services and payment  
19 structure changes and so forth, this would be one area  
20 where, if we're not planning to do this already, we really  
21 should encourage diving deeply into how Medicare Advantage  
22 plans are coordinating post-acute care services. At least

1 the one I am familiar with just does -- we've solved for the  
2 communication issues. We've solved for, you know, the  
3 disruption from transitions between these different  
4 settings. And I really think the quality and service and  
5 cost outcomes are quite a bit better, but that's just an  
6 opinion. I think through this process, to the degree we can  
7 learn from those experiences, it could be tremendously  
8 valuable to us.

9 MR. CHRISTMAN: We've got two projects underway  
10 that will get at that. One is we have a project where we  
11 are interviewing private sector entities on how they manage  
12 PAC care, and looking at Medicare Advantage is one piece of  
13 that. And then if my understanding is correct, we will  
14 finally next year get access to the MA encounter data --  
15 take that as a vote of confidence -- and be able to look at  
16 PAC services, and we're very eager to do that.

17 MR. HACKBARTH: Okay. Thank you, Evan and Carol.  
18 So we are now off to home health.

19 Oh, Right. Evan is going to hang around.

20 MR. CHRISTMAN: Sure. Here we go. We're going to  
21 look at home health next, and as a reminder, here's our  
22 framework. It's the same one in earlier presentations with



1 one twist, that after we review the framework, we will also  
2 examine a potential policy to reduce hospital readmissions  
3 for beneficiaries in home health.

4           And just as a reminder, Medicare spent about \$18  
5 billion on home health services in 2012 and has over 12,000  
6 agencies in the program. We provided about 6.7 million  
7 episodes to 3.4 million beneficiaries.

8           We begin with supply, and as in previous years,  
9 the supply of providers and the access to home health  
10 appears to be adequate. Ninety-nine percent of  
11 beneficiaries live in an area served by one home health  
12 agency. Eighty-four percent live in an area served by five  
13 or more. And in terms of supply, the number of agencies was  
14 over 12,300 and there was a net increase of 257 agencies in  
15 2012. Growth is concentrated in a few areas, such as Texas,  
16 Florida, and Michigan. Many of these areas also have higher  
17 utilization.

18           Next, we look at volume. The volume trends in  
19 2012 declined slightly. However, this break in growth comes  
20 after several years of rapid increases. Home health  
21 spending declined by 1.5 percent in 2012. This decline was  
22 mostly due to a slight reduction in the base rate and a

1 slight decline in episode volume, and though volumes for  
2 this year show declines, keep in mind that since 2002, users  
3 have increased by over one-third, episodes have increased by  
4 more than 60 percent, and spending has almost doubled.

5           Next, we look at quality, and this table shows the  
6 risk adjusted rates of functional improvement among those  
7 patients not hospitalized at the end of their home health  
8 episodes. Across the two years, you can see that the rates  
9 of functional improvement slightly increased on most  
10 measures, implying a modest improvement in quality, and  
11 these measures are similar to what we've seen -- to the  
12 changes we've seen since the quality indicators were started  
13 in 2004.

14           In terms of capital, it is worth noting that home  
15 health agencies are less capital intensive than other health  
16 care providers and relatively few are part of publicly  
17 traded companies. Nonetheless, financial analysts have  
18 concluded that publicly traded agencies have adequate access  
19 to capital, though because of the payment reductions in the  
20 PPACA, the terms are not as favorable as prior years. For  
21 agencies not part of publicly traded companies, the  
22 continuing entry of new providers indicates that smaller

1 entities are capable of getting the capital they need to  
2 expand. As I mentioned earlier, the number of home health  
3 agencies increased by over 250 in 2012.

4 Here, we look at margins, and you can see that the  
5 overall margin for freestanding providers is 14.4 percent.  
6 We show the margins here for different categories of  
7 providers, and the trends you see here are similar to prior  
8 years in terms of the spread.

9 I would also note that these data rely upon the  
10 Home Health Cost Report. CMS audited a sample of 2011 cost  
11 reports and found that costs for Medicare services were  
12 overstated by eight percent in 2011. If reported margins  
13 were adjusted for this error, our home health Medicare  
14 margins reported for 2011 would have exceeded 20 percent  
15 last year. While it is speculative to apply the eight  
16 percent to other years, the results suggest the very high  
17 margins we report for home health could be higher.

18 This year, we also examined the performance of  
19 relatively efficient home health agencies compared to  
20 others. Relatively efficient providers had a cost per visit  
21 that was 15 percent lower than the other agencies and  
22 Medicare margins that were 23 percent higher. Relatively

1 efficient providers were typically larger in size, providing  
2 about 25 percent more episodes in a year. They had lower  
3 hospitalization rates, but they provided about the same mix  
4 of nursing therapy and aide services to their patients and  
5 they served a similar number of dual eligible patients.

6 We estimate margins of 12.6 percent in 2014. This  
7 is a result of several payment and cost changes. There is a  
8 three percent add-on in effect for rural areas in 2013 and  
9 2014. The payments in 2013 were adjusted downward by a  
10 reduction to the market basket and a coding adjustment.  
11 Payments in 2014 were also adjusted to reflect several  
12 payment policies, including a payment update, grouper  
13 changes, and payment rebasing, the last of which I will  
14 discuss on the next slide.

15 We assumed cost growth of half-a-percent a year in  
16 2013 and 2014, a conservative rate that is a little higher  
17 than recent average rates of growth. Our estimates here  
18 don't include the sequester. With it, the margins would be  
19 about two percent lower.

20 The PPACA includes a rebasing provision intended  
21 to lower Medicare payments. Under this provision, payments  
22 will be adjusted downward by \$81 per episode for each year

1 in 2014 through 2017. However, this reduction is offset by  
2 the annual payment update, which adds back much of what the  
3 rebasing adjustment removes.

4 MedPAC's recommendation to rebase did not include  
5 the payment update, and this chart shows why. The net  
6 effect is that the base rate will fall by 0.2 percent to  
7 half-a-percent a year as a result of rebasing.  
8 Cumulatively, the base rate in 2017 will be 1.6 percent less  
9 than the base rate in 2013. These small reductions are  
10 unlikely to change margins significantly.

11 I would also note that these cuts may be further  
12 offset if providers are successful in lowering their costs  
13 or increasing their payments, as they have done in the past  
14 when faced with these types of reductions. And it is  
15 important to remember that the rebasing adjustments do not  
16 take into account the eight percent overstatement of costs  
17 found in home health cost reports.

18 Here is a summary of our indicators.  
19 Beneficiaries have good access to care. The number of  
20 agencies continues to increase, reaching over 12,300. The  
21 number of episodes and rates of use declined slightly after  
22 several years of rapid increases. And quality shows

1 improvement on most measures. Access to capital is  
2 adequate. Margins for 2014 are estimated to equal 12.6  
3 percent, again, without the effect of the sequester. And I  
4 would note that these are average margins. And our review  
5 of quality and financial performance for relatively  
6 efficient providers suggests that better performing agencies  
7 can achieve better outcomes with higher profits.

8           Since our indicators for 2014 are mostly  
9 unchanged, the Chairman has proposed that we rerun our  
10 payment recommendations from earlier years. We recommended  
11 a more robust form of rebasing that would address the  
12 historically high margins of home health agencies. Our  
13 recommendations also address a payment vulnerability in the  
14 PPS. We recommended that CMS eliminate the use of the  
15 number of therapy visits provided in an episode as a payment  
16 factor in the PPS. This change is budget neutral, but it  
17 would increase payments for agencies that do less therapy,  
18 which have typically had lower than average Medicare  
19 margins.

20           We have also advocated that CMS fully use its  
21 authority to address fraud and abuse in the home health  
22 benefit. There are many areas of aberrant utilization that

1 suggest enforcement efforts are still needed.

2           Finally, we have also recommended that Medicare  
3 establish a copay for episodes not preceded by a  
4 hospitalization or PAC stay.

5           Next, we'll pivot away from payment adequacy to  
6 discuss establishing a readmissions reduction policy for  
7 home health. Reducing readmissions is a major goal of many  
8 of the new models of payment in Medicare, such as the  
9 Hospital Readmission Reduction Program and others, such as  
10 ACOs and medical homes. Extending an incentive for home  
11 health agencies to lower readmissions might be appropriate  
12 because home health is the most common site of post-acute  
13 care and many of the beneficiaries in these new models will  
14 be served by home health. Adding an incentive for home  
15 health would align their incentive with those of other  
16 providers seeking to reduce readmissions. Adding an  
17 incentive is also important because readmission is a  
18 relatively common occurrence in home health. About 29  
19 percent of post-hospital home health stays ended in  
20 readmission in 2010.

21           The broad regional and provider-level variation  
22 and readmission rates suggest that there may be substantial

1 opportunities for improvement. For example, providers in  
2 the top quartile of readmissions, those with the highest  
3 rates, had a rate of 58 percent, while the rest of agencies  
4 averaged 26 percent. Across the States, readmissions were  
5 highest in four States that also had very high rates of home  
6 health utilization. Providers in Texas, Louisiana,  
7 Oklahoma, and Mississippi averaged a readmissions rate of 38  
8 percent. If providers in regions with higher than average  
9 rates were able to lower their readmissions closer to those  
10 achieved by better performing providers, beneficiaries would  
11 experience fewer readmissions and Medicare spending would  
12 fall.

13           A home health readmissions policy would have  
14 several parts to it, and first, I will take you through the  
15 basics of how a financial incentive could work. I would  
16 note that these elements are based on the Commission's  
17 review of the Hospital Readmission Reduction Program that  
18 was included in our 2013 June report.

19           For each year, Medicare would establish a  
20 benchmark based on the industry's past performance, say, the  
21 80th percentile. Agencies with readmission rates in excess  
22 of the benchmark would be subject to the penalty. The



1 penalty would be equal to the amount Medicare paid for home  
2 health services provided in the stays that resulted in  
3 excess readmissions.

4           The key part of this incentive is that the  
5 benchmark readmission rate an agency has to be below is set  
6 in advance and does not change. Agencies would assumedly  
7 know how their performance in prior years compared to the  
8 benchmark and those with high rates could avoid the penalty  
9 by working to lower their readmissions rate.

10           The policy should also include some other features  
11 to ensure appropriate incentives. Agencies that serve more  
12 dual eligibles generally had higher readmissions rates, so  
13 it would be appropriate to compare a home health agency to a  
14 peer group of providers who served a similar share of low-  
15 income beneficiaries. This would lessen an incentive to  
16 avoid these patients to improve care.

17           The time period of the measure should include the  
18 entire home health stay plus 30 days after discharge.  
19 Including a post-discharge period would be appropriate given  
20 that a successful return to the community is a typical goal  
21 in home health.

22           Finally, the measure should focus on potentially

1 preventable readmissions and exclude those readmissions that  
2 are not necessarily attributable to home health.

3           Again, many of these policies are applying the  
4 principles the Commission has laid out for future changes to  
5 the HRRP.

6           To get a better sense of this policy, we modeled  
7 its impact using 2010 data. For this exercise, we  
8 identified agencies that were above the 80th percentile on  
9 readmissions rate compared to other agencies that serve  
10 similar shares of low-income beneficiaries. We only had one  
11 year's worth of readmission rates to work with, so what we  
12 will show is how many agencies crossed the 80th percentile  
13 benchmark based on 2010 data. Keep in mind that if the  
14 policy were in effect, those above the benchmark would  
15 likely work to lower readmissions, so fewer would be subject  
16 to the penalty.

17           Overall, 20 percent of agencies would be at risk,  
18 a result of setting the benchmark at the 80th percentile.  
19 The shares would vary by group, but they broadly track the  
20 trends and readmissions rates by various agency  
21 characteristics. For example, for profit agencies would  
22 have a little bit more than 20 percent of agencies above the

1 benchmark. Government and nonprofit would have a lower  
 2 share above the benchmark. Freestanding would have  
 3 relatively more above the benchmark. The rate for urban and  
 4 rural was about equal. But perhaps most strikingly, 36  
 5 percent of agencies in the States with the four -- excuse  
 6 me. Thirty-six percent of agencies in the four States with  
 7 the highest rates would be above the benchmark.

8           In sum, adding a Home Health Readmissions  
 9 Reduction Program would align home health agency incentives  
 10 with those of other providers seeking to reduce  
 11 readmissions. It would encourage providers with the highest  
 12 rates to improve, and it would recognize that avoiding  
 13 readmissions is a primary goal for post-hospital users of  
 14 home health.

15           With these considerations in mind, the Chairman  
 16 has offered a draft recommendation for your consideration.  
 17 The recommendation reads, the Congress should direct the  
 18 Secretary to reduce payments to home health agencies with  
 19 relatively high risk adjusted rates of readmission.

20           For spending implications, this policy would lower  
 21 Medicare spending, either through lower payments to home  
 22 health providers that incurred the penalty or lower spending

1 for inpatient care when agencies are successful in lowering  
2 their readmissions rates.

3 In terms of beneficiary and provider implications,  
4 beneficiaries may experience fewer readmissions and the  
5 recommendation should not adversely affect beneficiary  
6 access to care or affect providers' willingness or ability  
7 to care for Medicare beneficiaries.

8 This completes my presentation. Please let me  
9 know if you have any questions.

10 MR. HACKBARTH: Okay. Thank you, Evan.

11 Let me just say a little bit more about the  
12 context for the draft recommendation on readmissions  
13 penalty. I think it was 2008 when we first recommended the  
14 hospital readmission penalty, penalty on excess  
15 readmissions. When we did that work, we said -- we  
16 identified readmissions as a potential problem, not just on  
17 cost but quality grounds, as well, and said, broadly  
18 speaking, there were two paths available to us to address  
19 that issue.

20 One would be to move towards bundled payment,  
21 whereby you would bundle in the hospital payment with post-  
22 acute care payments and establish one party as having both

1 the clinical and financial responsibility for managing the  
2 care transition and making sure it goes well for patients.  
3 And, at that time, we recommended the creation of a Hospital  
4 Admission Bundling Project, which is only now, in fact,  
5 getting up and running, as I understand it, and somebody  
6 correct me if I'm wrong, but it's really just beginning now.  
7 Who's the right person to answer that for me, confirm that  
8 for me? Is that true?

9 MR. GLASS: [Off microphone.] Second year.

10 MR. HACKBARTH: Second year? So it's beginning  
11 the second year of three, is that right, David?

12 MR. GLASS: [Off microphone.]

13 MR. HACKBARTH: Okay. So it's 2013 now and we're  
14 up and running and then there will be the phase where we  
15 wait for the data to be analyzed and reports to be written  
16 and all that. So, hopefully, at some point in the not-too-  
17 distant future, that will prove to be a productive path.

18 Realizing in 2008 that that journey may be a long  
19 and complicated one, we said the other path that we can  
20 pursue perhaps more quickly is to institute a penalty for  
21 excess readmissions, and we made such a recommendation for  
22 hospitals, and subsequently we've talked about how to refine

1 that to make it more effective and fairer, for example, to  
2 institutions that have a lot of lower-income patients.

3           Now, a common critique of the hospital penalty is  
4 that, wait a second, you're holding us responsible for  
5 things that happen outside our institution and that's not  
6 really fair. And our retort to that has always been, well,  
7 that's one of the problems with payment silos. Not only do  
8 they silo payment, they also silo responsibility, and people  
9 don't want to look beyond their silo, be held accountable,  
10 and we need to start breaking down silos, so this is one  
11 step in that direction.

12           But we also concluded that it would be both fairer  
13 and potentially more effective if hospitals had some willing  
14 partners in this effort to reduce avoidable readmissions,  
15 and so we recommended that there be a sort of analogous  
16 incentive created, first for skilled nursing facilities, and  
17 now with this draft recommendation we would be doing the  
18 same for home health. And my thinking here is very simple,  
19 some would say simplistic. I want to be sure that when a  
20 hospital says, this is a problem that I'm eager to try to  
21 solve, that it has willing partners coming to the table,  
22 namely skilled nursing facilities and home health agencies,

1 and that's why I'm bringing forth this draft recommendation.

2 I should also note, incidentally, that CMS has in  
3 the Physician Fee Schedule included a new code for  
4 coordination of care post-discharge, and so that's sort of  
5 another payment piece of this picture.

6 So that's the history that's behind this draft  
7 recommendation.

8 So, let me see hands for round one clarifying  
9 questions for Evan. Mary, then Cori.

10 DR. NAYLOR: Thanks, Evan. Can you clarify the  
11 definition of efficient home health, because here it says,  
12 page 23, either low cost or low rehospitalization rate, and  
13 I was trying to figure out -- in other definitions of  
14 efficient, there seemed to be some combination. I know  
15 you're looking for the --

16 MR. CHRISTMAN: Well, it may be a choice of -- I'm  
17 sorry. I didn't mean to cut you off. It may be a choice of  
18 words, and I may have -- we should be -- we've gone to  
19 lengths to make sure we're using the same definition of  
20 efficient provider, where we look at three years of data for  
21 a set of providers and, you know, you have to be in the top  
22 third on quality or cost and not in the bottom third of

1 either. I can look at the language in the chapter, but  
2 we're using the --

3 DR. NAYLOR: The same exact --

4 MR. CHRISTMAN: The same definition, yes.

5 DR. NAYLOR: Thanks. And the second question, and  
6 thank you for looking at distinguishing the distinct  
7 populations post-acute care, those getting skilled after  
8 hospitalization versus those who start in the community.  
9 Have you looked at the differences in margins for those two  
10 groups, one having 1.4 episodes per beneficiary per year,  
11 the other 2.6. So I'm wondering if there are differences in  
12 agencies that serve primarily one versus the other.

13 MR. CHRISTMAN: We looked at -- I don't know that  
14 we were looking at it specifically that way, but we did look  
15 at -- we did split agencies into, you know, quintile groups  
16 based on profitability in one analysis we did, and sort of  
17 the share of community-admitted patients was not that  
18 different among the low margin and the high margin  
19 providers.

20 There's sort of -- the community admits could cut  
21 two ways in terms of an agency's profitability. One way is  
22 they -- those episodes typically use more visits in an



1 episode, but often a slightly cheaper mix of services, and  
2 that might push their costs up a little bit. But on the  
3 other hand, what we've observed for a variety of reasons is  
4 that the community admits can be a big source of volume and  
5 larger agencies that provide more episodes generally seem to  
6 find economies of scale that smaller agencies can't. So, if  
7 you specialize in community admits and are very good about,  
8 you know, and it helps push up your agency size, it may  
9 ultimately get you some efficiencies there.

10 We can go back and look at this a little bit more,  
11 but nothing so far leads me to believe that there's  
12 something gross that -- a difference in profitability among  
13 the sort of community admits and the people who do primarily  
14 post-acute care.

15 MR. KUHN: Evan, a quick question on 11, Slide 11.  
16 So, I see the run rate that you have here in terms of the  
17 CMS rebasing plus the market basket updates and other  
18 interactions here, so it almost kind of washes out here. At  
19 the same time during that four-year period, we have cost  
20 growth for the industry. So, that cost growth, when we did  
21 our margin calculations, all this stuff was kind of rolled  
22 up and captured. Did I understand it right?

1           MR. CHRISTMAN: Right, and to be straight, we've  
2 only presented margins here for 2014.

3           MR. KUHN: Right, for the first year.

4           MR. CHRISTMAN: Right. And so the -- you know,  
5 forgive me for saying this, but the old joke Yogi Berra made  
6 was that predictions are hard, especially about the future.  
7 And what makes this hard is that agencies have proven an  
8 ability to nimbly recalibrate what they do when what  
9 Medicare pays changes. And in the interest of time, I'll  
10 only give you a few examples, but the canonical one is the  
11 one that got us here in the first place, when CMS went from  
12 per visit payment to per episode payment. The number of  
13 visits they provide in a comparable episode dropped by,  
14 like, a third.

15           And so as you think about what's going to happen  
16 going through 2017 as they face these things, you know,  
17 they've been able to retool in the past and they may well in  
18 the future. There's a couple of things that they've done in  
19 the past to offset these types of reductions, and one is  
20 they pushed up the amount of therapy they do, which  
21 frequently can improve their payments and their  
22 profitability. The ability to do that is a little bit --

1 it's a little bit harder now because of some changes CMS has  
2 made, but it illustrates that they can be resourceful.

3 The other thing is they've been able to bring down  
4 the visits per episode they provide. That analysis, I can  
5 take you through a little bit more if you're interested in.  
6 And there's -- other examples are they've been able to  
7 substitute lower-skilled, cheaper practitioners, like,  
8 they'll use LPNs instead of full RNs when they can do that.

9 So, in the past, they've been able to maintain  
10 these high margins, even though in most years the market  
11 basket has been reduced, for example, so --

12 MR. KUHN: Yeah, so not only to be able to manage  
13 the program, but manage their costs more effectively, things  
14 like that.

15 So, the other question I had in the margin  
16 calculation, and I think I remember this from the reading,  
17 but just to be sure, we use both the data from freestanding  
18 as well as hospital-based to develop the entire margin  
19 calculation?

20 MR. CHRISTMAN: The numbers we show here are just  
21 for the freestanding agencies.

22 MR. KUHN: Okay. That's why I just want to be

1 clear. Okay. Thank you.

2 DR. MARK MILLER: Back on the calculations of  
3 costs and that part of the exchange, it's true we take our  
4 margins only through 2014. We take that into account. And  
5 you're saying it's hard to predict and all the rest of it,  
6 but the historical run-out on cost has been extremely low  
7 cost growth. And if you've been seeing some other numbers  
8 which are being circulated, the people who are doing that  
9 analysis have assumed much more aggressive cost growth than  
10 has been seen historically, as well as a couple of other  
11 assumptions.

12 So, while it is hard to predict some of the  
13 behaviors, even if you just sort of doubled the cost growth  
14 that we've seen historically there, you still would have  
15 very aggressive margins left here in 2017, all other things  
16 being equal. In other words, you shouldn't look at this and  
17 assume two-and-a-half percent cost growth for three more  
18 years eating up all the remainders of their margins. It  
19 hasn't been growing anywhere near that. It's been, like,  
20 half-a-point types of --

21 MR. HACKBARTH: [Off microphone.] And even lesser  
22 --

1 DR. MARK MILLER: -- yeah, of growth. So, a lot  
2 of people think of cost as two and two-and-a-half. Not  
3 here.

4 And then -- well, I'll stop there.

5 MR. HACKBARTH: Okay. Peter, did you have a  
6 clarifying question?

7 MR. BUTLER: Two questions. The eight percent  
8 differential on the cost report audit caught my attention,  
9 and I'm sure some others, as well. So that in 2001 is when  
10 we went to PPS and home health agencies have continued to  
11 supply cost reports and those have been the basis for our  
12 calculations. That's the way I understand it. And then you  
13 go along and audit and said, whoops, at least for one year,  
14 2011, there was an eight percent difference, right --

15 MR. CHRISTMAN: Right.

16 MR. BUTLER: -- and as you said, you could  
17 speculate it's eight percent across all the years. We don't  
18 know. Was there anything systematic, though, in the  
19 reporting in the audits to say, well, they all considered  
20 this kind of expense this way and that would explain the  
21 difference, or is there something --

22 MR. CHRISTMAN: It -- you know, the publicly

1 available information on the cost reports doesn't go into  
2 great detail on what they did. It typically was, you know,  
3 very high-level information in that what we know about is  
4 things like including non-covered services, like their  
5 private duty nursing costs, and then including extraneous  
6 things -- as CMS characterized it, including extraneous  
7 things that must have been errors, such as personal  
8 purchases and things like that.

9 MR. BUTLER: But their errors are all in one  
10 direction, it sounds like.

11 MR. CHRISTMAN: Oh, I'm sorry. I didn't see that  
12 question. No. That's right. It wasn't all in one  
13 direction. The majority of them were overstatements, and it  
14 was somewhere around 70/30, 80/20 in terms of the majority  
15 of them were overstatements, but some were understatements,  
16 and that eight percent is a net number.

17 MR. BUTLER: Okay. The second question relates to  
18 the episodes that occur prior to the hospitalization versus  
19 post, and I think they're increased, or increased at maybe  
20 double the rate or something that the post-acute episodes  
21 have occurred at.

22 MR. CHRISTMAN: Right.

1           MR. BUTLER: And so the readmission rate, if we go  
2 forward with this, really just addresses the post-acute  
3 piece, right?

4           MR. CHRISTMAN: That's exactly right.

5           MR. BUTLER: And just to clarify myself, the  
6 incentives, one could argue that there's an incentive to cut  
7 -- to actually have preventable admissions in the pre-  
8 hospital stay because of the way episode payments work. You  
9 get in trouble and say, let's ship them off to the hospital  
10 sooner rather than later. So there's really -- it doesn't  
11 really address that incentive issue, the policy that we'd be  
12 adopting, is that right?

13          MR. CHRISTMAN: That's right. It won't -- for the  
14 community-dwelling beneficiaries, the readmissions incentive  
15 obviously doesn't pick up their hospitalizations. After the  
16 patient -- assuming the patient returns to home health after  
17 their hospitalization, that would be in.

18          MR. BUTLER: [Off microphone.]

19          MR. HACKBARTH: That's what I was thinking.

20                   [Laughter.]

21          MR. HACKBARTH: Okay. Round one clarifying  
22 questions, anybody here?

1           Okay, Peter, let's begin round -- no, you've  
2 already gone first. How about Bill Gradison. You can start  
3 round two. Round two. So, I need to know what you -- so,  
4 round two, and in particular, what I need to know is --  
5 where's our draft recommendation, Evan -- is your thinking  
6 about the draft recommendation.

7           MR. GRADISON: I support the recommendations. I'm  
8 intrigued by the possibility that with this readmission  
9 policy, the hospitals themselves, when they discharge into  
10 home health care, they're going to be asking a lot --  
11 gathering data and asking a lot of questions about how good  
12 a job did this home health agency do, and I think it -- and  
13 perhaps it's already been covered adequately, I won't dwell  
14 upon it -- but it seems to me that that could be a very  
15 positive, powerful, actually, incentive in sort of sorting  
16 out these organizations in terms of quality by who gets the  
17 business from hospitals, because the hospitals have a huge  
18 stake at that point because they're going to get dinged,  
19 too, if there's excessive readmissions.

20           DR. COOMBS: So, I was thinking along the lines of  
21 our discussion last year, specifically about the patients  
22 who are admitted to home health from a physician referral or



1 provider referring them. And just to follow up with that,  
2 if you are an agency that actually receives patients who are  
3 not quite ready to be discharged from the hospital, so that  
4 puts you in a whole different conundrum in terms of your  
5 vulnerability as an agency.

6           So, how that happens and what that does, actually,  
7 to the decision making for the home health agency is that  
8 they may begin to be more selective in the process. I  
9 certainly would be if I was an agency in terms of looking at  
10 the history of a hospital when they refer or a provider  
11 that's referring patients from a hospital. So, I don't  
12 think that this gets at that. At some point, it will have  
13 to be addressed.

14           MR. HACKBARTH: So, and this is successive  
15 comments. Bill sort of focused on the hospital perspective  
16 and said, boy, I want to be selective about the home health  
17 agencies I deal with, and you sort of gave the opposite  
18 perspective. Well, as a home health agency, I may be  
19 worried about what the hospital is doing.

20           And in a siloed payment and clinical  
21 accountability system, the problem we have is that nobody is  
22 really responsible. And so my objective here is real

1 simple. Get them to go to the table and say, we've got a  
2 mutual stake in working this out.

3 Dave.

4 DR. NERENZ: Supportive of the general direction.  
5 The devil is in the details, as it is in so many things when  
6 we look at this. I'm thinking, for example, that the phrase  
7 "reduce payments" could actually be implemented in several  
8 different specific ways. It could be a one-time penalty, as  
9 it is in the hospital case. It could be that the payments  
10 for all episodes in a subsequent time period would be  
11 reduced. You could actually apply a much more stringent  
12 reduction to those episodes that resulted in a readmission,  
13 kind of like the same philosophy that applies to "never"  
14 events in hospitals.

15 So, I guess this may be a question. Are any of  
16 those three or any other part of what we're thinking about  
17 when we do this, or is it details left open in the future?

18 MR. CHRISTMAN: I think that the way we were  
19 thinking about this was largely the template from the work  
20 we did looking at the HRRP. And so there would be a -- you  
21 know, you would sort of total up the Medicare payments for  
22 episodes that resulted in what we're calling these excess

1 readmissions and then you would -- for a given year -- and  
2 you would sort of figure out how much that total amount,  
3 say, \$10,000, was equal to sort of if you spread it out over  
4 all of the episodes an agency provided in that year. So  
5 you'd get like a sort of a per episode reduction amount, and  
6 then that amount comes out of the next year's payments.  
7 That's sort of when the penalty takes place.

8           And I should note that, generally, like when this  
9 was implemented in the HRRP, there is sort of a stop loss.  
10 I believe, ultimately, when it's fully phased in, the  
11 penalty can reduce a hospital's payments by no more than  
12 three percent. And so you would have to eventually think  
13 about a similar feature for home health, sort of the size of  
14 that upper limit. You know, it would be -- I would think  
15 about it -- realistically, you would have to relate it to  
16 what agency margins were. If you're successful at rebasing,  
17 maybe it would look more like what the HRRP looks like with  
18 three percent. If margins continue where they are, three  
19 percent is not going to be a lot to motivate a lot of  
20 agencies, so you might have to think about a different  
21 benchmark.

22           DR. NERENZ: Okay. But at least in principle,

1 there could be even quite different approaches --

2 MR. CHRISTMAN: It could be a different approach.

3 I guess I'm not sure. Is there one that you're leaning

4 towards or --

5 DR. NERENZ: No, no. I'm just observing that

6 there are several somewhat distinct ones. I guess I'd have

7 to say, in terms of the clarity of the signal, a penalty

8 that applied to a specific episode resulting in a

9 readmission would be a more immediate, clearer signal than

10 something that takes two years to calculate and is -- sort

11 of goes through some arcane formula. But we'd want to see a

12 model of that applied.

13 Now, another thing I wondered about -- it was not

14 mentioned in the chapter or your briefing -- is there a bid

15 process that goes on now for home health agencies through

16 which agencies become eligible to participate in Medicare,

17 or am I misconnecting something that doesn't --

18 MR. CHRISTMAN: Well, it's sort of an any willing

19 provider for people who meet Medicare's accreditation

20 requirements and, you know, there's State licensing in there

21 and things like that. I wouldn't -- you know, the word

22 "bid" suggests there's some sort of competitive element, and

1 in terms of getting into the program, I don't think it is.  
2 I think there's been concerns that the program is too easy  
3 to get into and that has opened the door to too many  
4 agencies, areas being flooded, and made it easier for  
5 marginal providers to get in.

6 DR. NERENZ: Okay. I may be confusing DME, for  
7 example, with home health, and -- okay. I was just trying  
8 to clarify.

9 I guess just to extend the thought, though,  
10 conceivably, that would be another avenue of dealing with  
11 this, that if a barrier to entry was created, or a barrier  
12 to staying in was created for those with excess  
13 readmissions, that would just be another approach. It might  
14 be a very stringent all or none approach, but at least that  
15 would be on the table, as well, just as a means to  
16 accomplish this.

17 MR. HACKBARTH: If you really want to shake up  
18 home health, moving to a bidding type system would be one  
19 path for doing that, yes.

20 DR. MARK MILLER: A couple people in the audience  
21 just seized up.

22 [Laughter.]

1 DR. MARK MILLER: Just to respond to a couple of  
2 other things that you said, so the way it would work in the  
3 report is, and this is not atypical, and I know you have  
4 some experience but also still working your way in, this is  
5 a general statement, but the text would describe the process  
6 that Evan went through with you. And the reason that we're  
7 following that path is we took the Commission in rigorous  
8 detail through the readmissions penalty process, got to a  
9 consensus point on that, and, by the way, it adjusts for  
10 things like SES and has the limitation and would work the  
11 penalty in the same way that Evan described. And so we  
12 would say, here's a way you could do it, and write it out in  
13 the text, although we might not be dogmatically taking a  
14 position that it has to be that way.

15 The other thing I would comment on, and I think we  
16 should continue this conversation perhaps offline, but there  
17 was lots of discussion early on and out in the field about  
18 whether a penalty specific to this admission or a penalty  
19 specific to a rate that suggests you're off the charts, and  
20 lots of concern both technically and in the field over  
21 specific, because any given readmission may not be easily  
22 avoidable. But a rate that suggests you're way out of line,

1 people tended -- to the extent that they would support any  
2 of this -- thought that that was preferable. But we can  
3 talk offline.

4 DR. REDBERG: I support the recommendation. I  
5 think it's very positive. I mean, I think home health  
6 agencies do have a lot of potential to avoid -- help avoid -  
7 - improve health and avoid readmissions, and the idea of  
8 getting hospitals and home health agencies to work together  
9 with the goal of improving beneficiaries' care is great.

10 DR. HALL: I also support the recommendation. I  
11 think it's going to be hard to -- this is a hard thing to  
12 implement. Are there legal or other reasons why one  
13 couldn't consider a two-sided risk model such as we're doing  
14 with successful ACOs, Pioneer ACOs?

15 MR. HACKBARTH: Say more, Bill, of what you mean  
16 on two-sided --

17 DR. HALL: So, both the hospital and the home  
18 health care agency have something to gain as well as lose by  
19 cooperating --

20 MR. HACKBARTH: Mm-hmm.

21 DR. HALL: -- as opposed to just having them point  
22 their fingers at each other, who was responsible for the

1 readmission. I can see lots of legal reasons why this might  
2 not work with a not-for-profit entity and a profit entity.

3 MR. HACKBARTH: So, let me -- we can talk some  
4 more about this. You know, one of the reasons that just a  
5 bundled payment approach appeals to me is then you can get  
6 the parties around the table and say, here are the resources  
7 we've got. If we can improve the care within these  
8 resources, we can share in those gains, and we will agree  
9 among ourselves on how we divide those gains --

10 DR. HALL: To be sure.

11 MR. HACKBARTH: -- or, potentially, losses. And,  
12 to me, this kind of approach that we're talking about here  
13 is the second best alternative to that, albeit one that I  
14 think is necessary because it's been such a difficult, time  
15 consuming thing to try to get to a bundled approach.

16 DR. HALL: Mm-hmm.

17 MR. HACKBARTH: So, we can talk more about that.

18 DR. HALL: Yeah.

19 MR. HACKBARTH: Kate.

20 DR. BAICKER: So, I'm very supportive of this and  
21 I think it's really important to get those incentives lined  
22 up the way you describe. I think it could serve to amplify



1 the incentives that the hospitals and the home health  
2 agencies face if they're both on the hook for the same  
3 adverse event we're trying to avoid.

4 The first line of argument against such a thing  
5 which I think we want to be prepared to address is the risk  
6 adjustors aren't good enough. You're just punishing  
7 agencies that are taking care of sicker patients, more  
8 disadvantaged patients, you know, that that's not fair.

9 The material in the chapter dealing with the sort  
10 of overall SES of the group, that takes care of one bucket.  
11 I didn't see a lot of detail, and maybe it's too hard at  
12 this point, on some of the other buckets like health status.  
13 I don't think that that needs to hold this up at all, but it  
14 might be helpful to bolster the case, to be able to show  
15 that the risk adjustors -- there are risk adjustors that  
16 would do a decent job. We don't need to say exactly which  
17 risk adjustor is right, but I think you'd want to be able to  
18 dispel the argument that you're not able to capture patient  
19 underlying risk well enough to avoid creating a disincentive  
20 to care for very sick patients. But I say that only because  
21 I'm very supportive of this direction.

22 DR. CHERNEW: I'm also supportive and I echo

1 Kate's point about worrying about the potential, how you're  
2 going to deal with unintended consequences. I'm not  
3 particularly worried, but I agree with Dave that the details  
4 of how you do this matter. I actually view this as a subset  
5 of a broader notion of sort of quality measures that could  
6 apply outside of just people who came for a hospital risk of  
7 readmissions. You could think of a whole series of ways  
8 that you might want to hold the home health agencies  
9 accountable for various types of quality and better care  
10 that would extend beyond the patients who came from a  
11 hospital.

12 I think because of the coordination issues that  
13 are rife here, I think this is a fine way to begin to  
14 explore. I like the general lack of specificity, actually,  
15 in the recommendation because it gives time to sort through  
16 some of those details without us having to get hung up on  
17 exactly the details.

18 MR. HACKBARTH: Peter.

19 MR. BUTLER: So, to start with a -- I still have  
20 time in round two?

21 [Laughter.]

22 MR. BUTLER: So, I was looking at the --

1 MR. HACKBARTH: [Off microphone.] Oops, out of  
2 time.

3 [Laughter.]

4 MR. BUTLER: I'm watching the red light.

5 [Laughter.]

6 MR. BUTLER: So, I was looking at the sectors and  
7 there's \$29 billion in SNF, \$18 billion in home health,  
8 around \$6 billion or a little less in IRF and LTCH, kind of  
9 the four kind of options, just to put it in perspective.  
10 And the other three are all big costs of entry and big costs  
11 of exiting, and we've always said home health is not. It's  
12 an easy cost to enter and easy cost to leave.

13 I would add on to that, it also has an operating  
14 model that is pretty easy to change year to year compared to  
15 the institutional setting. So, you really can't -- so, it's  
16 not just the capital in. They can kind of respond pretty  
17 quickly in the way they do things. I think that's a good  
18 thing, but it also means that they're much, much more  
19 sensitive to payment changes.

20 And those of us, you know, that look at the array  
21 of post-acute providers see this is the -- we talk about  
22 tradeoffs and site neutral between IRFs and SNFs and LTCHs.

1 This is the big tradeoff, if you can make home health work,  
2 because it is so much cheaper and potentially effective.  
3 But it is all the more reason that the -- if you can use  
4 very aggressively, and you can be pretty sure they're going  
5 to respond to whatever the changes are. So that's context  
6 for my comment.

7 I strongly believe we ought to have a readmission  
8 one. I also think that the teeth in it might be stronger,  
9 in other words, if you really put more dollars into it, I  
10 bet you they would really aggressively work on this in a  
11 much different way than -- and the hospital, we put a  
12 percent or something like that, you could put probably some  
13 pretty significant dollars on this. And I would do a  
14 sliding scale, probably, not just at or above 80 percent,  
15 because I think you'd want to engage as much of the industry  
16 as possible. And if you just say, I'm going to go after the  
17 high guys and they're the only ones worried about engaging,  
18 you don't have an opportunity there to kind of get everybody  
19 thinking about it in some ways.

20 I thought, Bill, you were going on the two-sided  
21 risk, have some bonuses for ones that are on the positive  
22 end --

1 DR. HALL: Right.

2 MR. BUTLER: -- and maybe you could. Maybe you  
3 could. If they're really the low ones, maybe there's an  
4 opportunity not just to take money away but, in fact, give  
5 more money to the home agencies that are really doing a heck  
6 of a job.

7 MR. KUHN: This is a good benefit and it really  
8 does help a lot of Medicare beneficiaries. So, I think the  
9 notion that we're talking about here of the readmission  
10 policy for better alignment makes all the sense in the world  
11 and I strongly support it.

12 Evan, I did want to ask you one question, though,  
13 about the rebasing issue when it came to the Low Utilization  
14 Payment Adjustment, or the LUPA, the fact that that is an  
15 interesting part of the benefit, because it does deal with  
16 keeping, I think, five or fewer episodes, so you pay them at  
17 cost, and it keeps them from going into a 60-day episode, so  
18 it makes a lot of sense. But yet under the rebasing  
19 scenario we have now, they're paid well below costs, I think  
20 20 to 35 percent, I think, in the information that you  
21 shared. I've heard some people say it's even higher, as  
22 high as 50 percent.

1           Is there anything that can be done in this area to  
2 make sure that that part of the benefit stays firm, because,  
3 again, I want the incentive in order -- we don't want to  
4 encourage those folks into longer episodes when they don't  
5 need them. And then, per the conversation or the thing I  
6 mentioned earlier with the Jimmo decision, the fact that  
7 now, I think, maintenance therapy is going to be much  
8 easier, that does worry me that the LUPA benefit might not  
9 be totally functional here.

10           MR. CHRISTMAN: So, what happened with the LUPA  
11 was important. I guess what I would say is that when CMS  
12 did the rebasing relative to what we would have wanted them  
13 to do, they ended up taking out too little from the 60-day  
14 episode rate, and I took you through that, and they didn't -  
15 - when they rebased, they didn't bring up the LUPA payments  
16 enough. And that was, in part -- a big piece of that was  
17 the PPACA limited how much they could change rates. And so  
18 in the case of the LUPA, they found that on a -- the way the  
19 LUPA works is if that there's fewer than five visits in an  
20 episode, Medicare simply makes a per visit payment for each  
21 episode, and the analysis CMS did found that the LUPA rates  
22 were somewhere between 20 and 40 percent too low and the

1 PPACA provision only really permitted them to bring payments  
2 up by -- the math varies, but it's 12 to 14 percent. And so  
3 that leaves a significant gap.

4 Overall, LUPAs are around 12 to 14 percent of  
5 episode volume and they're one percent of dollars. They're  
6 not the biggest part of the action. But as Herb mentioned,  
7 they're a key part of -- they're sort of the short stay  
8 outliers in this system and ensuring that agencies sort of  
9 have the right incentives to do LUPAs when they're necessary  
10 is important because the average LUPA payment is, you know,  
11 it's going to be around \$400 and that's going to cover,  
12 roughly, four visits. If they do the fifth visit, they're  
13 going to get bumped into the full episode payment, which  
14 averages \$2,800. So they could do one visit and push their  
15 payments up by \$2,400.

16 So, you know, I think under our recommendation, we  
17 would want things to be rebased to cost, not have these  
18 arbitrary limits on what CMS could do, and that would help  
19 to ensure that the short stay rates are where we want them  
20 to be.

21 MR. KUHN: So our existing recommendation that we  
22 have in play now would address that as part of it. We

1 wouldn't need to rewrite anything --

2 MR. CHRISTMAN: Right.

3 MR. KUHN: Okay. Thank you.

4 MS. UCCELLO: So, I am supportive of this  
5 recommendation, and when we think about some of the details  
6 of implementation, I want to talk, or think out loud,  
7 almost, about the SES issue. If we think back to the  
8 hospital readmission recommendation where we talked about  
9 peer group comparisons, and part of the issue there --  
10 correct me if I'm wrong -- is that there was a concern that  
11 the hospitals don't necessarily have full control over what  
12 happens outside as well as you don't want hospitals to avoid  
13 certain risky people.

14 And if we think about those things in terms of  
15 home health, I think you can make the argument that the home  
16 health agency has more control over what happens outside the  
17 hospital in the community, so maybe that's less of a big  
18 deal. On the other hand, it may be easier for a home health  
19 agency to avoid certain risky people, patients. So it just  
20 might be worth kind of thinking about that a little more.

21 And I would also request that, similar to the  
22 hospital readmission recommendation, text around it when we



1 talk about the QIO targeting, to also include that within  
2 this discussion.

3 DR. NAYLOR: So, in terms of the recommendation, I  
4 support the general direction of this recommendation. I  
5 think achieving alignment is extraordinarily important.

6 I know -- I saw in the text it was -- we moved  
7 away from thinking about preventing avoidable index  
8 hospitalizations, somewhat because of our conversation. But  
9 I really think we need to revisit that in light of the data  
10 in this report about the rapid growth of community-based  
11 home care admissions, and in alignment with what Cori said,  
12 not wanting to create an environment that incents community-  
13 based admissions when people need post-acute care following  
14 hospitalizations.

15 I also want to comment a little bit in terms of  
16 the text on what the -- my question around the efficient  
17 providers. What happened, I think, is worthy of just at  
18 least thinking about. In this analysis of efficient  
19 providers, it turns out that a much higher -- well, I  
20 shouldn't say -- 41 percent versus 33 percent are coming  
21 from the community versus post-acute hospitalization. The  
22 efficient provider is offering about an average of one-and-

1 a-half fewer visits per episode.

2           So I think we really need to be -- I guess what my  
3 final plea is, that we continue our effort to think about  
4 post-acute home care following hospitalization differently  
5 than community-based care. I think the 1.4 visit per  
6 episode is right in line with what the evidence suggests  
7 people coming -- Medicare beneficiaries coming from a  
8 hospital need for good transitions versus these large  
9 numbers of visits that are coming to community-based, almost  
10 double that of post-acute care. And so as we think about  
11 payment updates, we begin to really crystalize that these  
12 are distinct populations, that we want to promote great  
13 hospital and post-acute care through home care and great  
14 hospital care, and we may not want to be creating the  
15 incentives for more community-based home-based care.

16           I think that's it. Thank you.

17           MR. ARMSTRONG: So, just a few brief points.  
18 Actually, I want to come back to what Mary just said.

19           First, in terms of the proposed draft  
20 recommendation, again, I like what we're trying to do,  
21 leaping silos, you know, trying to create connections  
22 between them, and then this idea that rather than just

1 paying for volumes, we're paying for some other kind of  
2 outcome, like reduced readmission rates is, again, extension  
3 of the policy that we're looking for or trying to advance.

4           To Mary's point, I just have to say, while I  
5 support going forward, that one issue I have is just that  
6 that's like paying more to reduce what's a very high rate of  
7 readmissions, which is not good. And so it's, like, if  
8 we're -- I mean, to me, home health is a pathway for  
9 patients to efficiently and really with great care get back  
10 home. And patients get there through the hospital, through  
11 skilled nursing facilities. Some come into home care from  
12 home. And while paying more for lower readmission rates or  
13 penalizing them for higher readmission rates deals with an  
14 issue, it doesn't exactly pay for what we're trying to  
15 achieve.

16           And so, anyway, I don't have a particularly well  
17 thought out next point there, but it just --

18           [Laughter.]

19           MR. ARMSTRONG: It seems like the readmission rate  
20 payment connection accomplishes some goals, but it's really  
21 just, I think, a compromise toward what we're really trying  
22 to get to.

1           Last point. I don't want us to go beyond --  
2    although we won't be voting on this, I do want, just for the  
3    record, to affirm that we are reprinting our recommendations  
4    from earlier based on a general conclusion that the Medicare  
5    program is overpaying, on average, home care providers, and  
6    I just think no one has said that yet, and I affirm that  
7    that is something that MedPAC, to the degree we can change  
8    that, should be trying to change that.

9           DR. HOADLEY: So, I, too, support the general  
10   notion of the recommendation. The thing that I've been  
11   trying to think about is the overlap or non-overlap between  
12   the kinds of cases that this program in the home health  
13   sector would address, or in the home health silo would  
14   address, versus the cases that would be coming out of the  
15   hospital perspective. So, to some degree, by the concepts  
16   of preventable readmissions, from the home health  
17   perspective, you're kind of excluding some -- you could be,  
18   again, it depends a lot on the details -- you could be  
19   excluding some of the ones that the hospital is sort of at  
20   fault for and vice-versa. You've got time periods that are  
21   different, so the hospital is concerned about things that  
22   happen within 30 days of the hospital discharge and here

1 you're talking about things that are going to happen much  
2 further out in time.

3           So, I don't think there's any problem with this in  
4 terms of the policy, but, I mean, to the extent that we're  
5 thinking about this as getting everybody looking at the same  
6 issues, in a broad sense, that's correct. In the sense of  
7 which exact cases and examples this applies to, it may  
8 actually be a fairly different set. And I don't know if we  
9 have anything data-wise that would help us think about how  
10 much or how little overlap there is between the sort of set  
11 of cases that this policy would address and the set of cases  
12 that the hospital readmission policy would address. So, it  
13 would be useful to sort of think about that or even just  
14 think about it more qualitatively. But that's the thing  
15 that's been kind of sticking in my head.

16           MR. HACKBARTH: Any comment on that, Evan?

17           MR. CHRISTMAN: Yeah. I think that that's an  
18 important question, and I really hope -- I'm digging a  
19 little deep into my knowledge of HRRP, and, hopefully, I  
20 don't make a mess.

21           But before I say that, Medicare has developed a  
22 measure of rehospitalization in home health that could sort

1 of serve as the engine for this. There are some tweaks we  
2 would want to make. But one thing that I don't think would  
3 have to change is sort of the definition of what is a  
4 potentially avoidable hospitalization, is tied to this AHRQ  
5 CCS system. I think they're moving in the same direction in  
6 terms of their definition -- in that definition.

7           As I recall, HRRP looks at readmissions for index  
8 admissions for six select conditions, and, you know, you  
9 could certainly start with those in home health. When we  
10 talked to home health practitioners, when they think of who  
11 should be in the denominator of this type of exercise,  
12 they've always pushed us for more. You know, they've said  
13 that this is a -- there's, of course, people you can't do it  
14 with, but, you know, I think we convened a technical panel  
15 three years ago and they pushed us heavily for more, and I  
16 think there are people who would say you could go far beyond  
17 these six for home health, but you could certainly include  
18 those six.

19           So, I think the opportunity for some alignment  
20 there is certainly clear, and in fact -- but I would hope  
21 that they would wind up with a hospitalization measure that  
22 was perhaps a little bit more expansive than the HRRP six.

1 DR. MARK MILLER: As a Commission, we talked about  
2 the next generation of the hospital readmissions penalty and  
3 came to consensus that what we were looking for was all  
4 condition potentially preventable, and I think that's what  
5 we would, at least, be our opening notion here on the home  
6 health side. If there needed to be a transition, fine, but  
7 with the notion being that you're headed to all condition  
8 potentially preventable.

9 I took your question just a little bit  
10 differently, and I want to make sure I understand it. So,  
11 let's pretend for a minute we were in an all condition  
12 world, so we have this big long list of conditions, and  
13 you're saying, well, what if home health is readmitting  
14 these cases but hospitals tend to be responsible for these  
15 cases, right? Is that kind of what you were saying?

16 DR. HOADLEY: Yeah.

17 DR. MARK MILLER: And at least one -- and do not  
18 take this the way it's going to sound, but --

19 MS. UCCELLO: Then don't say it that way.

20 [Laughter.]

21 DR. MARK MILLER: Well, then I guess I just have  
22 to stop, I mean.

1 [Laughter.]

2 DR. MARK MILLER: I mean, let's pretend they were,  
3 and only some overlap. But wouldn't you still want the  
4 signals to both sets of cases? That's why -- I was  
5 wondering where your -- what if you found if they were  
6 perfectly aligned or if you found them perfectly unaligned  
7 or very unaligned, would you be in a different place?

8 DR. HOADLEY: Yeah. No, I think --

9 DR. MARK MILLER: So I don't mean it to be  
10 argumentative --

11 DR. HOADLEY: No, the program makes sense under  
12 either way, but I think it's a matter of us sort of thinking  
13 about -- so, part of what Glenn said initially was we want  
14 everybody focusing on the same situations, and if a bunch of  
15 the reasons for hospital readmission is, you know, people  
16 that were maybe discharged a little too early or without  
17 some things happening, that's kind of not the home health  
18 agency's fault. If something's happening down the road, you  
19 know, 45 or 60 days after the hospital stay, that's still  
20 something we want to hold the home health agency responsible  
21 for, but that's no longer the hospital's issue.

22 And that's fine. If we get everybody all across



1 the spectrum dealt with, that's the best outcome, but it  
2 just sort of understanding the extent to which we're  
3 focusing on that same cluster of cases versus, you know, a  
4 bigger cluster here and a bigger cluster here with a little  
5 bit of overlap. You know, nothing wrong with that, just  
6 sort of understanding where we are.

7 DR. CHRISTIANSON: Well, I also agree with the  
8 draft recommendation, the direction it goes. I think,  
9 listening to the conversation -- I'm just about at the end  
10 of the comments here -- I think everybody is suggesting the  
11 devil really is going to be in the details here, and I  
12 actually think this is going to be fairly difficult to get  
13 right. So, maybe it was Mike that commented, having a  
14 certain amount of ambiguity in terms of the actual direction  
15 here, not being prescriptive in the direction, is probably  
16 the right place where we should be right now.

17 MR. GEORGE MILLER: Yes. I do support the  
18 direction of the draft recommendation. I just, since the  
19 devil is in the details, I'd like to ask you to consider one  
20 more detail, and that is because of -- the chapter was very  
21 well written -- still talking about the high rate of fraud  
22 and abuse, that we consider -- that the Secretary consider

1 putting a moratorium on those States with high use to try to  
2 address that issue, as well.

3 MR. HACKBARTH: So, Evan, remind me where we are  
4 on this. We made a recommendation of that sort, that the  
5 Secretary ought to have such authority. Congress did, in  
6 fact, give the Secretary the authority and she has exercised  
7 it in some instances. Take it from there.

8 MR. CHRISTMAN: Right. The PPACA included the  
9 ability for Medicare to declare a moratorium on the  
10 enrollment of new agencies, and at the end of this summer,  
11 CMS implemented that authority in two areas, and I believe  
12 it was sort of the Chicago metropolitan area and --

13 DR. NAYLOR: Miami.

14 MR. CHRISTMAN: -- Miami. Miami. And I would --  
15 you know, I think we'd certainly agree that's a good start.  
16 I think we're sort of waiting to see if other areas get  
17 pulled in. CMS has been relatively slow to roll this  
18 authority out. I wonder if they're waiting to see what  
19 happens before they use it more broadly.

20 MR. HACKBARTH: Thank you, Evan. Good job.

21 We'll now have our public comment period, and let  
22 me just see how many people want to go to the microphone.

1 [Pause.]

2 So, what do we have, five there?

3 Okay, so let me just repeat the ground rules.

4 Please begin by identifying yourself and your organization.

5 You have two minutes. When the red light comes back on,

6 that signifies the end of your two minutes.

7 Again, I want to remind people this isn't your  
8 best or your only opportunity to provide input on the work  
9 of the Commission. The best opportunity is to contact the  
10 staff. Second best is to write letters to Commissioners or  
11 to post information on our website.

12 So with that, you're up.

13 MS. UPCHURCH: Thank you. My name is Linda  
14 Upchurch and I work for NxStage Medical. We're a  
15 Massachusetts based device company and the leading innovator  
16 in the field of home hemodialysis.

17 We appreciate the opportunity to share  
18 observations, and particularly this has been a long day for  
19 you guys and I really appreciate your thoughtful  
20 consideration of everything brought before you.

21 Each of us here in line has a passion about a  
22 particular topic and you've been expected to summarize them

1 all, so thank you for that.

2           Rather than read extensive comments, I want to  
3 respond to some of the questions that you raised today. In  
4 2012 and 2013 you appropriately focused on the benefits of  
5 home hemodialysis. That work has made a difference, so  
6 thank you for that.

7           Medicare, in the final rule for ESRD, just cited  
8 the work that MedPAC did in making some of the changes that  
9 they made. There's still a ways to go but it really makes a  
10 difference. So I encourage you, that your work does make a  
11 difference there.

12           It is important to look at both the dialysis and  
13 the physician fee schedules. You've worked to look at  
14 alignment across things in different areas today. That's an  
15 area that particularly can have impact in the home dialysis  
16 world.

17           Specifically of concern today, I heard a notion  
18 raised that home dialysis is uniformly cheaper to provide.  
19 I want to correct that because that is not the case. The  
20 data has shown repeatedly that that is not consistently the  
21 case. While it can be, in some circumstances, it is not  
22 uniform.

1           There was also a question raised about mortality  
2   and I think, George, that was you. A published article from  
3   the USRDS has demonstrated through extensive propensity  
4   matching of 17 characteristics, including whether or not  
5   they were listed for the transplant list or not, that there  
6   is a distinct and significant survival advantage for  
7   patients treated with home hemodialysis, as compared with  
8   patients treated in the center. There's also a transplant  
9   advantage, even for those who were not previously listed on  
10  the transplant.

11           So home dialysis can make a difference.

12           I also heard many questions about health care  
13  disparities so I want to point you -- and I'll be submitting  
14  it online. Avalere did a study showing that nationally  
15  black dialysis patients are 20 percent less likely than  
16  average to be receiving home hemodialysis. Hispanic  
17  patients, 37 percent less likely to receive home  
18  hemodialysis.

19           So again, there is work to be done.

20           Finally, just for perspective, I want to bring  
21  back Dana Kelley's comment. She reflected on the fact that  
22  the 20 percent mortality rate in the LTCHs is a reminder of

1    how very sick these LTCH patients are. For the dialysis  
2    world, that is a pretty typical mortality rate in dialysis.  
3    So these patients are treated in the outpatient setting on  
4    an ongoing basis but a 20 percent mortality rate is not  
5    uncommon in these patients.

6                So again, we will be submitting additional  
7    comments. We appreciate the work of staff.

8                MR. ELSWORTH: Thank you. Good afternoon, my name  
9    is Brian Elsworth and I'm representing myself today.

10               Two comments. One on the readmissions program for  
11   home health. I think that's a very laudable idea. I would  
12   very much echo the comment that was made about don't just  
13   focus on the top 20 percent. There's no reason to believe,  
14   at all, that an agency at the 50th percentile, 40th  
15   percentile, couldn't make a measurable impact on  
16   readmissions.

17               I would also encourage you to adopt a bonus  
18   framework. Home health agencies have a variety of tools  
19   like home telemonitoring and care transitions that are very  
20   highly effective, but they take resources, in some cases  
21   labor, in other cases technology, to implement.

22               But the good news is that they can make a

1 measurable impact on readmissions. So I would encourage you  
2 to adopt a bonus framework and to reach across the full  
3 spectrum, not just the top 20 percent.

4           The other comment I'd like to make is about the  
5 CARE tool. It has been a long time. I was in a meeting on  
6 September 11th, 2001 on this topic at HHS. One thing I  
7 would say to you is 15 years ago it was definitely a good  
8 idea to rationalize the assessment instruments. I think now  
9 it's going to be a lot harder because these instruments are  
10 so ingrained in the various silos.

11           That said, I would encourage you to think very  
12 carefully about what you would use a common assessment  
13 instrument for and put as much time and energy into that as  
14 you are on the technical exercise of actually harmonizing  
15 the instruments.

16           I think things like rationalizing the use of  
17 therapy in SNF and home health is a very worthwhile  
18 exercise, and do the conceptual homework on that as much as  
19 the technical homework on how to make a uniform assessment  
20 instrument.

21           Thank you very much.

22           MS. CEPRIANO: I'm shorter than the other

1 speakers.

2 I'm Cherilyn Cepriano. I'm the Executive Director  
3 Kidney Care Council of the Kidney Care Council. We  
4 represent the nation's dialysis providers.

5 I want to thank you for your time today on the  
6 ESRD PPS.

7 I first want to thank you for thinking broadly  
8 about this payment system. It is, indeed, a bundled payment  
9 system. As you might imagine, we were somewhat disappointed  
10 that the actual legislation focused only on one component,  
11 this one class of drug utilization, without calling  
12 specifically for a broader look at the bundle as it is  
13 working or not working.

14 And so we strongly encourage you to continue to  
15 encourage CMS to look at the bundle in its entirety as a  
16 bundle.

17 In addition, I appreciate that you focused on  
18 access. I want to encourage you to think about access not  
19 just as whether or not there's a facility open or closed.  
20 Access is also about to what services patients have access  
21 to.

22 What we are hearing from our providers is that



1 they will need to scale back those services. Nutritional  
2 programs, something we think improves quality of care. They  
3 might not be affordable if this \$30 cut goes into effect,  
4 whether it's done over one year, two, three, or four. At  
5 the end of the day, what the Agency has proposed is that if  
6 this full \$30 is taken out, a complex health care system  
7 that is life-sustaining that involves labor, drugs, supplies  
8 across the board will be compensated by Medicare at about  
9 \$216. That is simply an unsustainable trajectory going  
10 forward.

11 Finally, I very much appreciate that as you look  
12 broadly at this system you, as our provider members do, look  
13 at things like access to capital, building, we know you're  
14 probably looking at stock markets, et cetera. But in  
15 addition to that, keep in mind that Medicare is the primary  
16 payer for dialysis patients. They represent north of 85  
17 percent of all of our patients in our clinics. And of  
18 those, 45 percent or better are also Medicaid beneficiaries.  
19 Medicaid reimbursement has come down substantially.

20 Our ability to cross-subsidize what is a barely  
21 break even and now going negative compensation from Medicare  
22 is being challenged by erosions of commercial coverage as we

1 see changes and challenges that will limit our ability to  
2 receive reimbursement on the commercial side.

3 So we are very committed to providing quality  
4 care, to doing so, but we think we have a very challenging  
5 number of years ahead of us in the ESRD PPS.

6 We look forward to working with you and your staff  
7 to make sure that we can continue to provide quality care  
8 for our Medicare beneficiaries.

9 Thank you.

10 MS. BENNER: Good afternoon. My name is Mara  
11 Benner and I'm here representing the Partnership for Quality  
12 Home Health Care. We appreciate the opportunity to comment.

13 The Partnership is usually focused on helping to  
14 evolving the Medicare program, including home health  
15 services, and really trying to offer up substantive  
16 solutions. But unfortunately, today we are faced with the  
17 CMS final rule with rebasing and our concerns at this point  
18 for its impact to access to care as we go over the next for  
19 years.

20 Prior to its release, the Small Business  
21 Administration, as well as AARP and other significant  
22 stakeholders, recognize the concerns for this upcoming 14

1 percent reduction. Amazingly, CMS did not follow through  
2 with regulatory requirements to consider the four-year  
3 impact on both patients as well as on job loss and on the  
4 small businesses providing the home health care.

5           At the same time, in their final rule that was  
6 released November 22nd, they did state that they feel that  
7 approximately 40 percent -- that, again, is 40 percent -- of  
8 all home health agencies will face negative profit margins  
9 by 2017. Because we are primarily a Medicare funded  
10 provider, that means that many are likely to go out of  
11 business. Therefore, we are very concerned about access to  
12 care.

13           So we are currently asking that MedPAC take the  
14 opportunity now to fully analyze the impact of this  
15 regulation, especially on seniors and the ability for them  
16 to access care, as well as solo county providers and also on  
17 clinician loss.

18           So we'd appreciate the opportunity to work with  
19 the staff because we believe that the impact of this  
20 regulation will significantly impact access.

21           Thank you again.

22           MS. McCANN: Thank you. I'm Barbara McCann and I

1 represent Interim HealthCare, but I've also been on the  
2 OASIS Technical Advisory Panel on and off for 25 years.

3 I would like to say to you thank you for bringing  
4 up the idea of a standardized tool, but I want to ask you to  
5 think about doing it faster, please.

6 We do 75 items on every patient that comes  
7 through. If you're not short of breath when you're  
8 admitted, you will be by the time we get through the  
9 assessment.

10 There are probably 20 to 30 items that I'd be  
11 happy to provide that are an overlap between risk adjustment  
12 measures and HHRG. The other 50 are very special, but I can  
13 tell you that I think we'd be happy to give them up.

14 Why? Because I can tell you at tables from  
15 Connecticut to California right now, we are working on  
16 bundling, we are working with ACOs on cross process and we  
17 are right now creating our own instruments.

18 What an incredible waste of time and resource to  
19 do that. And we're doing it on top of our assessments.  
20 Give us something to work with earlier.

21 A second comment, coming from the OASIS  
22 perspective. The data that you looked at today on

1 functional improvement was not solely Medicare fee-for-  
2 service data. Because we're required to submit that dataset  
3 on Medicare Advantage, Medicaid beneficiaries and Managed  
4 Medicaid, that's a mix of everything. It's not the same as  
5 the pure original Medicare data that you usually see.

6 But that also says to you, as MedPAC, you have the  
7 ability to create analysis that looks at those measures by  
8 different payer types.

9 My caution is, as we look at 17 states going into  
10 dual eligibles, what are we going to lose about the  
11 information on those individuals when they all go together  
12 under a managed care practice in those individual states  
13 just at the moment that we're the kind of progress we're  
14 also making with Medicare Advantage plans around the  
15 country.

16 Thank you.

17 MS. GAGE: Hi, I'm Barbara Gage, Fellow from  
18 Brookings Institute and PI on the development of the CARE  
19 tool and the management of the post-acute care payment  
20 reform demonstration.

21 I just wanted to underscore the great work that  
22 the staff has done on these different issues.

1           The comment that you just heard was a comment that  
2 we heard very frequently as we traveled around the country  
3 to over 200 types of -- 200 providers, including the acute  
4 hospitals, the home health agencies, the SNFs, the rehab  
5 hospitals and the long-term care hospitals.

6           What they appreciated, particularly on home health  
7 and SNF, was the level of granularity. So I would also add  
8 to those comments about that impairment analysis on the  
9 OASIS is that with the items that are on the OASIS, you  
10 can't really measure mobility or self-care to the degree  
11 that the therapists typically do. And that's kind of the  
12 approach that we took with the CARE items, was to get down  
13 to the granularity of the type of professional that  
14 typically assesses whatever the issue is.

15           I'm happy to answer any questions or come back in  
16 the future and do so.

17           MR. DOMBY: Bill Domby with National Association  
18 for Homecare and Hospice.

19           If no one else is behind me, maybe I can end it on  
20 a very high note, from our end of it at least.

21           The Chairman's recommendation, you can expect our  
22 organization to provide full support for it. We think it's

1    been an overdue change in the payment model. We would  
2    recommend the model which both rewards and penalizes. We  
3    think there is strong data available already to use that and  
4    to grow from that model going forward and getting more  
5    sophisticated.

6                    So thank you for that recommendation.

7                    MR. HACKBARTH: Okay, we are adjourned until 8  
8    a.m. tomorrow morning. See you all then.

9                    [Whereupon, at 5:04 p.m., the meeting was  
10   recessed, to reconvene at 8:00 a.m. on Friday, December 13,  
11   2013.]

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## MEDICARE PAYMENT ADVISORY COMMISSION

## PUBLIC MEETING

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

Friday, December 13, 2013  
8:00 a.m.

## COMMISSIONERS PRESENT:

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



AGENDA	PAGE
The Medicare Advantage program: status report, and employer bid and hospice policies - Scott Harrison, Carlos Zarabozo, Kim Neuman	3
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1 P R O C E E D I N G S [8:00 a.m.]

2 MR. HACKBARTH: Okay. Good morning. Our first  
3 topic this morning is Medicare Advantage. Although there is  
4 no update recommendation for Medicare Advantage, each year  
5 by statute we are required to report on the status of the  
6 Medicare Advantage program.

7 DR. HARRISON: Good morning. This is going to be  
8 a very tightly packed session. I'm going to present  
9 analysis of current plan enrollment and the plan bids for  
10 2014. Carlos will then update you on plan quality  
11 performance. Due to time constraints arising from our loss  
12 of the October meeting, this material will be compact. We  
13 will be happy to take your questions and requests and follow  
14 up in the January meeting when you will have the MA draft  
15 chapter to review.

16 Later in this session, Kim and I will present  
17 draft recommendations arising from last month's discussion  
18 on employer plan bids and payments and the inclusion of  
19 hospice in the MA benefit package.

20 In 2013, MA enrollment increased by 9 percent to  
21 14.5 million beneficiaries. Enrollment in HMO plans -- the  
22 largest plan type -- increased 10 percent to nearly 10

1 million enrollees. Local PPO enrollment grew at about the  
2 same rate to 3.3 million enrollees. Regional PPO enrollment  
3 increased about 16 percent, reversing a prior year decline.  
4 Heads up here because plans project a decrease again for  
5 2014. Regional PPOs seem subject to large swings because  
6 there are only five plan sponsors and any action by one of  
7 them can have a large effect. Finally, enrollment in  
8 private fee-for-service plans decreased sharply, continuing  
9 the expected decline resulting from legislative changes back  
10 in 2008.

11           Currently, about 28 percent of Medicare  
12 beneficiaries are enrolled in MA plans, 30 percent in urban  
13 areas and 18 percent in rural areas.

14           The MA plan bids submitted to CMS project an  
15 increase in overall enrollment for 2014 of 3 to 5 percent,  
16 exclusively in HMOs and local PPOs.

17           Medicare beneficiaries have a large number of  
18 plans from which to choose. MA plans are available to  
19 almost all beneficiaries; 0.4 percent of beneficiaries do  
20 not have a plan available, which is unchanged from last  
21 year.

22           This table shows three changes for 2014 on the

1 last three lines:

2 Private fee-for-service availability continues to  
3 decline, consistent with expectations from past legislation:  
4 53 percent of beneficiaries will have access to a private  
5 fee-for-service plan in 2014, down from 59 percent in 2013.

6 The number of average plan choices declined from  
7 12 to 10 per county, largely because of declines in private  
8 fee-for-service plans.

9 Finally, fewer beneficiaries will have a zero  
10 premium plan with drugs available in 2014, declining from 86  
11 percent to 84 percent. This is an indication that as  
12 benchmarks have tightened, plans may have less with which to  
13 provide extra benefits.

14 We estimate that 2014 MA benchmarks, bids, and  
15 payments -- including the quality bonuses -- will average  
16 112 percent, 98 percent, and 106 percent of fee-for-service  
17 spending, respectively.

18 HMOs are bidding an average of 95 percent of fee-  
19 for-service; all other plan types average over 100 percent.  
20 And payments for all types are above fee-for-service. Also  
21 note that employer group plans are bidding 107 percent, and  
22 we will come back to that shortly.

1           One finding not on this page is that if there were  
2 no quality payments for 2014, MA plans would be paid at 103  
3 percent of fee-for-service, assuming a 1.0 risk.

4           Now you may remember that last year we projected  
5 most of these numbers to be a couple of points lower.  
6 However, our estimates of 2013 fee-for-service spending were  
7 probably too high last year; and, therefore, our ratios were  
8 projected too low. Our takeaway from these new numbers is  
9 that plans in 2014 are bidding and will be paid about the  
10 same relative to fee-for-service as they were in 2013.

11           Carlos will now present the analysis of plan  
12 quality.

13           MR. ZARABOZO: Comparing last year's quality  
14 indicators to the most recent results, we see that the  
15 majority of measures remain stable, including intermediate  
16 outcome measures such as the control of blood pressure among  
17 patients with hypertension. Also remaining stable or  
18 unchanged were patient experience measures from beneficiary  
19 surveys where enrollees rate their health plans, and the  
20 plans' providers, in terms of ease of access to care,  
21 customer service, and the perceived level of care  
22 coordination.

1           There was improvement in a number of indicators,  
2 including process measures such as cancer screenings, as  
3 well as in hospital readmission rates, and Part D drug  
4 adherence measures.

5           Beginning with the year 2012, Medicare Advantage  
6 plans are eligible for the bonus payments that Scott  
7 mentioned.

8           The level of the bonus is based on a star rating  
9 on a scale of 1 to 5. The star rating is a rating of the  
10 plan's overall performance. The elements of the star rating  
11 include the kinds of quality indicators I just discussed, as  
12 well as contract performance measures, such as disenrollment  
13 rates and the number of complaints about a plan. Each  
14 measure has a weight assigned to it, with outcome measures  
15 given the greatest weight and process measures the least  
16 weight.

17           Under the statutory provisions originally  
18 authorizing bonus payments, only plans at 4 stars or higher  
19 are eligible for bonuses. Under a program-wide  
20 demonstration that continues through 2014, plans at 3 stars  
21 or higher receive bonuses. Both the Commission and the GAO  
22 have commented on the design and the cost of that

1 demonstration.

2           Plan star ratings are updated in October of each  
3 year in order to provide the most current information to  
4 beneficiaries participating in the October-to-December  
5 annual MA election period. However, the level of bonus  
6 payments for plans is based on the ratings available at the  
7 time that plans submit their bids for the coming year, which  
8 is in June.

9           In this table, we look at a fixed enrolled  
10 population -- which is MA enrollees as of September 2013,  
11 before the annual election period -- to show what proportion  
12 of enrollees are in the highest-rated plans based on the new  
13 star ratings released in October, compared to the status of  
14 those same plans and the same enrollees under the previous  
15 year's star ratings for the same plans. This table shows  
16 that a majority of MA plan enrollees are now in plans where  
17 the most current star rating is 4 stars or higher. In other  
18 words, a number of MA plans had improvements in their star  
19 measures that were sufficient to raise the plan's overall  
20 star rating and which puts plans in a position of being  
21 eligible for bonuses even under the statutory provisions  
22 regarding bonuses. So in 2015, assuming that the enrollment

1 distribution across plans is unchanged from September, 51  
2 percent of plan enrollees will be in plans getting bonuses.

3 What we also show in this table is the effect of  
4 the difference between the statutory provisions regarding  
5 bonuses and the demonstration rules that determine which  
6 plans get bonuses. In 2014, only 5 percent of enrollees are  
7 in non-bonus plans, while under the statutory provisions,  
8 almost half of all enrollees would be in plans that are not  
9 eligible for bonuses.

10 DR. HARRISON: Now we are revisiting the two  
11 topics from last meeting: employer group bidding and the  
12 inclusion of the hospice benefit in the MA package. First  
13 we will go over the employer plan bidding issue.

14 Recall that we laid out last time how the employer  
15 group plans do not compete for enrollment through the bids  
16 they submit to CMS, and we showed how much higher the bids  
17 for these plans were relative to non-employer plan bids.

18 You have seen a version of this table last month,  
19 and we have updated it for 2014. The median employer plan  
20 bid is 99 percent of its benchmark, while the median  
21 non-employer plan bids 87 percent of its benchmark.

22 As a result of the bidding behavior, for 2014, the



1 employer group plans bid an average of 107 percent of fee-  
2 for-service spending and are paid about 109 percent of fee-  
3 for-service, while non-employer plans bid an average of 97  
4 percent of fee-for-service and were paid about 106 percent.

5           So last time we discussed an option to base the  
6 payments for employer plans on the payments made to non-  
7 employer plans. The option would set each employer plan's  
8 bid at its individual benchmark times the national bid-to-  
9 benchmark ratio. The payment to the plan would then be its  
10 resulting bid plus the rebate based on its quality rating.

11           We spoke with several plans and organizations in  
12 the industry and got some feedback. Some pointed out that  
13 most of the enrollment in the employer market was in PPOs;  
14 whereas, most of the non-employer enrollment was in HMOs.  
15 You may remember a few slides ago that we showed that HMOs  
16 tend to be significantly lower than PPOs. Thus, we felt it  
17 would not be unreasonable to account for the difference and  
18 modified the option so that the policy could be implemented  
19 by plan type.

20           Under this modified option, which is presented in  
21 more detail in your meeting materials, HMOs and PPOs would  
22 use different bid-to-benchmark calculations.

1           So here is the Chairman's draft recommendation,  
2    which reads: The Congress should direct the Secretary to  
3    determine payments for employer group MA plans in a manner  
4    more consistent with the determination of payments for  
5    comparable non-employer plans.

6           One way to accomplish this is the modified option  
7    I just described. That formulation would accommodate the  
8    different benchmarks that the plans may face in local areas  
9    and acknowledge that the bids may be higher for PPOs than  
10   HMOs.

11           However, alternative options may also work, and  
12   under the wording of this draft recommendation, the  
13   Secretary could use other formulations she found preferable.

14           As for implications, we expect that the draft  
15   recommendation would reduce Medicare spending. Most  
16   employer group plans would be paid less by Medicare. Thus,  
17   plans would either charge employers more, make lower  
18   profits, or lower their costs. Some employers might choose  
19   to stop offering employer group MA plans.

20           So some beneficiaries may find that their former  
21   employers or unions would drop MA plan offerings or pass  
22   higher plan costs onto them. As a result, some employer

1 group plan enrollees might instead choose plans in the  
2 non-employer market or move to fee-for-service Medicare,  
3 sometimes with an employer-subsidized wrap-around plan.

4 Now Kim will discuss hospice in MA.

5 MS. NEUMAN: In November, we talked about the  
6 hospice carveout from Medicare Advantage and discussed the  
7 idea of including hospice within the MA benefits package.  
8 We'll continue that discussion today.

9 First, to follow up on a question from November,  
10 Alice, you asked about how diagnosis profile of the fee-for-  
11 service and Medicare Advantage hospice populations compared.  
12 We have included a chart in the mailing materials with that  
13 data, and it shows that the diagnosis profile of the two  
14 populations is generally similar.

15 As you know, hospice provides palliative and  
16 supportive services for beneficiaries with a life expectancy  
17 of six months or less who choose to enroll. When a  
18 beneficiary elects hospice, the beneficiary agrees to forgo  
19 curative care for their terminal condition.

20 Both beneficiaries in fee-for-service and Medicare  
21 Advantage can enroll in hospice. When a beneficiary in  
22 Medicare Advantage elects hospice, financial responsibility

1 for that beneficiary's care becomes split between Medicare  
2 fee-for-service and the MA plan. Fee-for-service pays the  
3 hospice provider a per diem for all care related to the  
4 terminal condition. Fee-for-service also pays other  
5 providers for any Part A or B services unrelated to the  
6 terminal condition. The MA-PD plans pays for any unrelated  
7 Part D drugs and supplemental benefits such as reduced cost  
8 sharing. With this structure, financial responsibility for  
9 care becomes fragmented for MA enrollees when they elect  
10 hospice; whereas, their care would otherwise be fully under  
11 the umbrella of the MA plan.

12           The hospice carveout also makes MA plans'  
13 responsibility for end-of-life care uneven across its  
14 enrollees. The MA plan has full financial responsibility  
15 for end-of-life care for some enrollees but not others  
16 depending on whether they elect hospice.

17           In contrast to MA, which does not have  
18 responsibility for hospice services, Medicare fee-for-  
19 service pays for hospice, and ACOs have financial  
20 accountability for hospice through their benchmarks. Also,  
21 most private insurers include hospice in their benefits  
22 package.

1           If the purpose of Medicare Advantage is to give a  
2 health plan financial responsibility and accountability for  
3 managing the care of an individual, and for that plan to do  
4 so in an integrated and coordinated fashion, it would make  
5 sense that the MA plan have responsibility for the full  
6 continuum of care, including hospice.

7           MA plans also have flexibility that the fee-for-  
8 service program does not; for example, the opportunity to  
9 offer supplemental benefits that are beyond what is covered  
10 by fee-for-service but that adds value to the beneficiary.  
11 Including hospice within Medicare Advantage would give plans  
12 the chance to offer concurrent hospice and conventional care  
13 if they wished to do so.

14           If hospice were included within Medicare, how  
15 might that work?

16           Well, first, the full hospice benefit would be  
17 included in the Medicare Advantage benefits package. That  
18 would mean the plan would be responsible for the full  
19 benefit as outlined in the Social Security Act; the plan  
20 could not pick and choose what services within the hospice  
21 benefit it would cover.

22           To reflect the MA plans' new responsibility for

1 this broader set of services, the government's capitation to  
2 the MA plan would increase for all MA enrollees. Different  
3 from the current system, the capitation would not change if  
4 the beneficiary elected hospice.

5 Now, this would be a change for MA plans and  
6 hospice providers, so there would need to be lead time to  
7 negotiate contracts and develop networks.

8 With that in mind, the Chairman has developed a  
9 draft recommendation, and it reads: The Congress should  
10 include the Medicare hospice benefit within the Medicare  
11 Advantage benefits package beginning 2017.

12 The effect of this draft recommendation on  
13 Medicare program spending is expected to be minimal. In  
14 terms of beneficiaries, we expect no adverse impact on  
15 beneficiary access to hospice care. Like other MA services,  
16 choice of providers may be more limited than fee-for-  
17 service. Some beneficiaries might obtain access to  
18 concurrent care, as plans would have the option to offer it  
19 as a supplemental benefit if they wished to do so. Plans  
20 also would have the option to charge cost sharing.

21 Jack, you asked about the financial effects on  
22 beneficiaries. It's hard to know for certain whether plans

1 would charge cost sharing; but if experience with home  
2 health is any guide, we see very few MA plans charge cost  
3 sharing for home health agencies in their network.

4           As far as the implications for plans and hospice  
5 providers, there would be administrative costs for plans and  
6 hospices related to contracting. Plans, though, would be  
7 better positioned to manage and coordinate end-of-life care  
8 for patients than they currently are. And this may give  
9 hospices opportunities to work with plans to participate in  
10 new models of care delivery.

11           In terms of quality and delivery system reform,  
12 this would promote integrated, coordinated care and would be  
13 a step toward synchronizing policy across Medicare systems.

14           So that concludes our presentation, and we look  
15 forward to your discussion and any questions.

16           MR. HACKBARTH: Okay. Thank you. Good job.

17           So Round 1 clarifying questions?

18           MR. GEORGE MILLER: Thank you. Good morning and  
19 great presentation. On Slide 6, please, I think, Carlos,  
20 you stated that there was a perception of care coordination.  
21 How do we measure or how do we determine what that care  
22 coordination was?

1 MR. ZARABOZO: That references to a particular  
2 CAHPS question that asks: Do you get information from your  
3 physician? When you go to the physician, are they aware of  
4 what your needs are? And so on. So that's the basis of  
5 that particular measure.

6 MR. GEORGE MILLER: Okay. Thank you.

7 DR. COOMBS: Did you say capitation rates would  
8 not increase?

9 MS. NEUMAN: Including hospice and MA, the  
10 capitation rates would increase across all enrollees. But  
11 the not increased part is that if somebody elects hospice,  
12 the capitation would be the same. The capitation wouldn't  
13 be affected by an individual beneficiary electing hospice.

14 MR. BUTLER: On Slide 14, at the bottom you  
15 contrast this to MA, in contrast to MA. The minimum  
16 required benefit package to be on the health exchange, does  
17 it include hospice benefit?

18 MS. NEUMAN: That's not outlined specifically in  
19 the minimum benefit structure, but if you look at the  
20 benchmarks --

21 MR. ZARABOZO: Benchmark plans.

22 MS. NEUMAN: Yeah, the benchmark plans across the



1 states, almost all of them have hospice.

2 MS. UCCELLO: So what responsibilities, if any, do  
3 hospices currently have for coordinating the care for the  
4 unrelated care?

5 MS. NEUMAN: So the hospice -- in the conditions  
6 of participation, the hospice is required to share  
7 information with the non-hospice providers, and I think the  
8 extent to which that works and sort of how you'd ideally  
9 like it to I think really varies from what I hear  
10 anecdotally.

11 MR. HACKBARTH: Any other clarifying questions?

12 DR. CHERNEW: Can I ask a question?

13 MR. HACKBARTH: Yeah.

14 DR. CHERNEW: I have a question on Slide 5. We  
15 were in this transition period. We were moving from the old  
16 system to the new system under the Affordable Care Act that  
17 was going to put the MA plans in quartiles and have them  
18 range from 115 percent to 95 percent of the fee-for-service  
19 for the benchmarks. There was a transition period for that?

20 DR. HARRISON: So counties that didn't have to  
21 move a lot have fully transitioned. That was a two-year  
22 transition. So it was '12 and '13.

1 DR. CHERNEW: Okay.

2 DR. HARRISON: Counties that had a medium amount  
3 to move had a four-year transition, so they're --

4 DR. CHERNEW: In the middle.

5 DR. HARRISON: -- 75 percent of the way there.

6 And then the counties that had a lot to move are halfway  
7 towards where they're going to be.

8 DR. CHERNEW: So my question is: We were at like  
9 -- if I remember correctly, the top-line number of  
10 benchmarks to fee-for-service was like 113 percent a few  
11 years ago. We've been through this transition for a bunch,  
12 and now we're at 112 percent of --

13 DR. HARRISON: I remember 117 and 119 from years  
14 back.

15 DR. CHERNEW: Okay. So --

16 DR. HARRISON: I haven't looked at the right year.

17 DR. CHERNEW: So the point is, going to 112  
18 actually does reflect a lot of this transition that's  
19 happened, because I think it's going to end up at like 103  
20 or something like that, is what we projected, .

21 DR. HARRISON: Well, without quality, I think  
22 we're going to end up at 101.5

1 DR. CHERNEW: So it's quality that gives you this  
2 benchmark --

3 DR. HARRISON: The 112 includes quality.

4 DR. CHERNEW: That was my -- I understand now.

5 DR. HARRISON: If you took quality out right now,  
6 they're at about 106.5.

7 DR. CHERNEW: Now I understand. Thank you.

8 MR. HACKBARTH: Any other clarifying questions?

9 [No response.]

10 MR. HACKBARTH: Let's see. Mary, do you want to  
11 lead off Round 2?

12 DR. NAYLOR: Actually, may I lead with a question?  
13 The bonus system in the Affordable Care Act, how long will  
14 that be? Are there defined limits to its implementation?

15 MR. ZARABOZO: The duration, it's statutory.

16 DR. NAYLOR: I know it's statutory.

17 MR. ZARABOZO: Yeah, it's statutory and will  
18 continue --

19 DR. NAYLOR: Will continue indefinitely.

20 MR. ZARABOZO: Four stars and above, yes.

21 MR. HACKBARTH: And just as a reminder, in Round 2  
22 I do want your reaction to the two draft recommendations.

1 DR. NAYLOR: So to the first recommendation, which  
2 I'll find pretty quickly, that the Congress should direct  
3 the Secretary -- yes, I support the direction of this  
4 recommendation. This is very consistent with all the  
5 principles, all the work that you've done beforehand, this  
6 great report and this set of principles around getting to  
7 alignment for payment that are as comparable. I was  
8 interested -- I probably should have clarified. Remind me  
9 of the estimates in terms of other than would reduce  
10 Medicare spending when we achieve this final transition, the  
11 estimates for that.

12 DR. HARRISON: Do you mean where the benchmarks  
13 end up?

14 DR. NAYLOR: Where we get to a system where the  
15 employer group plans are more consistently aligned with the  
16 non-employer.

17 DR. HARRISON: Well, they would end up as the non-  
18 employer, and the non-employer would end up with benchmarks  
19 at 101 percent plus quality in 2017.

20 DR. NAYLOR: Plus quality, okay. Thank you.

21 And then in terms of the hospice recommendation, I  
22 also support including the Medicare hospice benefit within

1 the Medicare Advantage benefits.

2 MR. ARMSTRONG: I also support both of these  
3 recommendations. Just one comment on the second. I think  
4 this is really an excellent advancement in the right  
5 direction, and predictably, I would say it seems like you're  
6 really dragging it out by targeting 2017 as an effective  
7 date. And the kind of issues around building relationships  
8 between plans and hospice providers and so forth I just  
9 don't think are as complicated as you describe them to be.  
10 And so I just -- I support this. I would pick up the pace a  
11 little bit if we could.

12 DR. HOADLEY: Yeah, I support the recommendations.

13 On Recommendation 1, I had sort of talked last  
14 month about the issue of the relatively few plans that are  
15 more locally based, where the employers are more locally  
16 based, and I like the fact that, you know, you're not trying  
17 to get so specific that it leaves some ability to look  
18 later. I know you have at least one line in the text that  
19 kind of points out that that could be an issue in some  
20 cases. I think it's probably a relatively small issue, but  
21 I think it's good to keep that flexibility for the Secretary  
22 to think through whether that's something that they need to

1 deal with.

2           On Recommendation 2, I'm struck by Scott's comment  
3 about sort of how long it takes to do this, and I guess  
4 maybe one question is: The bidding cycle and sort of even  
5 just separate from the issue of making relationships, you  
6 know, what's the timing for a bidding cycle to actually know  
7 how to formulate a bid? I can't remember how much in  
8 advance the bids go in.

9           DR. HARRISON: The bids will be in by June 1st for  
10 2015.

11           DR. HOADLEY: '15. So, I mean, that's one part of  
12 what has to be, but it still might be that we could say  
13 2016, even for --

14           MR. ZARABOZO: Also the risk adjustment system  
15 needs to be --

16           DR. HOADLEY: Adjusted?

17           MR. ZARABOZO: Changed.

18           DR. HOADLEY: And then I had one thought just on  
19 the more general questions. You may do this in the more  
20 detailed analysis that you do in the full chapter, but I  
21 don't know if you -- have you looked at, you know, with the  
22 overall growth of enrollment in MA over a period of years,

1    how much change there has been in sort of the demographic  
2    and other kinds -- geographic and mixes?  And is there any  
3    thought that that shift in the enrollment base is having any  
4    effect on the quality score?  So if you've got more people  
5    enrolled who are younger, say, is there any thought -- I  
6    mean, I know a lot of the quality scores have risk  
7    adjustments built in, but is that something that's likely to  
8    affect --

9           MR. ZARABOZO:  It would be difficult to look at in  
10   the sense that the quality scores now matter so much, so any  
11   change -- I mean, everybody, all plans, I mean, it's in  
12   their interest to improve the quality scores.

13           DR. HOADLEY:  Right.

14           MR. ZARABOZO:  We could try to look at differences  
15   across time and across populations.

16           DR. HOADLEY:  Anyway, thank you.

17           DR. CHRISTIANSON:  So a general question, I guess,  
18   first.  Is there anything in your general presentation about  
19   the trends in the MA program that would be predictive of  
20   issues that the Commission might want to or need to address  
21   in the future?

22           DR. HARRISON:  Most of what we do quantitatively

1 and with trends you will have seen. There's some longer-  
2 range trends. Is there something specific you're thinking  
3 of?

4 DR. CHRISTIANSON: No. I mean, it's a lot of  
5 data, and I was just wondering. You're very close to the  
6 data. Are there things here that might raise any flags for  
7 you?

8 DR. HARRISON: Not at this time, I think.

9 DR. CHRISTIANSON: Okay. Not yet.

10 DR. MARK MILLER: The only thing I would say here  
11 is there was a period where we were looking very intensively  
12 at the data and the trends and felt that the payment system  
13 was way off track and made a series of recommendations that,  
14 again, as usual, were highly popular. And, you know, there  
15 has been change put into the system as a result of our  
16 recommendations. And the way I see our work now, at least  
17 in a couple of areas, is we're watching this transition, you  
18 know, to the lower benchmarks and trying to be very  
19 cognizant of any negative impacts there. There's also some  
20 of the same problems for the four quartiles of the way  
21 they've organized the counties that we've raised in the  
22 past. We continue to watch the quality stuff, and we make



1 recommendations -- or comments, for example, each year as  
2 they come along on how to work that. And the employer and  
3 the hospice piece were a couple of items that we've always  
4 had around but had bigger fish and didn't have the bandwidth  
5 really to go through.

6           But I think going forward it's monitoring the  
7 impacts of the benchmarks, looking at those seam issues,  
8 staying on top of the quality issues. And I think, you  
9 know, as the transition goes, we'll probably have to come  
10 back and then start thinking about these rates relative to  
11 ACOs and fee-for-service, some of the other stuff that we've  
12 been --

13           MR. HACKBARTH: That's the piece that I was going  
14 to add. So that would be the next major look at this,  
15 trying to establish the level playing field across fee-for-  
16 service ACOs and MA as we began to discuss at the last  
17 meeting.

18           There was a period of pretty intensive focus on MA  
19 some years ago, well in advance of the Affordable Care Act,  
20 where we made these really popular recommendations that are  
21 referred to. The Affordable Care Act moved in the general  
22 direction that we had been advocating, do exactly what we

1 had been advocating. It has been my judgment that even  
2 though the Affordable Care Act isn't the way I would write  
3 the MA payment policy, it doesn't make sense for us this  
4 soon after the act to sort of pick at it and say you ought  
5 to do this differently, you ought to do that differently.  
6 Let's, you know, allow it to run for a while, monitor what  
7 happens.

8           And now we'll shift our focus down the road to  
9 this level playing field issue across the different  
10 platforms -- MA, ACO, fee-for-service. So that's been my  
11 sense, Jon, of how to proceed.

12           DR. CHRISTIANSON: Thank you.

13           On the two recommendations, the first one seems,  
14 you know, eminently sensible, but I wonder, it also seems  
15 pretty easy to understand how the incentives don't work  
16 there. And I agree with allowing quite a bit of wiggle room  
17 in terms of trying to address it and change the incentives  
18 as in the recommendation. But I wonder if given that, in my  
19 view at least, it should be a pretty easily understood  
20 problem and there are solutions, or at least potential  
21 solutions, why we don't have kind of a target date for that  
22 like we do for the second recommendation. It seems to me

1 like it's something that wouldn't take that long to do, and  
2 I would encourage us to -- I'm sort of chiming in with  
3 Scott's usual comment here, saying I think we can move this  
4 along. It's been a problem for a while. Why not do  
5 something about it?

6 And then I support the second recommendation. I  
7 think that makes all the sense in the world.

8 MR. GEORGE MILLER: Yes, thank you. I support the  
9 Chairman's Draft Recommendation 1. As others have said, it  
10 makes perfect sense. And just to lend my voice to  
11 accelerating the pace that Scott and Jon illuminated on the  
12 second recommendation, No. 2. But I would like to ask a  
13 question in more detail on Slide 7, and I think the  
14 corresponding slide would be No. 8. That is, on No. 7, have  
15 we determined or have you determined in your analysis the  
16 difference in the five-star -- once you get above four and  
17 those who move to five, is there a discernible difference?  
18 And do you drive -- the plans are driven to a five-star  
19 significant enough or is there enough quality difference and  
20 the financial incentive difference that they want to stay at  
21 five-star? Or is there some that may be a five-star that  
22 say, well, you know, four stars is good enough or four and a

1 half stars is good enough? Is there enough incentive,  
2 enough built in in the cost difference so that a plan  
3 doesn't say, well, I was at five stars, it's not worth the  
4 extra effort, I'll just slide back to four stars?

5 MR. HACKBARTH: One thing to keep in mind, George,  
6 is that in addition to the payment difference, there is an  
7 enrollment difference, and I'll ask Scott to address this.  
8 Five-star plans and only five-star plans can enroll people  
9 at any time of the year.

10 MR. GEORGE MILLER: Yeah, I remember that.

11 MR. HACKBARTH: Scott, do you want to --

12 MR. GEORGE MILLER: So is that enough of a  
13 difference to drive --

14 MR. HACKBARTH: Here's the man who would know more  
15 about it.

16 MR. ARMSTRONG: Yeah, actually I think it's a  
17 reasonable question to ask. We do ask ourselves that. We  
18 are a five-star plan. But it's a lot to maintain five  
19 versus four and a half. Year-round marketing is an  
20 advantage. Frankly the brand and the pride that comes from  
21 it is pretty powerful, too.

22 MR. GEORGE MILLER: Thank you.

1           MR. GRADISON: I support both recommendations. I  
2 continue to be interested in gaining a better understanding  
3 of why this percentage participation in MA is growing, and  
4 in particular, anything you may be able to dredge up with  
5 regard to the demography, the people that are moving in.  
6 I'm especially interested in knowing whether a significant  
7 explanation for the percentage increase are people who are  
8 new to Medicare, and the reason I'm interested is just a  
9 hypothesis that folks may be more comfortable with MA if it  
10 looks more like what they've experienced prior to their  
11 Medicare eligibility, because I think that could have long-  
12 term implications in terms of options that may be wise to  
13 offer in the future, even beyond MA, that would provide a  
14 more seamless transition from pre-retirement to pre-Medicare  
15 eligibility into Medicare eligibility in terms of plan type.

16           Thank you.

17           MR. HACKBARTH: That's an interesting point, Bill.  
18 Somebody earlier raised a question about whether changes in  
19 the composition of enrollment influences satisfaction  
20 scores. It would be interesting to look at whether people  
21 who are enrolled in a managed care plan before Medicare  
22 eligibility have different satisfaction scores than

1 beneficiaries who had never experienced managed care  
2 enrolled for the first time. I suspect the answer is yes.  
3 But I don't know if it would be feasible to look at that.

4 DR. HARRISON: We can look at people who age into  
5 a given plan, so that, for example, they were a member of  
6 Group Health the preceding month as an active worker and  
7 continue under -- an early retiree continue under Medicare.

8 MR. HACKBARTH: Just to be clear, I wouldn't  
9 invest a huge amount of resources on it, but, you know, I  
10 suspect that future cohorts of Medicare beneficiaries,  
11 having become accustomed to managed care during their  
12 working lives, will have different attitudes, different  
13 propensity to enroll, and different levels of satisfaction  
14 than beneficiaries who never experienced managed care  
15 before.

16 DR. COOMBS: First, I support both  
17 recommendations.

18 Kim, I'm very grateful for you having done this  
19 graph because it was something that was in the back of my  
20 mind based on another hospice chapter that we did unrelated  
21 to MA plans. And the thing I was specifically interested in  
22 was the non-cancer diagnosis; and if they're comparable, I

1 think that this is an easy transition. So I speak in favor  
2 of that.

3 Thank you.

4 DR. NERENZ: I'm fine with the recommendations. I  
5 have a very general background question about the extent to  
6 which MA plans have flexibility in terms of the kind of  
7 payments they make to providers, the sort of covered  
8 services. For example, are they fully free to enter into  
9 bundled payment arrangements as opposed, for example, to  
10 being quite limited by the fee-for-service regulations? I  
11 realize that's a fairly amorphous question, but I'm going to  
12 get to something from that.

13 DR. HARRISON: They are free to set up their own  
14 payment arrangements. There are certainly medical groups  
15 that work with plans that get global capitation, and there's  
16 a lot of fee-for-service payment, and I think all kinds of  
17 arrangements in between.

18 DR. NERENZ: All right. So as a new for instance,  
19 an MA plan could contract with an ACO on some sort of  
20 agreed-on financial terms.

21 DR. HARRISON: I believe they are doing that.

22 DR. NERENZ: Okay. Then if we go to Slide 5,

1 every time we have this discussion, I'm interested in the  
2 right-hand column, and I'm trying to decide whether the fact  
3 that these are over 100, does that represent good value for  
4 the Medicare program and for the taxpayers? And I  
5 understand there's a quality component to that. I  
6 understand there's an added benefit component. But I still  
7 always wonder why aren't those numbers closer to 100. And  
8 if there is this flexibility and there has been this  
9 flexibility for a long time, I'm wondering, you know, why we  
10 don't see perhaps greater evidence at the aggregate level of  
11 some creativity that would ultimately lead to lower costs.  
12 So that's where this all goes.

13 DR. HARRISON: Well, the reason why things have  
14 been above one isn't necessarily the bid. Some plans can  
15 bid below, so their costs presumably are below.

16 DR. NERENZ: Understood, yeah.

17 DR. HARRISON: But the benchmarks had been so high  
18 that you were going to get a higher payment.

19 DR. NERENZ: And that was also another question,  
20 and I think Mike kind of got into that, because it is driven  
21 by the benchmarks, not strictly by the bids. And we've  
22 talked about that in the past, and we're, you know, trying



1 to drive that down. So, again, I'm not observing any acute  
2 specific problem, but still it's sort of a bottom-line  
3 question if you look at right-hand Slide 5. Is this good  
4 value or not good value?

5 DR. HARRISON: All right. So two things. One, if  
6 you got rid of the quality payments, the 106 would be 103.  
7 So there's not a lot we're playing with there.

8 Now, the beneficiaries do get extra benefits. The  
9 rebates give them extra benefits. What we've always  
10 objected to is that it's Medicare that's paying for these  
11 extra benefits instead of the beneficiaries.

12 DR. NERENZ: Understood [off microphone].

13 MR. HACKBARTH: Dave, my view has always been that  
14 we ought to pay the same amount, let the beneficiary choose,  
15 so it ought to be a financially neutral choice.

16 Now, you know, I could live with a system that  
17 said, well, if an MA plan has higher quality than fee-for-  
18 service, there could be an added increment for quality, just  
19 as we provide added payments for quality on the fee-for-  
20 service side. And if on average all MA plans had higher-  
21 than-average quality, then you could have 100-plus percent  
22 with the quality add-on. But that's not what's happening

1 here yet. This isn't purely quality. This is a function of  
2 quality and benchmarks that are too high.

3 DR. REDBERG: I support the Chairman's  
4 recommendations and would hope we could transition to them  
5 as soon as feasible to including the hospice in the MA  
6 plans.

7 My question -- well, it's not really a question,  
8 but I'm interested in the relationship of quality measures  
9 and beneficiary health, and I'm just wondering, you know,  
10 now that we have many more people in MA plans and more time,  
11 whether we could start at some point finding information  
12 that actually looks at, you know, rates of flu or cancer or  
13 diabetes or heart disease related to the quality ratings,  
14 the star ratings, to see whether we're really measuring what  
15 we hope we're measuring with the star ratings, which is that  
16 they're getting better care and, therefore, would have  
17 better outcomes.

18 DR. HALL: I'm in favor of both of the  
19 recommendations. Apropos of the star ratings, I think we  
20 may be into an era where we're seeing a ceiling effect with  
21 star ratings. I think anything below a three doesn't really  
22 count. But so now we're really talking about a three, a

1 four, or a five. Who's to say that five is the right level  
2 for quality? So I think that's another thing as we go  
3 forward we might want to keep track of.

4 If you go on Medicare.com and try to look up --  
5 .gov, I'm sorry, and look up what are the distinctions  
6 between the various levels, it's not that easy. You really  
7 have to want to know, like you're preparing for a MedPAC  
8 meeting or something, to do this.

9 [Laughter.]

10 DR. HALL: A word about the hospice carveout and  
11 what we're trying to do about it. I think this is a  
12 momentous thing for us to be doing. I live in a community  
13 that has very, very high managed care penetrance in MA plans  
14 and also, I think, a relatively advanced sort of  
15 understanding of hospice benefits for a variety of reasons.  
16 And even where the deck is stacked in our favor, the  
17 confusion that results with families and people trying to  
18 take care of -- or take advantage of hospice benefits is  
19 really enormous. There's a lot of turnover in personnel  
20 that are taking care of them, and there is a lot of mis-  
21 billings. They just don't need this sort of thing. And so  
22 I think it would help very much if this were part of the MA

1 -- if it was more uniform in the MA plans versus fee-for-  
2 service. So I think we're making some great progress with  
3 both of these recommendations.

4 MR. HACKBARTH: Bill's initial comments about the  
5 stars raises a question for me, so, you know, we've got this  
6 star system. You know, within the levels there are measures  
7 of performance that aren't constant. They can be changed.  
8 Is there a systematic plan for how aggressive the targets  
9 should be to qualify for levels? How does CMS think about  
10 that systematically?

11 MR. ZARABOZO: There was a mention in the mailing  
12 material that the four-star threshold did not change this  
13 year, but CMS can change the four-star threshold and say,  
14 for example, plans have been performing at a very high level  
15 on this particular measure.

16 One thing that happens in that case is the measure  
17 is no longer used because all plans are performing at a high  
18 level. Or they could say we established a four-star  
19 threshold based on historical results; we now see that the  
20 results are coming in much better and, therefore, we're  
21 raising the cut point for what determines a four-star plan.  
22 So some plans might drop below the four-star level. So it

1 does vary from year to year.

2 MR. HACKBARTH: So have they articulated a  
3 standard that, you know, they're going to use a certain  
4 percentile of performance, you have got to exceed that  
5 percentile in order to qualify?

6 MR. ZARABOZO: Yeah, I think when they established  
7 the four stars, it was based on the percentile performance.  
8 But they're saying now, I think, that they're going to look  
9 at the four-star thresholds in the next round.

10 MR. HACKBARTH: Okay. Thanks.

11 DR. HALL: You know, I think it's a little bit  
12 like Lake Wobegon where all the children are above average.  
13 And I think probably there should be a star rating of seven  
14 or eight. There should be some reach goals, and at some  
15 point we might want to look about incentivizing institutions  
16 to get to a higher level than -- five is not perfection.  
17 It's just a metric.

18 DR. BAICKER: We have to fight grade inflation  
19 everywhere we see it.

20 [Laughter.]

21 DR. HALL: Harvard. Everything [off microphone].

22 DR. BAICKER: Yeah, I've heard.

1           So I support both recommendations. I think it's  
2 appropriate -- I think it's a great tactic to have the first  
3 one be broadly cast with then some examples of the  
4 specifics, because I do think there are a lot of -- the  
5 devil is always in the details, and the specifics about the  
6 way the benchmarks are set nationally versus regionally,  
7 thinking about breaking out the HMOs versus the PPOs, there  
8 are a lot of moving parts. But the examples will show that  
9 it's implementable and concrete, and the recommendation will  
10 give the flexibility to explore the details. So I think  
11 that's a great combination.

12           DR. CHERNEW: So I also support both  
13 recommendations, and let me just take a quick second to say  
14 what I think the tradeoffs are.

15           For the first one about MA, I think the basis  
16 issue, which you went over last month and again here, is  
17 that in the individual market, in order to give extra  
18 benefits, you have to bid below the benchmark and pay for  
19 those with the rebate, and the employer doesn't have to do  
20 that. And as we discussed last time, it's too hard to make  
21 the system symmetric because there's too many employer plans  
22 doing too many things. So basically, effectively, there's

1 essentially a tax if you're buying an MA plan sort of  
2 individually that the employer doesn't have to pay; the  
3 employer can get the whole benchmark.

4 And so I think in the end of the day, I find it  
5 compelling that we'd like those systems to be as comparable  
6 as we can make them, given administrative complaints. And  
7 so that's why I support the recommendation.

8 That said, you mentioned -- and you went through  
9 it relatively quickly on one of the slides -- the  
10 beneficiary perspective about employers dropping MA plans.  
11 I do think that that is a concern. So while I support the  
12 recommendation, it is a concern if we were driving too many  
13 beneficiaries away from things that we thought were  
14 particularly good or concern employers were dropping out of  
15 the MA market or things like that. I don't have any reason  
16 to believe those behavioral responses will be particularly  
17 large, and so in the end of the day, I don't think we can  
18 justify this asymmetric system between the employer and not.  
19 And so equalizing them I think is useful, which is why I  
20 support the recommendation. And I do like the generality of  
21 the way that it's set, the way that it's stated.

22 With regard to the hospice benefit, again, I'm

1 always in favor of consistency and simplicity, and it  
2 strikes me that this is moving in the right direction for  
3 that reason. And I do believe that there's some ability for  
4 MA plans to integrate this benefit and do good things.  
5 There's been some examples of some companies that I think  
6 have done good things around this benefit, and I think  
7 that's good.

8           The only pause that I have -- and, again, let me  
9 reiterate I support the recommendation -- is there is this  
10 concern about the price that MA plans have to pay. And so  
11 the tradeoff is between the efficiency that you get and the  
12 simplicity and the integration of the benefit with the  
13 potential that the MA plans are ending up having to pay more  
14 for the same benefit because they have to negotiate the  
15 rates as opposed to using what the Medicare hospice rates  
16 would be.

17           Again, in the end of the day, I come down  
18 supporting the recommendation because I think that  
19 simplicity and consistency dominates and allows the  
20 potential for efficiency. But I think we have to monitor as  
21 this works through the potential downside. So I support  
22 both the recommendations. Both of them have a little bit of



1 tradeoffs in my mind about what the risks are, but I think  
2 monitoring them going forward, the benefits of both outweigh  
3 the potential risks.

4 MR. HACKBARTH: Mike, on the second point, if I  
5 understand you correctly, you're saying MA plans may need to  
6 pay hospices more than Medicare rates. Is that --

7 DR. CHERNEW: Yes, they may have to do [off  
8 microphone].

9 MR. HACKBARTH: How is that different from any  
10 other provider?

11 DR. CHERNEW: Any other service -- no, I agree 100  
12 percent. So for any other service, the tradeoff for MA is  
13 the efficiency of MA with the fact that they may have to pay  
14 for those services more than the Medicare rates. And so the  
15 MA program is basically a tradeoff between the efficiency of  
16 the plans versus you lose the price power. And so in the  
17 end of the day, consistency wins the day, but at the margin  
18 when you make this change, you would have to think about in  
19 this particular context how that was playing out.

20 DR. MARK MILLER: And at least in our  
21 conversations with both the hospice side of this discussion  
22 and the MA side of this discussion, those concerns were

1 expressed both ways: that the hospices came in and said,  
2 "We're going to get rates less than fee-for-service," and  
3 the MA plans came in and said, "We're going to have to pay  
4 rates above fee-for-service." And I suspect -- well, I  
5 suspect it will depend market by market and, you know,  
6 whether you have a large dominant hospice in any given  
7 market or whether --

8 DR. CHERNEW: And whether the recommendations on  
9 the hospice chapter, which we'll have, get followed, right?  
10 So when we think about the way that the -- I've got to keep  
11 my hand away from the mic. For certain services, the  
12 payment rates that the Medicare program pays to the  
13 providers are more generous than for other services, and so  
14 the potential for MA to undercut varies by the rate that we  
15 pay. If we were to lower the -- if the Congress were to  
16 lower the rates that the hospices cut, it's going to be  
17 harder for MA to pay under, or over.

18 DR. MARK MILLER: Understood [off microphone].

19 MR. HACKBARTH: Remind me, Scott, what the rules  
20 are about MA plans being able to require providers to accept  
21 fee-for-service rates. It used to be that they could do  
22 that at least in some circumstances. What's the status of

1 that now?

2 MR. ZARABOZO: That's for the out-of-plan services  
3 that they assume financial responsibility for. So if  
4 somebody goes to the emergency room, the liability of the  
5 plan is the Medicare rate.

6 MR. HACKBARTH: Yeah, but wasn't there -- maybe it  
7 was just sort of a private fee-for-service plan --

8 MR. ZARABOZO: Private fee-for-service paid  
9 Medicare rates, and there's a minor provision for the  
10 regional plans for essential hospitals to --

11 MR. HACKBARTH: Okay.

12 MR. BUTLER: First is just an observation on this  
13 Slide 5. You know, we spend a lot of energy understanding  
14 why these numbers are above 100 percent, and we've said it's  
15 benchmark driven, and it's the return of benefits for the  
16 excess, so there's some value there.

17 I'm kind of curious. We never show -- this is for  
18 the future, like medical loss ratios, and show in a fee-for-  
19 service plan how much of these percentages are tied up in  
20 administering the plan in the fee-for-service model versus  
21 the MA plan. And my guess is it's, what, 4 percent versus  
22 15 percent? I'll throw out, you know, some kind of average.

1 And it will be a little -- another way to look at this.

2 Now, the difference, of course, could be both the  
3 amount of care as well as the prices that are paid by the MA  
4 plans. But it might be another lens over time that would  
5 help us better understand some of these comparisons.

6 So now back to the --

7 DR. MARK MILLER: Just to make sure I follow,  
8 you're almost saying if I had that information, but I also  
9 knew by plan type what the average MLR is, that would be  
10 helpful.

11 MR. BUTLER: It would be an interesting way to  
12 evaluate, you know, what these options are providing. I  
13 think a lot of people say, "Boy, 96 percent of the dollars  
14 are going to health care?" That's another way -- well, you  
15 understand the point.

16 MR. HACKBARTH: And we have those data from bids.

17 DR. HARRISON: Right, we have the projected  
18 values.

19 MR. BUTLER: So now back to the recommendations.  
20 I support both of them. I'm not sure why we don't do 2016  
21 versus 2017. I'm sure ultimately the Chairman will respond  
22 in one way or another to that urging. It's not the biggest

1 deal in the recommendation.

2 But I would go back -- we kind of say, well, it  
3 makes sense to coordinate care. I think it's a little bit  
4 stronger than that. We probably should have had the hospice  
5 chapter first rather than following this discussion, because  
6 it highlights the emergence of the neurological diagnoses  
7 being so predominant. It also highlights the fact that, as  
8 we've said before, oversight and recertification is kind of  
9 an issue. You're not sure when you should be in or out of  
10 the hospice program. And if you have another set of eyes  
11 that are kind of coordinating this on behalf of the patient,  
12 it makes a lot more sense than kind of having these things  
13 separate. Hopefully people will end up in the right place  
14 at the right time, and we should spend far less time on the  
15 healthy 65-year-old and more on this particularly vulnerable  
16 part of life to kind of make sure that everybody's on the  
17 same page. So I think it's more than just kind of, well,  
18 that kind of makes sense. I think it's pretty essential.

19 I am sensitive to the hospice folks that say, hey,  
20 you know, this is the time that you need choice more than  
21 ever. But I would want to see some demonstration, not just  
22 concern that that may happen but demonstration in the

1 private plans that maybe it has happened in a way that, you  
2 know, would create some concerns. And I'm not sure there is  
3 that evidence. But I would be sensitive to that if that was  
4 available.

5 DR. SAMITT: So I support both recommendations as  
6 well. I want to direct my remarks at the imperative for the  
7 level playing field discussion between fee-for-service, ACO,  
8 and MA. And at the risk of disagreeing with the Chairman, I  
9 think that from my perspective -- huh?

10 MR. HACKBARTH: I said it won't be the first time  
11 [off microphone].

12 DR. SAMITT: Okay, it won't be the first time. So  
13 I would say that the imperative for the level playing field  
14 is not at the payment level; it's at the value level. So I  
15 think, you know, one of the things that we've been  
16 struggling with that we're unable to assess is what are the  
17 differences between service, access, quality, benefits  
18 between fee-for-service and ACO and Medicare Advantage?  
19 Because certainly if the Medicare Advantage model or the ACO  
20 model is in some way offering a higher level of quality,  
21 greater efficiency, better accessibility, there may need to  
22 actually be a differential payment if we find that that is

1 of value. So I think we just have to be careful not to  
2 swing the pendulum the other way in terms of creating equal  
3 payment when the two programs, as we study it, may not be of  
4 equal value to the beneficiary.

5           The second comment that I would make is about the  
6 star program. I'm a big fan of the star program. I think  
7 it continues to move us forward to better care at a lower  
8 cost. If I were to recommend any enhancements in the star  
9 program, I would say that we should be measuring star  
10 performance not just at the plan level but at the sub-plan  
11 level. For someone like Scott, it's one and the same, but  
12 there are several large MA plans that actually have sub-  
13 performance where perhaps more coordinated or integrated  
14 care models that are in that network are outperforming less  
15 coordinated models, and right now that difference gets  
16 masked. And I recognize I am beating my usual drum, which  
17 is getting at the sub-information that distinguishes  
18 performance within MA plans. But I think there would be  
19 merit to expanding the star program to rewarding sub-  
20 performance of quality within MA networks.

21           MR. HACKBARTH: I'm not sure we're that far apart,  
22 if at all, on the first point.

1           Let me just ask a question about the second. So  
2 in various contexts, we've noted that often MA contracts  
3 include, you know, large geographic areas and, you know,  
4 even different models of care. That choice resides in the  
5 hands of the plan on how they want to deal with CMS?

6           MR. ZARABOZO: That's correct. The star rating is  
7 at the contract level, and as we pointed out in other  
8 material, you have multi-state plans that get one-star  
9 rating across many different markets. And within  
10 California, for example, Northern and Southern California  
11 are under the same star rating, and those are very different  
12 markets.

13          MR. HACKBARTH: Has CMS ever looked at saying that  
14 we need to have contracts by market level or some other  
15 smaller unit?

16          MR. ZARABOZO: Well, the ratings used to be at the  
17 market level, at a smaller unit. And as we recommended when  
18 we did --

19          MR. HACKBARTH: Right.

20          MR. ZARABOZO: -- to do plan-level comparisons,  
21 they do, of course, have -- the special needs plans are  
22 separately reporting, so there's a subset of plans that are



1 separately reporting. But that is an issue that this is too  
2 broad, the unit of observation is too broad for the stars.

3 MR. HACKBARTH: Yeah. So it was, what, three or  
4 four years ago we did a mandated report on how you would  
5 have to redesign the system to be able to compare MA plans  
6 to fee-for-service in a more reliable way, and this was one  
7 of the recommendations.

8 What did CMS say in response to that specific  
9 recommendation about --

10 MR. ZARABOZO: The most recent thing that they've  
11 said is that it would be problematic to do so.

12 [Laughter.]

13 MR. ZARABOZO: Something to that effect.

14 DR. HALL: Just in terms of Craig's comments, most  
15 large insurers who have a pretty large book of business in  
16 MA also have data showing exactly what you're talking about.  
17 So they'll say, we've made substantial improvement, because  
18 now in 40 percent of our sites, we're operating at a five  
19 level. And then you say, well, and on the other side?  
20 Well, they're coming up.

21 So, I don't think that's public knowledge, but I'm  
22 sure that every insurer has that and then looks at that as

1 their own internal benchmark. But that could be obscured at  
2 the level that you're talking about, completely.

3 DR. MARK MILLER: [Off microphone.] I almost  
4 heard you saying an additional point. So, it's reported at  
5 the organization level. We've talked about having it at the  
6 plan. But I heard you say you wanted it even below the plan  
7 level. Was that correct --

8 DR. SAMITT: Yeah.

9 DR. MARK MILLER: -- or did I misunderstand?

10 DR. SAMITT: Yes. It's very much in line with  
11 what Bill's describing --

12 DR. MARK MILLER: Yeah. That's what I'm --

13 DR. SAMITT: -- that it's even within a plan,  
14 you'll find you have five-star performers and two-star  
15 performers and you mask, really, the ability to translate  
16 incentives for quality to those organizations when they're  
17 diluted within large networks.

18 DR. CHERNEW: I think -- so, I agree with that in  
19 a variety of ways, but ignoring any methodological or sample  
20 size issues, one of the other concerns is -- and I see this  
21 in -- if you read through the chapter, there's, like,  
22 there's the HOS measures, the HEDIS measures, there's the

1 CAHPS measures, there's tables that say, these ones got  
2 better, these ones were stable, these ones got worse, and  
3 then there's a discussion of them for one way or another.

4 Kate said something yesterday which I think is  
5 important and often not captured, which is there's a lot of  
6 noise around a lot of these things and I would be really  
7 hesitant to overreact to specific things, or if you started  
8 doing sub-measures, it might be that there's a good and a  
9 bad sub-plan. It might be that if you break things up  
10 enough, some are going to be good, some are not going to be  
11 good. You go two years down the line and they'll switch.

12 So, there's always this question about how you  
13 deal with the noise when you have multiple measures and  
14 finer cuts, so for whatever it's worth, I do think it's  
15 worth exploring when the plans have very different systems.  
16 There's, like, a more integrated and less integrated system.  
17 But if you allow too much flexibility about what the  
18 subgroup is, you run into complicated multiple comparison  
19 issues.

20 MR. HACKBARTH: Yeah. It's an important but  
21 really complex sort of issue to think through. There is  
22 that noise issue. But think of a large network plan, which

1 many of them are, and they encompass, you know, the vast  
2 majority of the providers in a given market area. And we  
3 know from other data that there's likely to be variation in  
4 the performance of the providers within that network, but  
5 they have chosen for their business reasons that they want a  
6 large, inclusive network.

7           Now, we tell the Medicare beneficiary that that's  
8 a four-star plan or a five-star plan or a three-star plan,  
9 whatever it is, knowing full well that the quality of care  
10 that the beneficiary gets depends not on the plan's star  
11 rating, actually, but which of the providers they choose  
12 within that all-inclusive network. That's where the rubber  
13 hits the road.

14           And so, in some ways, we could with the star  
15 system be sending signals that include a lot of noise, not  
16 just statistical noise --

17           DR. CHERNEW: Right. Right.

18           MR. HACKBARTH: -- but averaging performance kind  
19 of noise that doesn't help beneficiaries.

20           Herb.

21           MR. KUHN: The two recommendations, I support  
22 both, the first one, in terms of determination of payments

1 for employer group MA plans, and, of course, the inclusion  
2 of hospice, the second recommendation.

3 I would like to just ask one, maybe, question of  
4 Carlos, and per the slide that's up here, we've talked a lot  
5 today about the benchmarks and the payments relative to fee-  
6 for-service above the benchmarks. In the other payments  
7 issues we looked at yesterday, one of the metrics we looked  
8 at was margins, and we had a robust conversation about  
9 margins. Do we have any information in terms of general  
10 information about margins for MA plans? Is that something  
11 we could also look at in the future?

12 MR. ZARABOZO: I'm going to punt this to Scott, as  
13 prearranged.

14 [Laughter.]

15 DR. HARRISON: What we have -- so, the bids break  
16 down into medical costs, admin, and margin, but those are  
17 projected forward. What we don't really have is anything  
18 historical, like what's used -- we don't have cost reports.  
19 Now, we could present the projections, and we'll do that in  
20 January, if you'd like, but digging backwards is a little  
21 more challenging.

22 MR. HACKBARTH: Didn't GAO at one point several

1 years ago actually do a look-back and compare what was built  
2 into the bids with what they -- an estimate of what the  
3 actual was relative to the bid?

4 DR. HARRISON: Yeah. So, when you submit a bid,  
5 you're also supposed to build it up from past performance.  
6 I don't know how well that's audited, but there should be  
7 some historical stuff. I don't know whether we get that  
8 particular subset of data, but we could look into that, and  
9 it would be a few years back.

10 MR. HACKBARTH: Am I imagining the GAO study? Do  
11 you remember the one that I'm talking about?

12 DR. HARRISON: Yeah.

13 MR. HACKBARTH: And my broad recollection --  
14 please feel free to say, no, you don't remember correctly --  
15 but my recollection was that they said that the actual  
16 estimated profits were significantly higher than the margins  
17 that were built into the bid, is that --

18 DR. HARRISON: That may very well be true. Part  
19 of the problem, well, not problem, but part of the data  
20 issues may also be what gets counted as, like, Medicare  
21 allowed, like in the margins for --

22 MR. HACKBARTH: Yeah.

1 DR. HARRISON: -- some of the providers, and I  
2 don't know -- you know, if you're providing nurse hotlines,  
3 does that count as a Medicare-covered service --

4 MR. HACKBARTH: Yeah.

5 DR. HARRISON: -- and that kind of thing. So --

6 MR. HACKBARTH: So, if you would --

7 DR. HARRISON: We would have to take a little --

8 MR. HACKBARTH: Yeah. Just so I don't leave an  
9 inaccurate impression with people, would you just look up  
10 that GAO study and report back on what it actually said at  
11 the next meeting.

12 DR. HARRISON: Sure.

13 MR. HACKBARTH: I don't want to put out  
14 misinformation.

15 DR. MARK MILLER: Yeah, and I want to nail this  
16 down. So, we will report admin and margin in the January  
17 meeting --

18 DR. HARRISON: From the bids.

19 DR. MARK MILLER: Right, from the bids. That was  
20 the plan. We're going to start working on Peter's NLR  
21 thing, which is very similar to what we're talking about  
22 here, and we'll run the GAO thing down and so come back to

1 you with a specific number.

2 Does anybody want to pop off and say what the  
3 range is?

4 DR. HARRISON: In looking at the three-pronged  
5 breakdown of med, admin, and profit, I kind of remember that  
6 --

7 DR. MARK MILLER: I'll pop off. I think it ranges  
8 somewhere between, what, 12 and 15 percent for admin and  
9 profit?

10 DR. HARRISON: Admin and profit together, yeah.

11 DR. MARK MILLER: Now, you can't write that number  
12 down. We'll come back with a specific number, but I think  
13 that's the ballpark that we're talking about. Is that about  
14 right?

15 DR. HARRISON: That's about right, yeah.

16 DR. MARK MILLER: Okay.

17 MR. KUHN: [Off microphone.] Thank you.

18 MS. UCCELLO: I support both recommendations. I  
19 like the way the first one is framed more generally and I  
20 like the additional discussion about the separate ways to  
21 deal with the PPO and HMO plans.

22 I thought the quality section was well done,



1 Carlos, and I just want to confirm that I read this  
2 correctly, that it's just -- it's not clear that  
3 beneficiaries are moving from low-star plans to high-star  
4 plans.

5 MR. ZARABOZO: Right. That was the point. We're  
6 still looking at that.

7 MS. UCCELLO: Yeah. So, I think just  
8 understanding more, and I think that you guys are doing more  
9 work on this generally, about what factors play into  
10 beneficiaries' decisions on which plans to choose, I think  
11 is just important, kind of generally, to know.

12 MR. ZARABOZO: That's exactly what we're looking  
13 at, yeah.

14 MS. UCCELLO: Yeah.

15 MR. HACKBARTH: So, we're done for today. Thank  
16 you. Very good work. And we are ready to move on to  
17 hospice.

18 [Pause.]

19 MS. NEUMAN: So, now we're going to talk about  
20 hospice payment adequacy, and I'll start with some basic  
21 statistics for 2012.

22 In 2012, about 1,270,000 Medicare beneficiaries

1 used hospice, including more than 46 percent of  
2 beneficiaries who died that year. Over 3,700 hospice  
3 providers furnish care to Medicare beneficiaries, and  
4 Medicare paid those hospices about \$15 billion.

5           While it's not the focus of our hospice payment  
6 adequacy discussion today, we also note that Medicare paid  
7 about \$1 billion in 2012 to non-hospice providers for care  
8 provided to hospice enrollees unrelated to the terminal  
9 condition. More information on that topic is in the  
10 appendix of your mailing materials.

11           So, we've already talked about the hospice benefit  
12 in the prior session, so I'm just going to highlight one  
13 piece of background information on this first slide and that  
14 relates to the eligibility criteria. For a beneficiary to  
15 be eligible for hospice, they must have a life expectancy of  
16 six months or less if the disease runs its normal course.  
17 At the start of each hospice benefit period, a physician or  
18 physicians must certify that the beneficiary's life  
19 expectancy meets this criteria. There's no limit on how  
20 long a beneficiary can be in hospice as long as he or she  
21 continues to meet this eligibility criteria.

22           So, this next slide reviews the Commission's work

1 that led to recommendations in March 2009. We plan to  
2 reprint some of those recommendations in the upcoming March  
3 report, so I'll review this briefly.

4 In 2008 and 2009, the Commission looked at hospice  
5 in depth. Our analysis uncovered some trends. Since 2000,  
6 there had been substantial entry of for-profit hospices,  
7 increases in length of stay for patients with the longest  
8 stays, and higher lengths of stay among for-profit hospices  
9 than nonprofit hospices across all diagnoses. And this  
10 pattern of events suggested to us that there may be issues  
11 in the payment system that are creating opportunities for  
12 actors to pursue revenue generation strategies.

13 So, we took a look at the payment system and found  
14 that it doesn't align well with hospices' provision of care.  
15 Medicare generally makes a flat payment per day for hospice  
16 care, while hospices typically provide more services at the  
17 beginning of the episode and at the end of the episode, near  
18 the time of the patient's death. As a result, long hospice  
19 stays are generally more profitable than short stays.

20 In addition to issues with the structure of the  
21 payment system, we also uncovered issues with accountability  
22 of the benefit. We had information from a panel of hospice

1 physicians and administrators that suggested that the  
2 benefit needed stronger oversight. Panelists reported lax  
3 admission practices and recertification practices at some  
4 hospices, and some expressed concern about questionable  
5 financial arrangements between some hospices and some  
6 nursing homes.

7           So, to address these issues, in March 2009, the  
8 Commission made a series of recommendations to reform the  
9 payment system, to improve accountability, and to increase  
10 data reporting to better manage the benefit, and I'm going  
11 to highlight two of these recommendations where action has  
12 yet to be taken and where we plan to reprint the  
13 Commission's standing recommendation.

14           First is payment reform. The Commission  
15 recommended the payment system be changed to a U-shaped  
16 model, higher at the beginning and end, lower in the middle.  
17 Subsequent to this recommendation, Congress gave CMS the  
18 authority to revise the payment system as the Secretary  
19 determines appropriate in 2014 or later. CMS has been  
20 conducting research on payment reform, but to date has not  
21 made changes to the payment system, so we plan to reprint  
22 this recommendation.

1           The other recommendation I'll highlight relates to  
2 increasing accountability. The Commission recommended that  
3 the Secretary conduct focused medical review of all stays  
4 beyond 180 days for providers with unusually high shares of  
5 patients with very long stays. While PPACA included a  
6 provision for focused medical review, CMS has not  
7 implemented it, so we plan to reprint that recommendation,  
8 as well.

9           So, now we will look at our standard framework for  
10 payment adequacy. First, we have a chart showing growth in  
11 the supply of providers. Focusing on the green line, we see  
12 that the total number of hospice providers serving Medicare  
13 beneficiaries has been increasing for more than a decade.  
14 In 2012, the number of hospice providers continued to grow,  
15 up about 3.8 percent from the prior year.

16           Now, if we look at the other three lines in the  
17 chart, we see the trends in the number of providers by type  
18 of ownership. This shows that the growth in provider supply  
19 is being driven almost entirely by for-profit entry. The  
20 number of nonprofits and government providers have been  
21 stable or on a slight downward trend.

22           The next chart shows the increase in hospice use

1 among Medicare decedents. In 2012, 46.7 percent of  
2 decedents used hospice, up from 45.2 percent in 2011.  
3 Across a wide range of beneficiary characteristics -- age,  
4 race, urban/rural, gender, fee-for-service, managed care,  
5 dual and non-dual eligibles, hospice use among decedents  
6 increased between 2011 and 2012. Minorities and  
7 beneficiaries in rural areas continue to have lower hospice  
8 use than other beneficiaries, although hospice use is  
9 increasing for these groups, as well.

10 This next chart gives us a further picture of  
11 utilization growth. The number of hospice users grew to  
12 more than one-and-one-quarter million in 2012, a 4.5 percent  
13 increase from the prior year. Average length of stay among  
14 decedents also increased between 2011 and 2012, from 86 days  
15 to 88 days. Median length of stay was 18 days in 2012 and  
16 has been relatively stable at 17 or 18 days since 2000. Not  
17 shown in the chart, length of stay for the longest stays  
18 continues to increase. The 90th percentile in length of  
19 stay among decedents grew from 241 days in 2011 to 246 days  
20 in 2012.

21 As we've talked about previously, both very short  
22 stays and very long stays are a concern. With short stays,

1 there's the concern that the patient doesn't get all that  
2 hospice has to offer. And with very long stays,  
3 particularly when they make up an unusually large share of a  
4 provider's case load, there is concern that some providers  
5 may be seeking out patients likely to have long stays who  
6 may not meet the eligibility criteria.

7           As we noted earlier, inaccuracies in the current  
8 payment system make long stays more profitable than short  
9 stays, which makes the payment system vulnerable to patient  
10 selection. As shown on this slide, length of stay varies by  
11 observable patient characteristics, like diagnosis and  
12 patient location. This means that hospices that choose to  
13 do so have an opportunity to focus on more profitable  
14 patients. Consistent with that, we see for-profit providers  
15 having substantially longer lengths of stay than nonprofits,  
16 105 days versus 69 days, on average.

17           And when we look at the margin figures later,  
18 embedded in those margins will be the effects of length of  
19 stay differences on providers' financial performance.  
20 Payment reform would lessen the variation in financial  
21 performance across providers.

22           So, next, on to quality. We currently lack

1 publicly reported data on hospice quality. Per PPACA,  
2 hospices began reporting quality measures in 2013, and if  
3 they fail to do so, they face a two percentage point  
4 reduction in their update for the subsequent fiscal year.  
5 In 2013, the vast majority of hospices reported quality  
6 data.

7           Two quality measures were initially adopted. One  
8 seeks to measure the effectiveness of pain management and a  
9 second was a structural measure to help CMS identify  
10 additional measures for the future. CMS will be replacing  
11 these two measures in the near future. Beginning July 2014,  
12 hospices will be required to submit quality data for seven  
13 process measures through a standardized instrument. For  
14 example, a couple of the process measures relate to  
15 screening and assessment of pain and assessment in treatment  
16 of shortness of breath.

17           In 2015, hospices will also be required to  
18 participate in an experience of care survey. The survey  
19 will be sent to the bereaved family members or the informal  
20 caregivers of hospice decedents. Public reporting of data  
21 from these initiatives is not expected before 2017.

22           So, now, access to capital. Hospice is less



1 capital intensive than some other Medicare sectors.  
2 Overall, access to capital appears adequate. We continue to  
3 see strong growth in the number of for-profit freestanding  
4 providers, which suggests adequate access to capital for  
5 these groups. We also see for-profit chains engaged in  
6 acquisition of providers and we see interest in investment  
7 in the sector by private equity firms.

8           For nonprofit freestanding providers, less  
9 information is available on access to capital, which may be  
10 more limited. Provider-based hospices have access to  
11 capital through their parent providers, and as we've heard  
12 in other sessions, home health agencies and hospitals appear  
13 to have adequate access to capital.

14           So, this brings us to Medicare margins. We  
15 estimate in 2011 that the Medicare margin is 8.7 percent, up  
16 from 7.4 percent in 2010. A couple notes on how we  
17 calculate margins. This is the same as we do every year.  
18 We assume overpayments are fully returned to the government,  
19 and we exclude non-reimbursable costs, which means we  
20 exclude bereavement costs and the non-reimbursable portion  
21 of volunteer costs. If those costs were included in our  
22 margins, it would reduce our margin estimates by 1.4

1 percentage points and 0.3 percentage points, respectively.

2           Next, we have margins by category of hospice  
3 provider. As we have seen in prior years, freestanding  
4 hospices have strong margins, 11.8 percent. Provider-based  
5 hospices have lower margins, and this is partly a reflection  
6 of their higher indirect costs, which are likely inflated  
7 due to the allocation of overhead from the parent provider.  
8 If provider-based hospices have the same share of indirect  
9 costs as freestanding hospices, their margins would be  
10 substantially higher and the aggregate Medicare margin  
11 across all providers, which we currently estimate at 8.7  
12 percent, would be up to 1.9 percentage points higher.

13           We also see from this chart that for-profit  
14 hospices have a higher margin than nonprofits, 14.5 percent  
15 versus 2.5 percent. However, when we look at freestanding  
16 providers whose costs are not affected by the allocation of  
17 overhead, the nonprofit margin is 6.4 percent.

18           These next two charts show two phenomenon we've  
19 seen before. On the left, you see that hospice margins  
20 increase as average length of stay increases. You can see  
21 that margins increase for each quintile of length of stay  
22 until the margin dips slightly in the highest length of stay

1 quintile, and that dip occurs because some of the hospices  
2 with the longest stays who are in that quintile exceed the  
3 Medicare payment cap and we assume they return the  
4 overpayments to the government. Without that cap, the  
5 margin in that group would be much higher.

6           On the right, we see that hospices with more  
7 patients in nursing facilities have higher margins. As  
8 you'll recall, in our June 2013 report, we discussed reasons  
9 hospices with more patients in nursing facilities may have  
10 higher margins, including potentially longer stays,  
11 economies from treating patients in a centralized location,  
12 and overlapping responsibilities between nursing facilities  
13 and hospice staff. In the June report, we estimated that a  
14 three to five percent reduction in payments in the nursing  
15 facility setting might be warranted due to the overlapping  
16 responsibility between the hospice and the nursing facility.

17           So, next, we have our 2014 margin projection. To  
18 make this projection, we start with the 2011 margin and we  
19 take into account the market basket updates, including the  
20 productivity and other legislated adjustments, the phase-out  
21 of the wage index budget neutrality adjustment and other  
22 wage index changes. We also assume cost growth higher than

1 the historical rate for 2013 and 2014 due to some new  
2 administrative requirements. Putting that all together, we  
3 project a margin of 7.8 percent for 2014. If the sequester  
4 was in effect in 2014, the margin would be about two  
5 percentage points lower.

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

10 To summarize, indicators of access to care are  
11 favorable. The supply of providers continues to grow. The  
12 number of hospice users has increased, and average length of  
13 stay has increased. Quality data are unavailable. Access  
14 to capital appears adequate. The 2011 margin is 8.7 percent  
15 and the 2014 projected margin is 7.8 percent.

16 So, that brings us to the Chairman's draft  
17 recommendation, which reads, the Congress should eliminate  
18 the update to the hospice payment rates for fiscal year  
19 2015.

20 The implications of this recommendation are a  
21 decrease in spending relative to the statutory update.

22 In terms of beneficiaries and providers, no

1 adverse impact on beneficiaries is expected, nor do we  
2 expect any effect on providers' willingness or ability to  
3 care for Medicare beneficiaries.

4 So, that concludes our presentation.

5 MR. HACKBARTH: Thanks, Kim and Sara. Good work.

6 For the audience, let me just remind you that we  
7 consider draft recommendations in December. All the final  
8 votes will occur in January.

9 And our approach to considering update  
10 recommendations is that we assume that the existing base  
11 rates ought to continue to the year in question, in this  
12 case, fiscal year 2015, unless there is evidence --  
13 convincing evidence -- that they should either go up or down  
14 from the current level. So, we begin at zero update, if you  
15 will, and then look for evidence to warrant either an  
16 increase or a decrease.

17 We make our recommendations off the base rate. If  
18 the sequester means that the actual rates paid are lower  
19 than our recommendation, then that indicates that we oppose  
20 the sequester. And for this year, the sequester is set to  
21 the side. And we adopted that approach when the sequester  
22 first went into effect because the sequester was purportedly

1 temporary and there were indications that Congress was eager  
2 to replace it with other measures. As time has gone by and  
3 the sequester has stayed in place, that assumption looks  
4 ever more problematic. So, next year when we consider our  
5 process for the update recommendations, we will rethink --  
6 think again about how to incorporate the sequester into our  
7 analysis and recommendations.

8           So, round one clarifying questions. Bill  
9 Gradison, then Bill Hall, Dave, and Rita. Anybody over  
10 here? Bill.

11           MR. GRADISON: Thank you. I'd like to draw your  
12 attention to page five of the material you sent out ahead of  
13 time. Right in the middle, it has this sentence which,  
14 frankly, I just don't understand, and I wonder if you can  
15 help me understand it. It says, "An additional reduction to  
16 the market basket update of 0.3 percent was required in  
17 fiscal years 2013 and 2014 and possibly in fiscal years 2015  
18 through 2019 if certain targets for health insurance  
19 coverage among the working-age population are met."

20           I don't understand the connection between the two,  
21 which is a policy issue, I guess, but can you help me  
22 understand the best you understand it?

1 MS. NEUMAN: So, there was a provision in PPACA  
2 that said that in 2013, there is a legislated 0.3 reduction.  
3 And then in 2014 through 2019, we look at the rate of  
4 uninsurance among the working-age population compared to CBO  
5 projections, and if it's within a certain distance, there's  
6 an additional 0.3 reduction. And so in 2014, that threshold  
7 was hit and that additional, that 0.3, was taken. So, it's  
8 likely that the additional 0.3 would be taken in 2015, as  
9 well.

10 It's hard to speak to the exact rationale for that  
11 policy, so I'll --

12 MR. GRADISON: Yeah, I had a little trouble with  
13 that, too. I'm not fighting with the Congress, but I just  
14 couldn't quite understand why they took it out on hospice,  
15 or maybe they've done it on other parts of the program, too,  
16 with the same rationale, based upon actual reductions in the  
17 uninsured rate. I don't know.

18 MS. NEUMAN: Yeah. I mean, you can speculate that  
19 maybe the idea is that if there are more people covered,  
20 they can -- and not uninsured -- they could bear more of a  
21 reduction on the Medicare side. You know, that may be a  
22 rationale that was put in place.

1           MR. HACKBARTH: But was this adjustment unique to  
2 hospice?

3           MS. NEUMAN: This, as it is currently structured,  
4 is unique to hospice. I think in the hospital side, there  
5 is something --

6           MR. HACKBARTH: Yeah. Conceptually, there are  
7 some things on the hospital side that may be roughly  
8 analogous, but this is interesting.

9           MR. GRADISON: Thank you.

10          MR. HACKBARTH: Let's see. Let's just go down the  
11 row. Then I have Dave and then Rita and Bill Hall.

12          DR. NERENZ: Just a clarification on the  
13 terminology, freestanding, home health, hospital-based.  
14 This refers to the organizational structure as opposed to  
15 the physical location of services, is that correct?

16          MS. NEUMAN: It refers to the organizational  
17 structure. So, specifically, it refers to the type of cost  
18 report they submit.

19          DR. NERENZ: Okay. Just so, for instance, a  
20 hospital-based hospice may actually provide care entirely in  
21 patients' homes, not physically in a hospital --

22          MS. NEUMAN: Exactly.



1 DR. NERENZ: -- or even, theoretically, the other  
2 way around.

3 MS. NEUMAN: Exactly, and another really common  
4 one is all of these types of providers likely provide some  
5 care in nursing facilities, even though many of them are  
6 hospital-based or home health-based or freestanding. So it  
7 does not correlate with where the care is necessarily  
8 provided.

9 DR. NERENZ: All right. Thank you. Thank you.

10 DR. REDBERG: On Slide 15, when you were talking  
11 about the calculation of margins, you mentioned that the  
12 highest one dropped because of the assumption that the  
13 overpayment was returned. Does that actually occur, do you  
14 know?

15 MS. NEUMAN: So, we don't have data on the success  
16 rate in getting the overpayments back. There is -- I think  
17 a conservative statement would be there is likely some  
18 slippage, at a minimum. We have, you know, some provider  
19 closures, other issues. So, I can't quantify how much, but  
20 100 percent is probably not likely.

21 DR. HALL: In the -- on page seven of the material  
22 you sent us, you made reference to the 2013 report that

1 described a U-shaped curve for costs. So, does that factor  
2 into our recommendation at this point? How do we compensate  
3 for the fact that with payment decreasing according to  
4 length of stay, that the costs are going to go up for a  
5 number of people at the end of life, the very end of life?

6 MS. NEUMAN: So, the U-shaped recommendation would  
7 have the payments higher at the beginning, lower in the  
8 middle, and then higher at the last seven days of life.

9 DR. HALL: So, how do you predict that? That's  
10 pretty good --

11 MS. NEUMAN: How do you predict --

12 DR. HALL: Well, I mean, that's sort of  
13 soothsaying. I predict you're going to die in seven days.

14 MS. NEUMAN: Oh, it's --

15 DR. MARK MILLER: You don't. When it turns out  
16 that those were the seven days, the reimbursement goes to  
17 the hospice.

18 DR. HALL: Retrospectively?

19 DR. MARK MILLER: Yeah.

20 DR. HALL: Okay. Thank you. That helps.

21 MR. HACKBARTH: Could you just remind everybody  
22 what the status is of our recommendation on moving to a U-

1 shaped system?

2 MS. NEUMAN: So, we made the recommendation in  
3 2009 and we have been reprinting that recommendation. The  
4 Secretary does have the authority to change the payment  
5 system and CMS has been conducting research, but they have  
6 yet to make a change. So, it's unclear when or exactly what  
7 the structure of a change would be.

8 MR. HACKBARTH: Okay. Jon, did you have your hand  
9 up?

10 DR. CHRISTIANSON: [Off microphone.] Next round.

11 MR. HACKBARTH: Okay. Mary.

12 DR. NAYLOR: So, two questions, briefly. Have we  
13 ever used any kind of payment incentive to encourage  
14 enrollment into hospice? So, we're watching pretty slow  
15 growth, modest growth over the last several years. Or,  
16 alternatively, to move a medial length of stay, 17, 18 days,  
17 to higher? So, have we ever in a prior proposal made any  
18 recommendations to promote better engagement, earlier use of  
19 the service?

20 MS. NEUMAN: I don't think we've made a formal  
21 recommendation. I think a lot of the things that the  
22 Commission is interested in, like shared decision making and

1 ACOs, that those kinds of structures, which think about the  
2 patient more holistically in their overall needs, could have  
3 the potential to lengthen those shorter stays. But we  
4 haven't formally made a recommendation that goes at it  
5 directly.

6 MR. HACKBARTH: Do you have a particular idea --

7 DR. NAYLOR: I mean, in addition -- into an update  
8 -- I guess the formal recommendation would be, I would love  
9 to see us move in the direction of creating through payment  
10 incentives for organizations to actively engage, and there  
11 have been in the recent IOM reports, for example, on cancer,  
12 that very -- that was a number one investment, which is to  
13 say to really make sure that people understand their  
14 options, that they have information on costs and benefits  
15 from different services in a very timely fashion. So, in  
16 other words, and it -- because we continue to see a pattern  
17 --

18 MR. HACKBARTH: All right.

19 DR. NAYLOR: -- of just very incremental use of a  
20 very good service --

21 MR. HACKBARTH: Yeah.

22 DR. NAYLOR: -- when targeted to the right

1 populations.

2 MR. HACKBARTH: So, the key would be to reward the  
3 engagement as opposed to the outcome. You wouldn't want to  
4 say, oh, you get more money if more patients end up in  
5 hospice, because what we want to do is have the patient know  
6 they have a choice.

7 DR. NAYLOR: Exactly. Exactly. But the other  
8 part of this is, and so it's a little different, is whether  
9 or not payment could ever get us to a point where we incent  
10 organizations, once people have made those decisions and  
11 it's their choice and their preference and their value, to  
12 get earlier introduction into a service. A median length of  
13 stay of 17 to 18 days, and you're still seeing people three  
14 or four days, I mean, a high proportion, very late in the  
15 game. So, whether or not that might also be a strategy.

16 MR. HACKBARTH: Any other round one?

17 Okay. Bill, do you want to kick off round two.

18 DR. HALL: So, I support the recommendation for no  
19 update, and I guess I just have, I think, two comments.

20 One is, I think -- this is still a form of care  
21 that's an evolution, tremendous evolution. The last decade  
22 was fantastic in terms of -- if you compare our statistics

1 now with where they were in 2000, the acceptance of hospice  
2 is considerably higher. And also, there's age creep going  
3 in here, as well.

4           Since the for-profit sector is involved quite a  
5 bit, I would worry that if we didn't show that we have  
6 surveillance over margins -- I know that Mike doesn't like  
7 margins, but -- I think it could adversely affect the growth  
8 of the entire movement. That curve that you showed was very  
9 impressive. So, I think we're acting responsibly in this  
10 way and I don't think anyone could say that we are  
11 denigrating hospice by doing this. In fact, we're just  
12 keeping the market open, I think, for further evolution.

13           And I think as we follow this along, I would  
14 suggest that we need to pay close attention to the changing  
15 demography. We often think of cancer as the big killer  
16 here, and in many ways, it's much easier to define things  
17 for cancer in terms of expectation of how long people are  
18 going to live, what are the strategies for pain control.  
19 But I think what we're seeing is an evolution of neurologic  
20 disease and just sort of non-specific frailty, and this  
21 population is probably going to require a different kind of  
22 a look-see, not today, but at some point in the future. But

1 I think we're on the right track here with hospice.

2 DR. REDBERG: I support the recommendation of the  
3 Chairman, and I also wanted to agree with Mary and encourage  
4 us to have more end-of-life discussions -- encourage more  
5 end-of-life discussions or planning discussions because I do  
6 think a lot more beneficiaries would be informed and perhaps  
7 would be choosing hospice. Certainly, we know that more  
8 people are dying in ICUs than would ever -- I mean, when you  
9 poll, almost everyone wants to die at home in a setting  
10 where they are not hooked up to a lot of tubes and IVs, and  
11 yet many of our beneficiaries are, we know, dying and a lot  
12 of our efforts are in those last few weeks of life, which is  
13 okay if people are choosing that, but I think a lot of  
14 people are not having an informed choice.

15 And I also think it's not just patients, it's  
16 physicians. A lot of physicians are not really aware. I  
17 mean, certainly in my own specialty in cardiology, we have a  
18 lot of heart failure patients who are -- it's quite a  
19 terminal disease once you're in end-stage heart failure, and  
20 yet a lot of those patients don't have end-of-life  
21 discussions.

22 We just published an article recently in JAMA

1 Internal Medicine on ICD deactivation, showing that a lot of  
2 patients have not, even when they have the defibrillators  
3 implanted, don't have an understanding or a discussion of  
4 deactivation at end-of-life. And so I think it requires  
5 sort of a change in our physician and medical education as  
6 well as in encouraging shared decision making so that we  
7 really do have a better informed and more people able to  
8 understand what the hospice alternative is, to encourage it.

9 MR. HACKBARTH: Kim, do you know if any of the  
10 existing patient satisfaction instruments used by Medicare,  
11 CAHPS, et cetera, include questions asking beneficiaries  
12 whether they have been advised about end-of-life choices?  
13 Is that something we collect data on anywhere?

14 MS. NEUMAN: I'd need to get back to you on that.  
15 There is some shared decisionmaking type questions, but it's  
16 focused on end of life?

17 DR. SOKOLOVSKY: [off microphone].

18 MS. NEUMAN: Yeah. So as Joan is saying, there  
19 are kind of shared decisionmaking questions but not focused  
20 specifically on end of life. But that's not to say that you  
21 couldn't try to have some kind of CAHPS thing that sort of  
22 did a special look at folks at the end of life.



1 MR. HACKBARTH: Okay.

2 DR. NERENZ: Yeah, I think the adequacy indicators  
3 of various types support the direction of the  
4 recommendation. I'm fine with that. Here's another place,  
5 though, I want to bring up this point about the different  
6 types of programs and how the margins vary, if we could go  
7 to Slide 14. Here's perhaps even one of the more extreme  
8 examples of hospital based being at least apparently more  
9 expensive than others.

10 You discuss this on page 30 in the chapter, and  
11 I'm asking maybe in the finalization of this in January, if  
12 you have more detail or more examples, even specific case  
13 examples, of how this cost allocation gets done, I would  
14 find it very interesting, because, you know, I appreciate  
15 the concept but it's not yet tangible how this works. I'm  
16 trying to distinguish, for example, in my mind the idea that  
17 a hospital has a fixed set of overhead costs that it has  
18 some flexibility of allocating, and so we see them allocated  
19 in different ways. And the text implies that some of that  
20 allocation, I'll just call it inaccurate, meaning that it's  
21 a big central cost that has to be allocated somewhere, but  
22 it doesn't necessarily reside strictly, say, in this program

1 or in some other program.

2 Or it could be that every single one of these  
3 hospital-based programs is truly more expensive because of  
4 sort of the truly related set of overhead expenses. And I  
5 really would like to know how that works. So if based on  
6 the cost reports you could show us a little more what that  
7 cost allocation is -- what are its elements? What's being  
8 put in here? -- I'd like to know that.

9 MS. NEUMAN: So structurally the way the cost  
10 report works is that you have the hospital, and let's just  
11 use their A&G, for example, they allocate that down to their  
12 different lines of service. Then the hospice provider  
13 itself has its own A&G line, which then also gets allocated  
14 obviously just to the hospice. And so just the structure of  
15 the cost report creates --

16 DR. NERENZ: I'm sorry. A&G?

17 MS. NEUMAN: General and administration. So,  
18 yeah, thank you. Anyhow, it gets -- it's structurally set  
19 up in a way that there's these two allocations happening.  
20 Capital the same thing. And so when you talk to cost report  
21 experts, they'll tell you the way it's set up, there is  
22 going to be some extra money that's getting allocated over

1 to the hospice that probably isn't really the hospice's  
2 costs.

3 MR. HACKBARTH: Dave, in your comment you  
4 mentioned several possible different explanations for why  
5 the hospitals have higher costs and lower margins, not just  
6 here but sort of regularly. One is accounting and  
7 allocation of overhead costs. Second is that potentially  
8 their costs actually are higher. And a third is patients  
9 are different in the hospital-based providers. So there may  
10 be some other categories, but I think those are the three  
11 big ones. And I think the answer to this question, which I  
12 know is one that you've been thinking a lot about, it's all  
13 of the above or it can be all of the above.

14 And so, Kim, just to mention the allocation issue,  
15 in some cases hospitals may actually have higher-cost  
16 personnel because they have union labor, for example, that,  
17 you know, a free-standing provider may not. And in some  
18 instances that may be part of what's going on.

19 In other cases we have evidence that, in fact, the  
20 patients are not accurately paid for, like hospital-based  
21 SNFs. We've said that case mix system is not well designed.  
22 It underpays systematically for certain types of patients,

1 and as Peter noted yesterday, our estimate is that payments  
2 would increase by 27 percent or some such number for  
3 hospital-based SNFs if our case mix system was used.

4 So, you know, depending on the service and the  
5 institution, it can be allocation, it can be difference in  
6 actual costs, or it could be differences in patients. There  
7 isn't one single explanation for this phenomenon.

8 DR. NERENZ: Right, and that still leads me to  
9 always be curious about the underlying details, because it  
10 seemed like one of the major charges to us is to determine  
11 whether payments are adequate. And I look at that chart,  
12 and I say, well, they certainly seem to be adequate for  
13 free-standing. I don't know if they're adequate for  
14 hospital based. The numbers suggest they are not. But then  
15 it depends on all these -- the sausage making. How does  
16 that cost number ultimately get derived?

17 MR. HACKBARTH: I didn't intend for my answer to  
18 sound like, "Go away, Dave." You know, I've just answered  
19 your question. I'm trying to say that it is complicated.  
20 But on this last issue, you know, the notion that we should  
21 pay higher for a hospital-based providers because they have  
22 higher costs is something that, in fact, you know, we have a

1 pretty strong principle against because it violates the  
2 efficient provider concept. If there are other providers  
3 that, for whatever reason, can provide the same service to  
4 the same patients at a lower cost, we shouldn't pay more to  
5 some providers just because their costs are higher.

6 DR. NERENZ: And I would say I'm not opposed to  
7 that. I'm not trying to push in a different direction.  
8 Actually what this brings to mind is even sort of a bigger-  
9 picture strategic issue that in a number of times we've made  
10 positive statements about the general concept of system  
11 integration, that we favor that, we think it's a good idea.  
12 I think we have generally been agnostic about the  
13 organizational forms through which that occurs. But outside  
14 of our discussions, there are questions about, you know,  
15 Should hospital be the centerpiece around which one builds a  
16 system? If its fundamental costs are essentially higher, as  
17 evidenced here, one might then wonder whether that really is  
18 the preferred model. It is not our business to encourage  
19 one or the other, but we look at numbers like this, and the  
20 question arises. And that's, I guess, my observation.

21 DR. CHRISTIANSON: It looks like from your charts  
22 the government and other -- or the nonprofit hospices have

1 been slowly declining in number, but pretty stable. What  
2 about hospital owned? Is there exit from the industry  
3 through hospital? That would be an indication that there  
4 may be an issue.

5 MS. NEUMAN: There's a small -- we can see it here  
6 -- oh, actually, no, we can't. Let's see. It's in the  
7 paper. There is some decline in hospital based, and  
8 there's, I think, two components to it. Some are having  
9 financial issues and closing. Others are being bought out  
10 and becoming part of free-standing entities. So there's two  
11 things going on there.

12 MR. BUTLER: I was going to make this in my  
13 comments, but because you brought it up, I'll make it now.  
14 So sometimes I'm protective of the hospital-based services  
15 getting short shrift. I'm not sure that that's the case in  
16 hospice. So let's go back to the corporate allocation.  
17 There are several reasons why -- there are two reasons why  
18 it could be higher. One is that, as you point out, the  
19 allocation of the G&A -- you're forced to allocate some to  
20 the hospice that maybe isn't -- that really isn't true. Of  
21 course, that means that the others are understated; you  
22 know, somebody is -- we have our margins incorrect somewhere

1 else. But that would be one reason.

2 Another reason is that actually the people in  
3 legal, the people in finance, and the people that are --  
4 they're actually spending time on this. It is not the wrong  
5 allocation. It's a lot more expensive to run a small  
6 hospital-based SNF given the corporate people that we get  
7 involved in these free-standing ones, which is probably the  
8 case, I think.

9 And then the third reason could be, as we always  
10 like to focus on, are their patients different? Is there a  
11 severity issue? And there could be in the sense that the U-  
12 shape pricing, my guess is that the hospital-based ones are  
13 picking up the end-of-life ones that are going from the --  
14 you know, if you had the repricing, it might help the  
15 hospital-based ones. But we don't know if that's the case  
16 or not.

17 MS. NEUMAN: We have estimated the effect of the  
18 U-shape, and it would increase payments to hospital-based  
19 providers because they have shorter stays, so that would  
20 help

21 MR. HACKBARTH: This is sort of analog to the SNF  
22 thing where we think the payment system --

1           MR. BUTLER: And, therefore, their margins may,  
2 you know, look a lot different if we implemented that  
3 pricing difference.

4           DR. COOMBS: So I think when we look at the  
5 hospital, if we were to break it down, you probably would  
6 see a difference in the disease processes within the  
7 hospital-based hospice. And that may be partly because of  
8 just the location in terms of being able to transfer  
9 patients from ICUs who have gotten termination of care for  
10 various reasons, and that may be an issue there. I don't  
11 know whether or not you had a chance to look at that,  
12 because I think that's the first thing that crossed my mind  
13 in terms of why the margins for those patients with hospital  
14 based is different.

15           MS. NEUMAN: So the hospital based have shorter  
16 stays, and length of stay is correlated with disease. So it  
17 may be that there's a different disease profile. It may  
18 also be that they're just getting the shorter patients  
19 within each disease category. That is something we could  
20 look at and get back to you on.

21           DR. COOMBS: And I've been impressed that many of  
22 the patients that I come across -- and we do terminal



1 extubations -- they've never had a discussion, absolutely no  
2 discussion. They've been in the health care system for --  
3 some of us have admitted them multiple times to the ICU, and  
4 I feel there's this burden to get things squared away for  
5 the acute process, but once they get squared away, there's  
6 not an impetus to discuss the end-of-life topics that need  
7 to be covered in terms of what's done for patients. So I  
8 think the shared decisionmaking is really an important piece  
9 of this, and it almost needs to be in that recommendation in  
10 tandem with -- and I support the recommendation -- the  
11 primary recommendation.

12           On page 15 of the circulated material, there was  
13 the comment that there was no correlation, no relationship  
14 between supply of hospice and the utilization of hospice.  
15 But I have a different kind of question, and that has to do  
16 with geographic regulations and use of hospice in terms of  
17 utilization correlated with states that have different kinds  
18 of approaches to end of life, and that being either an  
19 enhancer of the discussion and an enhancer of the process.  
20 There might be lessons learned from states that have a very  
21 advanced kind of discussion around end of life and some of  
22 the other policies that may exist that may promote earlier

1 discussion where there's a culture where hospice can prevail  
2 in terms of being able to be maximized and appropriately  
3 utilized.

4 MR. HACKBARTH: Right, and I think you've reported  
5 previously on variation, regional variation, state-level  
6 variation, in use of hospice, and it's fairly significant,  
7 isn't it?

8 MS. NEUMAN: Yeah, it is fairly significant, and a  
9 host of factors could account for that. I was wondering,  
10 Alice, if you are thinking of things like states that have  
11 the most post kind of thing, or what are you --

12 DR. COOMBS: So one state might -- you can go  
13 backwards, if you want, or you can go forward. You can look  
14 at one of the states that you're very familiar with and look  
15 at their utility and actually look at what's their length of  
16 stay in hospice. I mean, if they're really good at  
17 predicting who needs hospice and, you know, their decedent  
18 rate is on par with what might be expected, you might have  
19 some lessons learned just from the environment that's  
20 created by that kind of policy.

21 DR. MARK MILLER: Alice, did you comment on the  
22 recommendation?

1 DR. COOMBS: Yes, I did [off microphone].

2 DR. MARK MILLER: And you were?

3 DR. COOMBS: I support it [off microphone].

4 DR. MARK MILLER: Okay. I'm sorry. I just missed  
5 it. I'm trying to keep track of everyone.

6 MR. GRADISON: I also support the recommendation.

7 With regard to a couple of these points, with  
8 regard to cost accounting, I have a hunch that the internal  
9 cost accounting that institutions do is not necessarily the  
10 same as what they're required to do for their reporting to  
11 CMS. I mean, cost accounting as a management tool is to  
12 help you make some internal decisions rather than to meet a  
13 governmental requirement. If you take these numbers too  
14 seriously, you have to ask why do any hospitals continue to  
15 have hospital-based SNFs or hospital-based hospices? And  
16 there are a number of answers, but one of them has to do  
17 with the allocation of overhead costs, and another one has  
18 to do with the difference between the contributions to  
19 overhead, which gets down to marginal cost, and the  
20 consideration of what percentage of the full cost you are  
21 getting reimbursed. And it's certainly worthwhile to  
22 continue to provide a service that continues to make a

1 contribution to overhead, even though on these reports it  
2 might show minus 15 percent or something like that.

3           With regard to the more fundamental questions that  
4 have been raised about the use of hospice, like many of you  
5 I've followed this for a long time, actually, in my case  
6 something over 30 years, and I think it's remarkable that  
7 we're up to 48 percent. Many of the challenges that were  
8 there at the very beginning still exist: understandable  
9 reluctance of physicians to have conversations about end of  
10 life is near or it's coming or it's six months or something  
11 of that kind. It's not as bad -- people are learning and  
12 getting more comfortable with that. But at the outset, that  
13 was one of the great difficulties, understandably, because  
14 at the risk of gross unfairness or overstatement, death is  
15 defeat for many people in this profession. It's not the  
16 outcome obviously they want, and sitting down and talking  
17 about it is not the easiest conversation in the world.

18           If you break down the participation in hospice by  
19 condition, I think it's quite remarkable. Cancer, I mean,  
20 I'm not sure how much further -- we can go further, yes,  
21 Bill, but with cancer, we're really up high in terms of  
22 percentage of people dying with cancer who have had some

1 hospice care? Were they early enough? No. Understandably.  
2 I think that's a very real question, as Mary has raised.

3 I'm a great hospice supporter, as I guess all of  
4 us are, but I keep coming back to a phrase which helps me to  
5 be a little more understanding of why this process is so  
6 slow, which is where there's life there's hope, and I think  
7 there's some degree of truth to that even under the most  
8 dire circumstances.

9 MR. GEORGE MILLER: Thank you. I'm in support of  
10 the recommendation. Just one comment about the cost  
11 reporting. Peter is exactly correct, although Bill has just  
12 pointed out an interesting comment about the methodology,  
13 and I think it's true, there is some concern. We do share  
14 our costs. There's some concern whether it's accurately  
15 reflective of the actual cost, the allocation to things like  
16 the SNF, the hospice. But we also are required, because we  
17 have those departments, to do some things that other free-  
18 standing organizations are not required to do.

19 Now, does it cover all the cost? I would not  
20 suggest that that's the case. But we do have some of the  
21 legal responsibility, and we've got to have our folks go  
22 through things that a free-standing organization does not

1 have to do. So it's certainly worth looking at. I would  
2 not disagree with that.

3 But what I would like to add to the conversation,  
4 just emphasize though that I think hospice is a very  
5 important benefit. If we looked at the total spend of the  
6 Medicare program and, like we did yesterday, we're able to  
7 link the hospice benefit across silos into other services  
8 and make that at least educational aware of this  
9 alternative, we may be able to lower the spend in those  
10 other areas, just like we talked about moving from MA to  
11 fee-for-service and ACOs, particularly with the mortality  
12 rates in LTCHs and dialysis, educating the physicians and  
13 the Medicare beneficiaries about some measures they're made  
14 aware of, and education I feel is the link. In spite of  
15 what Bill said about end of life, it is coming, and we have  
16 to be adult about it and have to have the conversation. And  
17 palliative care, as Rita talked about, is a better  
18 alternative than wasting away in an LTCH or some ICU with  
19 tubes coming out of every orifice. And, again, I emphasize  
20 death is coming.

21 DR. CHRISTIANSON: Thanks, George.

22 [Laughter.]

1 DR. CHRISTIANSON: I thought I had something  
2 important to say, but I don't know anymore.

3 I support the recommendation. I think, in fact,  
4 given the margins in the industry, it's probably on the  
5 generous side, if anything. Maybe it's on the generous side  
6 because we say we're not taking into account sequestration,  
7 but we are. And the margins would drop 2 percentage point  
8 if sequestration continues, so that makes me feel better  
9 about the recommendation, I guess.

10 I wonder, not being on the Commission, again, very  
11 long, we've known since 2008 that there's this payment  
12 incentive, made a recommendation in 2009, I think we  
13 restated -- did you restate the recommendation? You didn't  
14 restate it this time, and is that because CMS is, as Kim  
15 said, working on it? I didn't quite understand where they  
16 were or what they were doing, but there may be some  
17 advantage to keeping the spotlight on this payment reform  
18 issue.

19 MR. HACKBARTH: So I can't remember. It has been  
20 awhile since I read the chapter. Do we have a text box in  
21 the chapter restating the U-shaped recommendation?

22 MS. NEUMAN: Right.

1 MR. HACKBARTH: Yeah.

2 DR. CHRISTIANSON: That's not something you're  
3 asking us to do here? It wasn't part of your  
4 recommendation?

5 MR. HACKBARTH: My current thinking, Jon -- and  
6 I'm open to suggestions about this -- is that when we have a  
7 prior recommendation that, you know, we stand by, rather  
8 than re-voting we rerun them and we try to do so in a  
9 visibly prominent way, put them in a text box where they  
10 stand out, and that's the way we sort of, you know, hit the  
11 nail on the head again. If we start down the path of re-  
12 voting some things and not others, I'll need to figure out  
13 some decision rules about, you know, what qualifies for that  
14 and what doesn't.

15 DR. CHRISTIANSON: I understand that. Thank you.  
16 I am dismayed that it takes so long to get something --

17 MR. HACKBARTH: Yeah. On your initial point about  
18 the comparatively high margins, often what we've done in the  
19 past is link significant changes in payment levels to  
20 payment reform. So the update is about the payment level,  
21 and the U-shaped distribution in this case is about how to  
22 reform the distribution of payments. And often I have been



1 -- I won't use "we." I have been reluctant to say let's  
2 start actually cutting rates below the prevailing level  
3 until we get the distribution of dollars right, because if  
4 you start cutting the rates and you haven't improved the  
5 distribution, then sometimes the institutions that you most  
6 care about are really going to take it in the air, and it  
7 will be less painful for the ones who we think are overpaid  
8 on a distributive basis.

9           So I like to -- let's get the system fixed first,  
10 and that creates a solid foundation for saying, okay, now  
11 let's find the right level of rates

12           DR. CHRISTIANSON: So that's reasonable. Another  
13 view on that it has been taking a long time to get the  
14 system fixed, in my view, and putting more pressure on that  
15 process could occur by cutting the rates. And I'm a little  
16 bit reassured by Kim's response in terms of the hospitals  
17 having negative margins, but not exiting the industry in  
18 droves. We know from the MA experience that providers and  
19 plans will respond pretty quickly to payment changes that  
20 they feel actually have a negative impact on their bottom  
21 lines.

22           So I support the recommendation, and I wish we

1 were a little more aggressive.

2 DR. HOADLEY: I, too, support the recommendation  
3 and actually am very sympathetic with this last back-and-  
4 forth as part of the logic that goes on, including the  
5 notion about the old recommendation. And, you know, it  
6 would be nice if we knew there was some technical issue we  
7 could help sort of go to. If it's just, you know, one of  
8 those things that there's some reluctance or just some  
9 overload of a lot of things going on, you know, it would be  
10 nice to understand more about that. But sometimes we just  
11 don't. So I think reprinting it is probably our best step  
12 at this point.

13 The only other thing I was going to comment on, in  
14 looking at Slide 10 and sort of thinking about some of these  
15 differences in average length of stay but similarly some of  
16 the things you've done in more detail in the chapter on the  
17 long stays and things, it's trying to think about, you know,  
18 how do we better understand these. And, you know, you look  
19 at something like diagnosis and you're thinking, okay, but  
20 that may be very logical given clinical differences in those  
21 kinds of cases. Some of the other ones maybe not so much or  
22 are explained by some of the other reasons that people have

1 brought up in terms of the hospital based or things.

2 My first instinct was to say can we compare these  
3 numbers with anything else, like private sector experience,  
4 but in the end it just seems like the patient base is so  
5 different in an under-65 population that that may be not  
6 very helpful, probably not very helpful, although maybe  
7 within diagnosis there is some ability, although even then,  
8 you know, the difference of a cancer patient who's dealing  
9 with this at age 45 versus a cancer patient at age 80 that's  
10 dealing with this, very, very different circumstances.

11 So I think that's not a helpful suggestion, but I  
12 just sort of say it to think about whether there's any way  
13 to compare and think about these issues of whether there are  
14 aspects of the payment system that are driving differences  
15 inappropriately as opposed to things that are real and  
16 should be driving differences.

17 MR. ARMSTRONG: I don't have anything more to add.  
18 I do support the recommendation. Jon represented a point of  
19 view around whether, you know, zero increase was going low  
20 enough, but given the subsequent conversation, I think this  
21 makes sense.

22 DR. NAYLOR: I also support the recommendation and

1 encourage the continued work of the Commission that Kim and  
2 Sara and others have led around thinking about palliative  
3 and concurrent care as potentially one strategy to promote  
4 earlier entrance, reasonable entrance into hospice, to think  
5 about nursing homes and the relationship with hospice, and  
6 especially to think about opportunities for beneficiary  
7 informed decisionmaking.

8 MS. UCCELLO: I support the recommendation, and I  
9 share the frustration of the U-shaped curve not being  
10 implemented yet. But we have -- Kim, remind me, we did  
11 provide additional technical assistance on how that could be  
12 done in the June report, right, providing some examples of  
13 ways --

14 MS. NEUMAN: Right. Yeah, we did. We provided an  
15 illustrative example of a type of payment system you could  
16 implement with existing data. I will say one thing about  
17 the timing. PPACA limited the Secretary in terms of being  
18 able to implement payment reform no sooner than 2014. So  
19 this was the first year the Secretary has declined to make a  
20 change. She hasn't had the authority up until 2014.

21 MS. UCCELLO: Okay. Well, thank you for that  
22 clarification. So given that that time is coming then, do

1 we anticipate that she will move? Or is there more that we  
2 need to do on some of this technical assistance side?

3 DR. MARK MILLER: Want me to take it, Kim? I can  
4 tell Kim is getting uncomfortable, so I will say the things.

5 Despite the clarification that you just had on the  
6 timing, I will speak only for myself. I am concerned about  
7 the momentum here. I think CMS has a lot to do and there  
8 are some issues with this, but by and large, I think it can  
9 move forward faster than it appears to be happening in the  
10 background. And I don't tend to be highly critical of CMS'  
11 efforts. I think it's very hard for a Secretary to come  
12 forward and do something that has distributional impacts.  
13 And it's very hard for an industry to get behind something  
14 that has distributional impacts because it splinters people.

15 And, Jon, to your point, what starts to happen is  
16 when the Congress says, well, in the absence of anything  
17 else, I'm going to sequester or I'm just going to start  
18 cutting rates, people start to then turn around and look at  
19 these kinds of proposals because now they realize that  
20 everybody is going to take it.

21 So I think there is more. I think we could  
22 certainly write the chapter to be back to the urgency point

1 that we were saying at the time, in addition to reprinting  
2 the former recommendations.

3 MR. HACKBARTH: So, Mark, it wasn't clear to me,  
4 and maybe it was intentional that it wasn't clear, how much  
5 of this is workload at CMS versus how much is policy  
6 opposition or reluctance to do the necessary redistribution?

7 DR. MARK MILLER: Now, I wish Kim had taken the  
8 question. I don't know why I got in front of her.

9 [Laughter.]

10 DR. MARK MILLER: So, I mean, my own view of this  
11 is -- and Kim, you really should speak openly if you  
12 disagree -- is the technology needed to do it, I think, is  
13 available. You can move ahead and do this. And certainly  
14 within a couple of years, you can. So, that's one point.

15 They do have a lot going on. I don't think it is  
16 insignificant, the workload that is piled onto CMS on a  
17 regular basis.

18 The point I was making is I don't feel the  
19 momentum out of the agency, and so that even, you know, if  
20 there was a forward motion, here's a plan and here's what  
21 we're thinking of, it would still take a few years to kind  
22 of do it and do it in a rational way. And at least in my

1 sense, I don't feel that. But, Kim, you should respond or  
2 not as you see fit, because I buried myself.

3 MR. HACKBARTH: So, one other question, Mark, and  
4 I'm trying to explore Jon's point. So, you said that there  
5 are cases where a cut in the rates has prompted an industry  
6 to support reform in the distribution that previously it had  
7 not.

8 DR. MARK MILLER: I'll give you a very recent one.  
9 The home health industry has stood pretty firm for many  
10 years, resisting any kinds of cuts. The cuts have now  
11 started to become more serious and the Congress continues to  
12 look pretty seriously at them and they've come forward with  
13 a proposal that very much targets episode caps that has a  
14 highly distributional effect on the industry, and that's  
15 something that, I think, a few years ago, they would have  
16 never come forward with.

17 I'm not saying these are good policies, but I'm  
18 saying that they begin to look at things like that. I also  
19 think, to their credit, both home health and the skilled  
20 nursing facilities associations have tried to put forward  
21 things on readmission rates and other types of proposals.  
22 Again, I want to say this carefully. They aren't always

1 designed the way I think we would do them, but I think some  
2 of those conversations wouldn't have even occurred three,  
3 five years ago. Glenn, you may have other views.

4 MR. HACKBARTH: Well, on the home health example,  
5 and I may not have this right, so correct me if I'm wrong,  
6 but, basically, what they said, well, we don't like  
7 rebasing, so let's take this really extreme group of  
8 outliers and take them out and shoot them and leave the rest  
9 of us alone.

10 DR. MARK MILLER: Okay. Move to strike --

11 [Discussion off microphone.]

12 DR. CHERNEW: Yeah, exactly. That --

13 DR. MARK MILLER: Slow down there. I was worried  
14 I was getting myself in trouble.

15 [Discussion and laughter off microphone.]

16 MR. HACKBARTH: [Off microphone.] We covered that  
17 adequately.

18 DR. MARK MILLER: Send your cards and letters to  
19 me.

20 [Laughter.]

21 MR. GEORGE MILLER: [Off microphone.]  
22 recommendation.



1 MR. KUHN: I support the recommendation.

2 DR. SAMITT: I support the recommendation, as  
3 well.

4 MR. BUTLER: So, I support the recommendation and  
5 I support the stating some urgency. And I don't think it's  
6 inappropriate even, Glenn, to state the philosophy that you  
7 just stated, and that is that we're -- no, not the death  
8 panel part.

9 [Discussion and laughter off microphone.]

10 MR. BUTLER: No, the fact that you don't want to  
11 harm -- by an across-the-board reduction, you don't want to  
12 harm the ones that are victims of a poor pricing model now.  
13 I think you can -- why not just openly say that? I think it  
14 probably applies to the IRF issue coming up and a number of  
15 others. Because to just say, you know, you're making too  
16 much money in this sector, let's cut it down, then it gets --  
17 -- we're driven just by margin, and that's not the message --  
18 music to your ears, right, Mike? Okay. So, I won't --

19 But let me go back, if I can just one more time,  
20 to the hospital-based side. I think, Bill, if you look at  
21 the for-profit sector versus the nonprofit in hospital-  
22 based, it's very different answers. But getting back to

1 Scott's point yesterday about nonprofits kind of targeting,  
2 in general, a lower operating margin being enough to kind of  
3 fulfill their mission, they tolerate and say, well, this is  
4 consistent with our mission. We don't have to have  
5 everything make money. Whereas the for-profits -- and I'm  
6 not criticizing them -- they're kind of saying, you're  
7 trying to maximize the return. So, they sharpen their  
8 pencils a little bit more and say, this is just not a  
9 business that's paying for itself. So I think there's a  
10 little bit of that.

11           And I would also say that hospitals of all kinds,  
12 I think, but I know particularly us, have really ramped up -  
13 - you know, the hospitals' programs which started for one  
14 reason are now really involved in intensive care, really  
15 involved in palliative care, really are dialoging much more  
16 in ways that didn't occur before. And it affects not only  
17 the hospice interface, but LTCHs and things like that. And  
18 all this is, I think, a very positive direction that things  
19 are headed.

20           Now, back to the recommendation, which I support.  
21 I do think, and I'll reiterate, this is very much like home  
22 health. It's very price sensitive, very -- for-profit is

1 where the growth is, and whatever the pricing is, it's  
2 likely to be responded to pretty quickly and we shouldn't  
3 forget that.

4           The only thing I think we might be missing on the  
5 pricing recommendations, and maybe I'm just -- now my memory  
6 is slipping a little -- the institutional settings, like  
7 SNFs, where it looks like there's kind of -- it's either  
8 cheaper to do it there because you have a critical mass of  
9 patients or, in fact, they're duplicative services that are  
10 sometimes provided by a SNF. Sometimes, I wonder if there's  
11 a pricing opportunity to kind of reduce pricing when the  
12 hospice care is in an institutional setting versus a home  
13 care setting just because it's a different cost structure,  
14 and that might be a more accurate pricing of the services.

15           MR. HACKBARTH: Remind me, Kim, did we make a  
16 formal recommendation on that at the same time as we did the  
17 U-shaped, or separately from the --

18           MS. NEUMAN: You mean the nursing facility issue?

19           MR. HACKBARTH: Yes.

20           MS. NEUMAN: No. We just outlined it in the June  
21 report.

22           MR. HACKBARTH: Okay. So, that's something that

1 we may want to come back and make a separate formal  
2 recommendation on to complement. That would be true even if  
3 there was a U-shaped distribution in the payments, that we'd  
4 want to do that, as well.

5 MR. BUTLER: Yeah. I just think, fundamentally,  
6 the cost of --

7 MR. HACKBARTH: Yeah.

8 MR. BUTLER: -- doing it is probably less, to do  
9 it in those settings.

10 MR. HACKBARTH: Yeah.

11 DR. MARK MILLER: And I just want to say -- I'm  
12 really sorry to interrupt, Mike -- even though we didn't  
13 make a formal recommendation on it, we had a fairly strong  
14 discussion of this in the chapter and it has been noted in  
15 some of our conversations with the Hill staff. So, it's not  
16 a completely blank signal at this point on that.

17 DR. CHERNEW: I support the recommendation, and  
18 let me say the challenge in this industry is there's both  
19 under- and overuse and we struggle with how to deal with  
20 that. The U-shaped recommendation, I think, is one way to  
21 try and deal with that, but unfortunately, our concern about  
22 overuse pushes us to some of the administrative things that

1 we also have recommended in the past and I think there's  
2 this constant tension.

3 My concern is that we think about this as hospice  
4 as opposed to end-of-life, which segments the way we think  
5 about the patient. It moves us away from the patient  
6 towards the provider, which I don't think is particularly a  
7 good thing, and I think that manifests itself in a variety  
8 of ways. For example, I'm less concerned about quality  
9 measures of hospice, comparing one hospice to another, and  
10 more concerned about quality measures of people at end-of-  
11 life. So, I would rather the survey all decedents, not just  
12 the ones that ended up in hospice, because I think there's a  
13 lot of care that probably shouldn't be delivered to people  
14 that never got into hospice in the first place, and I think  
15 understanding that process matters.

16 Similarly, this tension of the level of  
17 profitability is complicated, because on one hand, I  
18 understand this tension. There's a lot of entry. It's  
19 profitable by the margin. We should lower the price more  
20 generally. I agree with that by nature.

21 On the other hand, there's a part of me, frankly,  
22 that likes this being profitable because I think it will

1 encourage groups to come in and provide more and deal with  
2 some of the underuse, and I have a nagging sense that, at  
3 least if well targeted, and that's a big "if," from an  
4 overall program perspective, a rise in hospice spending  
5 might not be the worst thing in the world. It's an area  
6 where, again, if done well, we could get lower spending and  
7 better outcomes in a difficult sort of stage of life.

8           And so it's, as Peter foretold that I would say,  
9 I'm not simply looking at the -- my mind doesn't simply look  
10 at the margin and say, oh, they're making a lot of money.  
11 Let's get them down. I think, well, there's a reason why it  
12 might be beneficial to have an incentive for entry in this  
13 area, but we do have to work on the targeting. I think some  
14 of the recommendations that we've made continue to do that,  
15 so I support the recommendation.

16           DR. BAICKER: I support the recommendation.

17           MR. HACKBARTH: Okay. Thank you very much, Kim  
18 and Sara.

19           So, moving on to our last item, inpatient rehab  
20 facilities.

21           [Pause.]

22           MS. SADOWNIK: Okay. Last but not least, in this

1 presentation we will discuss the adequacy of Medicare  
2 payments to inpatient rehabilitation facilities, or IRFs. I  
3 will present data on indicators of payment adequacy and then  
4 review a Chairman's draft recommendation for payment rates  
5 for fiscal year 2015.

6 IRFs provide patients with intensive  
7 rehabilitation services, such as physical and occupational  
8 therapy and rehabilitation nursing. In 2012, 1,166 IRFs  
9 treated 373,000 fee-for-service cases. IRFs may be  
10 specialized units within an acute-care hospital, or they may  
11 be free-standing hospitals. Hospital-based IRFs represent  
12 80 percent of facilities, but they account for only 55  
13 percent of Medicare IRF discharges. Relatively few Medicare  
14 beneficiaries use IRFs because patients must be able to  
15 tolerate the intensive therapy. Nevertheless, Medicare fee-  
16 for-service is the principal payer for IRF services,  
17 accounting for 60 percent of total cases in 2012 and over  
18 \$6.7 billion in spending. Since 2002, IRFs have been paid  
19 on a per discharge basis where rates vary primarily based on  
20 patients' condition, comorbidities, and level of functional  
21 impairment.

22 IRF patients must be able to tolerate and

1 reasonably be expected to benefit from three hours of  
2 therapy per day for at least five days per week, and they  
3 must require therapy in at least two disciplines.

4           For facilities to qualify as IRFs, they must meet  
5 certain criteria. In addition to meeting the Medicare  
6 conditions of participation for acute-care hospitals, IRFs  
7 must have a medical director of rehabilitation, have a  
8 preadmission screening process for patients, and use a  
9 coordinated interdisciplinary team approach led by a  
10 rehabilitation physician, among other criteria.

11           In addition, IRFs must meet a compliance threshold  
12 which stipulates that no fewer than 60 percent of all  
13 patients have at least one of 13 conditions. CMS developed  
14 the compliance threshold to ensure that this intensive,  
15 costly setting predominantly treated only the most  
16 clinically appropriate cases. Trends in volume and patient  
17 mix have been sensitive to policy changes in compliance  
18 criteria. When CMS renewed enforcement of the compliance  
19 threshold in 2004, patient volume declined substantially,  
20 and we saw a large shift in the discharge destinations of  
21 cases that did not count towards the compliance threshold,  
22 especially major joint replacements; hospital discharges



1 shifted away from IRFs for these cases and to home health  
2 agencies and SNFs. In 2007, the compliance threshold was  
3 capped at 60 percent, and the industry began to stabilize.

4 We will use the same framework to analyze payment  
5 adequacy for IRFs as for the other sectors.

6 Let's start with access. With respect to supply,  
7 there were 1,166 IRFs in 2012. The total number of IRFs  
8 stayed relatively stable between 2011 and 2012, the first  
9 year since 2005 that the number of facilities has not  
10 declined. The number of free-standing facilities continued  
11 to increase, while hospital-based IRFs continued to leave  
12 the market, although the decline in 2012 was smaller than in  
13 recent years. While free-standing facilities make up only  
14 20 percent of IRF facilities, they represent 45 percent of  
15 IRF discharges due to higher average bed size per facility  
16 and higher average occupancy rates. The majority of free-  
17 standing IRFs are for-profit, while the majority of  
18 hospital-based IRFs are nonprofit. Overall, for-profit  
19 facilities continue to enter the market, with a particularly  
20 large increase in 2012.

21 Occupancy rates represent another measure of IRFs'  
22 capacity to serve patients. Occupancy rates decreased

1 slightly in 2012 to 62.8 percent. Since 2008, when the  
2 industry began to stabilize, occupancy rates have fluctuated  
3 slightly, increasing in some years and decreasing in others,  
4 but changing by less than one percentage point overall from  
5 2008 to 2012. Occupancy rates were higher in free-standing  
6 IRFs than in hospital-based IRFs and higher for IRFs in  
7 urban areas than those in rural areas. Trends in IRF supply  
8 and relatively low occupancy rates suggest that capacity is  
9 adequate to handle current demand.

10           Now that we've reviewed capacity, let's turn to  
11 trends in volume and payment. The total number of cases  
12 grew half a percent from 2011 to 2012, to 373,000 cases.  
13 While the total number of fee-for-service cases increased,  
14 the number of unique fee-for-service IRF patients per 10,000  
15 fee-for-service beneficiaries declined to 92.4 in 2012.  
16 This measure has fluctuated in recent years, but the  
17 proportion in 2012 is similar to that in 2008, suggesting  
18 relative stability in IRF use compared to other  
19 rehabilitation alternatives.

20           Fee-for-service spending totaled an estimated  
21 \$6.72 billion in 2012, an increase of 4 percent from 2011.  
22 This increase reflects growth in number of cases and in

1 payment per case, which increased by 3.4 percent in 2012.  
2 Factors that impact the growth in payment per case include a  
3 1.8 percent update to the base rates in 2012, a 0.4 percent  
4 increase in outlier payments, and about a 1 percent increase  
5 in patient severity.

6           Access to capital is another measure of payment  
7 adequacy. Hospital-based units have access to capital  
8 through their parent institution. As we heard during the  
9 inpatient hospital presentation yesterday, hospitals have  
10 overall maintained adequate levels of access to capital.  
11 While we see an industry focus overall on shifting spending  
12 to outpatient, rather than inpatient, capacity, we also see  
13 that a small number of new hospital-based IRFs continue to  
14 enter the market. You might have seen in the news, for  
15 example, that competitor hospitals UCLA and Cedars Sinai are  
16 partnering to open a new 138-bed facility, which will be  
17 operated by the for-profit provider Select Medical.

18           As for free-standing IRFs, we are able to review  
19 access to capital for one major chain, which represents  
20 about half of free-standing IRFs. Continued acquisitions  
21 and construction of new IRFs, lower costs of borrowing, and  
22 implementation of several shareholder-friendly initiatives

1 reflect very good access to capital and positive financial  
2 health. Besides this chain, most other free-standing  
3 facilities are independent or smaller chains with only a few  
4 providers, and it is less clear how much access to capital  
5 these providers have.

6 Turning to quality of care, we evaluated outcomes  
7 on two functional measures that are important to  
8 beneficiaries: the amount of functional improvement, or FIM  
9 gain, and discharge to the community. We see an increase in  
10 both measures from 2011 to 2012, about a 3 percent increase  
11 in FIM gain and about a 1 percent increase in rates of  
12 discharge to the community. In previous work, we have  
13 looked at industry performance on a broader set of measures  
14 over earlier years and found improvement in quality of care,  
15 controlling for changes in the patient population over time.

16 I will now review IRF margins. Overall, Medicare  
17 margins were 11.1 percent in 2012, up from 9.8 percent in  
18 2011. Margins in free-standing facilities far exceed those  
19 of hospital-based IRFs. Free-standing IRFs had margins of  
20 almost 24 percent in 2012. They represent about 45 percent  
21 of Medicare spending. In contrast, hospital-based IRFs had  
22 margins of 0.8 percent. Hospital-based facilities that were

1 for-profit had higher average margins than hospital-based  
2 facilities that were nonprofit.

3 As context for discussing possible explanations  
4 for differences in margins between hospital-based and free-  
5 standing IRFs, recall that although hospital-based IRFs  
6 constitute 80 percent of all IRF facilities, they account  
7 for only 55 percent of Medicare discharges. Therefore, 45  
8 percent of Medicare IRF discharges are in free-standing  
9 facilities that have an average of 24 percent margins.

10 Free-standing IRFs have lower costs than hospital-  
11 based IRFs, which is impacted by volume and by demonstrated  
12 ability to constrain cost growth. Hospital-based IRFs tend  
13 to have fewer beds and lower occupancy rates, which keep  
14 them from fully capitalizing on the economies of scale of  
15 the more efficient free-standing facilities. With respect  
16 to constraining cost growth, among hospital-based IRFs, both  
17 direct and indirect costs were higher than in free-standing  
18 IRFs. In 2010, direct costs per case were 30 percent higher  
19 in hospital-based IRFs and indirect costs per case -- which  
20 include administration, capital, and general overhead --  
21 were 11 percent higher.

22 In addition, overall Medicare margins are about

1 two percentage points higher for acute-care hospitals that  
2 have an IRF unit than for those without an IRF. Hospitals  
3 have multiple lines of business, and these data suggest that  
4 IRF units may be able to make positive financial  
5 contributions to their parent hospital.

6 This year, we examined the performance of  
7 relatively efficient IRFs compared to other IRFs. We  
8 identified relatively efficient IRFs by examining cost and  
9 quality -- defined as risk-adjusted outcomes on FIM gain and  
10 discharge to the community -- for a three year period. We  
11 classified IRFs as relatively efficient if they were  
12 consistently in the top third on at least one of these  
13 measures in each of the three years and never in the bottom  
14 third on any measure. In 2010, about 17 percent of  
15 facilities met these criteria for relative efficiency.

16 The analysis indicates that relatively efficient  
17 IRFs can have relatively low costs and provide above-average  
18 quality. Relatively efficient IRFs had costs per discharge  
19 that were 28 percent lower. With respect to quality,  
20 relatively efficient IRFs had FIM gain scores that were 5  
21 points higher and had rates of patient discharge to the  
22 community that were 6 percentage points higher. Efficient

1 providers had patients with higher case mix and longer  
2 lengths of stay, but lower average costs per day.

3           The difference in margins between relatively  
4 efficient providers and all other providers was very wide, a  
5 median 24.8 percent versus negative 3 percent. Efficient  
6 providers were disproportionately free-standing. However,  
7 hospital-based IRFs that were relatively efficient were able  
8 to achieve healthy margins of 13 percent. Among free-  
9 standing IRFs, average providers can achieve healthy  
10 margins, but relatively efficient providers can earn  
11 substantial profits, with Medicare margins of over 27  
12 percent.

13           As we have seen, aggregate Medicare margins for  
14 IRFs in 2012 were 11.1 percent. To project the aggregate  
15 Medicare margin for 2014, we modeled the policy changes  
16 driving payment rates for 2013 and 2014. We project that  
17 Medicare margins for 2014 will be 13.1 percent. If a  
18 sequester is in effect for the full year of 2014, the  
19 projected margin would be about two percentage points lower.  
20 To the extent that IRFs restrain their cost growth, the 2014  
21 margin could be higher than we have projected.

22           In summary, our indicators of Medicare payment

1 adequacy for IRFs are positive. The supply of IRFs is  
2 relatively stable, volume has increased, and excess capacity  
3 in occupancy rates remain, suggesting that capacity remains  
4 adequate to meet demand. Margins average 24 percent for the  
5 sector of the industry that tends to operate more  
6 efficiently. Finally, overall quality of care continues to  
7 increase slightly, and access to capital appears adequate  
8 for both hospital-based and free-standing IRFs. We project  
9 that 2014 aggregate Medicare margins will be approximately  
10 13.1 percent.

11 The Chairman's draft recommendation for your  
12 review is: The Congress should eliminate the update to the  
13 Medicare payment rates for inpatient rehabilitation  
14 facilities in fiscal year 2015.

15 On the basis of our analysis, we believe that IRFs  
16 could absorb cost increases and continue to provide care  
17 with no update to the 2014 payment rate. We estimate that  
18 this recommendation will decrease federal program spending  
19 relative to current law. We do not expect this  
20 recommendation to have adverse impacts on Medicare  
21 beneficiaries. This recommendation may increase the  
22 financial pressure on providers, but overall we expect a



1 minimal effect on reasonably efficient providers'  
2 willingness and ability to care for Medicare beneficiaries.

3 This concludes the presentation, and we welcome  
4 any questions.

5 MR. HACKBARTH: Okay. Thank you. Good job.

6 So let me make a comment before we start Round 1,  
7 and I'm reflecting on the conversation that we just had  
8 about hospice and margins and links to payment reform. But  
9 I'm also thinking some about our LTCH conversation  
10 yesterday. So here, Sara, would you put up the slide with  
11 the projected margins? There we go.

12 So we've got, shall we say, substantial projected  
13 margins here, and this comes in the wake of implementation  
14 of rules that were designed to limit the number of Medicare  
15 patients going to these higher-cost facilities and move them  
16 elsewhere. And my vague recollection of that was that when  
17 those rules were implemented, there was a temporary decline  
18 in margins, probably because fewer patients were coming in,  
19 but now the margins have popped back up and are at a high  
20 level.

21 To the best of my recollection, we have no pending  
22 unimplemented reforms on the table about improving the case

1 mix system or anything for IRFs, so in that sense it's  
2 unlike hospice. We've got these high margins.

3 As I say, in some ways this sort of links back to  
4 our conversation about LTCH where we would be saying, you  
5 know, we want fewer patients using that high-cost facility,  
6 and here we have a case study of one type of institutional  
7 provider that responded to a similar, obviously not  
8 identical, set of signals.

9 So, you know, if I'm Jon, I would make the point  
10 again: "Hey, this number zero is too generous, and none of  
11 your reasons, Glenn, that you gave 15 minutes ago apply."  
12 And I'll have to think about how I would reply to Jon when  
13 he says that.

14 So let me just -- Mark, could you just talk a  
15 little bit about it? Am I making some legitimate  
16 connections? Is there an analogy here, at least a broad  
17 one, to what we've been talking about with LTCHs? What was  
18 the experience when we tightened up the criteria and the  
19 volume fell and now the industry has responded to that  
20 change in incentives? Elaborate on that history.

21 DR. MARK MILLER: The very specific comment that  
22 came up yesterday -- and I can't remember who I was having

1 the exchange with -- is we were saying there's five-some-odd  
2 billion dollars in LTCH; if you say I'm going to pay PPS  
3 rates for what we think are more PPS-like cases in LTCH, \$2  
4 billion leaves that pool; and if there's no response, then,  
5 of course, their margins would fall rapidly. And the  
6 question is, you know, will they respond? And they could  
7 respond by being more focused on the complex cases or  
8 respond by saying I'll continue to take the PPS cases, but  
9 I'll be, you know, more efficient about it.

10 In this instance, it was not dissimilar at all.  
11 There was a change in the criteria of patients who could go  
12 into an IRF, and it was a 75 but then it became a 60 percent  
13 rule, and it said, you know, no more than 60 -- you know, 60  
14 percent of your cases can be of a certain composition.

15 The big condition that I recall being affected was  
16 the joint replacement, and at that point in time, there were  
17 a lot of joint replacements going to the IRFs that people,  
18 including some clinicians that we talked to, felt like could  
19 be dealt with in less intense settings.

20 So the enforcement occurred, and the kinds of  
21 reactions that I recall are things like there was a drop in  
22 occupancy rates, there were drops in volumes. The margins,

1 you know, went from yay to yay, and yay in this instance I  
2 think means the six to eight range, is what I recall,  
3 although I'm not sure I can dredge that up.

4 MS. SADOWNIK: In 2004, when compliance was  
5 enforced with the rule at that point, they were about 17  
6 percent, and then they dropped overall.

7 DR. MARK MILLER: Yeah, but --

8 MR. HACKBARTH: But how low did it go?

9 DR. MARK MILLER: But the range, I think, was  
10 still in the six to eight --

11 MS. SADOWNIK: Yeah, the lowest industry-wide was  
12 8.4 in 2009. But free-standings have rebounded further and  
13 higher earlier than that.

14 DR. MARK MILLER: Right, and that's what I recall,  
15 sort of it got compressed and now it's moved back up.

16 They have changed their mix of cases. They've  
17 moved out of the joint replacements and gone into things  
18 like stroke, brain injury, a couple other things I can't  
19 remember offhand. But we started to see growth there, and  
20 so they -- and then I remember multiple conversations with  
21 them about talking about how long it was going to take them  
22 to respond with their costs, but it did appear that many of

1 the actors were responding with their cost structures,  
2 either by beds being taken off line or changing their mix of  
3 patients and, therefore, the staff needed to deal with those  
4 specific sets of cases.

5 So my sense is, yeah, a couple of years of sort of  
6 re-finding their way, but then it now appears that there  
7 seems to be some rebounding that's occurring. Any other  
8 trend or anything that I missed in that recollection?

9 MS. SADOWNIK: No. I think you hit all the high  
10 points. Once the compliance threshold was enforced, it --

11 DR. MARK MILLER: I should say two other things.  
12 We also tracked the data to where people went, and so those  
13 joint replacements did arrive in SNF and home health  
14 settings in ways that were anticipated, at least by some of  
15 the clinicians. And there was some reduction in supply, but  
16 not gigantic, as I recall.

17 MS. SADOWNIK: There was a contraction in all  
18 measures -- in supply and beds and occupancy rate.

19 DR. MARK MILLER: Right.

20 MS. SADOWNIK: And the free-standing, especially  
21 the for-profits, began to rebound around 2007, and free-  
22 standing not-for-profits a few years after that, maybe 2009,

1 2010, and now we're starting to see rebounding among  
2 hospital-based for-profits as well.

3 MR. HACKBARTH: Thank you. That's helpful.

4 Round 1 clarifying questions?

5 MR. GEORGE MILLER: Thank you. In the reading, I  
6 always appreciate the demographic information, and I was  
7 struck by the fact that Hispanics only use 4 percent -- the  
8 population, only 4 percent of Hispanics are in IRFs,  
9 although with the map you can see they're in states that  
10 have large Hispanic populations. Is there a reason for  
11 that? Do we understand why that's so low?

12 MS. SADOWNIK: Research suggests two reasons that  
13 seem the two biggest contributing factors. One is lower  
14 rates of joint replacements among Hispanic populations in  
15 general, and the second is that among Hispanic patients with  
16 that condition, higher rates of going home as opposed to any  
17 PAC use.

18 DR. MARK MILLER: One thing that was [off  
19 microphone] striking to me, George, in the conversations  
20 when all this compliance discussion was going on -- and I'm  
21 not going to say that this is the norm across the country,  
22 but we ran across clinicians who were saying, you know, with

1 a joint replacement -- and I don't mean in extremely complex  
2 and if the patient had other chronic conditions, but, you  
3 know, a relatively straightforward joint replacement, there  
4 were clinicians who were arguing that if you did work with  
5 the patient before they did the surgery, had the surgery,  
6 then brought them out, you could handle almost all of this  
7 on a home health type of basis. So when she says home, it  
8 could be that they're arriving -- you know, going home and  
9 then doing home therapy and then outpatient therapy to  
10 rebound from their --

11 MR. GEORGE MILLER: But why would Hispanics be so  
12 much different than the general population? That's my only  
13 question.

14 DR. MARK MILLER: I don't know [off microphone].

15 MR. GEORGE MILLER: Okay.

16 MR. HACKBARTH: Alice, you had a clarifying  
17 question [off microphone].

18 DR. COOMBS: So I was curious. There's not  
19 information about readmission to acute-care hospitals in  
20 this chapter. I was just wondering if you could comment.

21 MS. SADOWNIK: Sure. We did not -- we looked at a  
22 more limited set of quality measures this year and

1 prioritized ones that we thought would be of greatest  
2 importance to beneficiaries and aligned those with the  
3 efficient provider analysis. But generally we find that  
4 among IRF patients, you know, about 70 percent are  
5 discharged home, about 10 percent go to a SNF, about 10  
6 percent are discharged directly back to an acute-care  
7 hospital. And then in terms of 30-day readmissions, we  
8 found in previous research about 12 percent are readmitted  
9 within 30 days after discharge home.

10 DR. COOMBS: Still clarifying, one question I had,  
11 because you --

12 MR. HACKBARTH: [Off microphone.]

13 [Laughter.]

14 DR. COOMBS: Well, one question I had, because you  
15 said six days earlier for the free-standing, and I was  
16 wondering if that resulted in an increased admission rate  
17 with the data that you have. Maybe you can get back with us  
18 at some point, just correlating the free-standing versus...

19 MS. SADOWNIK: For the efficient providers?

20 DR. COOMBS: Yes.

21 MS. SADOWNIK: Do you mean six percent -- rates of  
22 discharge to the community that were six percentage points



1 higher.

2 DR. COOMBS: Six [off microphone].

3 MS. SADOWNIK: Yeah.

4 DR. CHERNEW: So there's a discussion in the  
5 mailing materials about the case mix group, which is like  
6 their DRGs or some version of that. Could you help me  
7 understand a little more how that relates to the DRGs? I'm  
8 just confused when you talk about certain things that I  
9 think in my mind are DRG-like, like knees and hips. But  
10 that doesn't seem how they're paid. They're paid according  
11 to this other thing that's discussed in the chapter called  
12 case mix groups, which relates to therapy needs and stuff.

13 MS. SADOWNIK: Right, exactly.

14 DR. CHERNEW: Surely that's not exactly.

15 [Laughter.]

16 MS. SADOWNIK: Yeah, moving on, next question.

17 So, right, patients have the DRG that they had -- the  
18 majority of patients --

19 DR. CHERNEW: When they were in the hospital,  
20 wherever it was.

21 MS. SADOWNIK: -- that came from the hospital.

22 Right. So they're in the hospital. They have a DRG. Let's

1 say they had a DRG for some --

2 DR. CHERNEW: Knee.

3 MS. SADOWNIK: Knee. So when they arrive at the  
4 IRF, they are coded into a completely different system,  
5 which may be broader in some cases or it may be more narrow  
6 in others. And there's sort of a hierarchy of  
7 classifications, so they have a more specific impairment  
8 group code. Then those are aggregated into larger case mix  
9 groups that are in some cases very --

10 DR. CHERNEW: And so if they -- you said in the  
11 chapter that, like, 30 percent of places or 31 percent of  
12 places don't even have an IRF, and many of the people even  
13 in those also go to SNFs and home care, which was the  
14 discussion you just had. But if they go to one of those  
15 other sites, they get coded into a completely different set  
16 of bins that's not -- so unlike the LTCHs where you had sort  
17 of a similar set of coding and you could just say, oh, it's  
18 higher here or there, here the actual underlying coding  
19 system they're getting put into is just completely  
20 different, so it's much harder to compare, I guess.

21 MS. SADOWNIK: Correct.

22 DR. CHERNEW: Okay.

1 MS. SADOWNIK: Right, which is why for --

2 DR. CHERNEW: I understand now [off microphone].

3 MS. SADOWNIK: -- making those types of  
4 comparisons, it's best to look at the DRG and where did  
5 those patients go as opposed to --

6 DR. MARK MILLER: And there is something that you  
7 just said that confused me. LTCH doesn't have a  
8 standardized assessment instrument. The thing I wanted you  
9 to say in response to his question is: When they show up at  
10 an IRF, there is an assessment instrument that uses  
11 functional status to put patients into groups and then --

12 MS. SADOWNIK: Not quite. So they are put into  
13 impairment groups on the basis of their clinical condition,  
14 which eventually feeds into the case mix group, and  
15 separately their functional status is assessed with, in the  
16 IRFs it's the FIM tool. And that functional status within a  
17 CMG drives the payment level. So you may have, let's say,  
18 stroke, CMGs for stroke, but there may be a bunch -- there  
19 are a bunch of levels based on their functional impairment.

20 DR. MARK MILLER: And that's where I was going, is  
21 you end up with something that's diagnosis like and  
22 functional status like to end up at a set payment.

1 MS. SADOWNIK: Correct.

2 DR. MARK MILLER: And that's why it has some  
3 relationship to DRG, which is very much diagnosis based, and  
4 then some functional piece. But the diagnosis can change  
5 when they go into the IRF.

6 MS. SADOWNIK: It can, but the payment is based on  
7 their initial diagnosis.

8 MR. LISK: The initial diagnosis is still based on  
9 the IRF diagnosis.

10 MS. SADOWNIK: Right.

11 MR. LISK: So you can have somebody who went into  
12 the hospital, they may have gone into the hospital for,  
13 let's say, a heart bypass operation, but they stroked out  
14 during the bypass operation. And so then they're actually  
15 treated -- the DRG in the hospital is for bypass, but the  
16 case mix group is going to be stroke in the CMG. So just to  
17 say that it doesn't always correspond one to one.

18 DR. MARK MILLER: That's what I was trying to get  
19 at [off microphone].

20 DR. CHERNEW: I understand a little bit better,  
21 but not quite better. It might not be that there's even a  
22 stroke thing. I was trying to figure out if there is, say,

1 a stroke CMG, or is it more just a severity and so it might  
2 not correspond at all, where in the LTCH I thought there was  
3 a correspondence between the words they had in an acute-care  
4 hospital and the words they had in the LTCH. But this might  
5 be an offline --

6 MS. SADOWNIK: No, you're right. There's a  
7 stroke--

8 DR. CHERNEW: -- level of clarification that I  
9 need.

10 DR. MARK MILLER: Actually you are right. I do  
11 now see what you're saying [off microphone].

12 MS. SADOWNIK: Overall I would say that the -- so  
13 the payment is based on -- payment buckets are based both on  
14 diagnosis and functional impairment. So there are a number  
15 of CMG categories for stroke, and those vary by functional  
16 level.

17 DR. CHERNEW: The reason I was asking, besides  
18 just general confusion, was there's a cross-sector pricing  
19 sense of things that happens sometimes, and it wasn't clear  
20 that that concept even really made sense here because the  
21 bundles were so different.

22 MR. BUTLER: I have two questions. The first

1 relates to geographic distribution. You have in the  
2 materials that you sent out the Dartmouth Atlas, like,  
3 picture of where these facilities are located. Either --  
4 and I'm focusing on the freestanding for-profit institutions  
5 -- either the existing set of these institutions or the  
6 growth skewed geographically compared to where the inpatient  
7 rehab facilities are overall.

8 MS. SADOWNIK: I'm not sure of the geographic  
9 distribution of those facility types. I can get back to you  
10 on that. Overall, so 30 percent of beneficiaries live in a  
11 county that has a freestanding IRF and 61 percent live in a  
12 county that has a hospital-based IRF. But I can get back to  
13 you on the geographic distribution of that.

14 MR. BUTLER: The second relates to the -- you  
15 referenced the UCLA-Cedars Sinai together building a new  
16 facility with a for-profit company. Do you know the  
17 ownership? Is UCLA and Cedars Sinai putting in money and  
18 owning, or are they just asking -- and just asking the  
19 company to manage, or what's the relationship?

20 MS. SADOWNIK: Well, we are -- we have spent some  
21 time internally trying to figure that out. So, first of  
22 all, those two facilities, their joint ventures would

1 actually probably be a freestanding one in this case because  
2 they're opening it in a separate freestanding location.

3 And as for the management or operation being by  
4 Select, I think we're not -- we're not actually sure if that  
5 would necessarily connote that it would be a for-profit --  
6 be classified as a for-profit facility or not, so --

7 MR. BUTLER: I'm trying to get at whether they're  
8 looking at this as a return on an investment in a fee-for-  
9 service world or, in fact, coordinating care in an ACO  
10 world, and I suspect it's more of the fee-for-service world  
11 approach. But, you know, it kind of says something about  
12 what motivates these things being built, and --

13 MS. SADOWNIK: Well, I think in this case --

14 MR. BUTLER: -- and maybe some of each.

15 MS. SADOWNIK: Right. And in this case, actually,  
16 both of those facilities, both UCLA and Cedars, have their  
17 own IRFs currently, very small, you know, a very small  
18 number of beds in each that are full to capacity, so the  
19 idea is to create a much bigger one together.

20 MR. LISK: But, both of those --

21 MR. BUTLER: They may want to backfill with other  
22 inpatient beds, for that matter, too.

1 MS. SADOWNIK: Right.

2 MR. LISK: Both those hospitals have actually very  
3 high occupancy, have high occupancy rates, so they may be  
4 wanting those beds actually for acute care, too.

5 MR. HACKBARTH: Other round one questions?

6 Let's see. George, do you want to lead round two.

7 MR. GEORGE MILLER: I support the recommendation,  
8 and like we said in all other silos, that moving it in the  
9 direction that we're going, I think, is positive. And  
10 again, I'd like to, as my previous comments, link all of  
11 these across all sectors, as well, so that we move from a  
12 silo model to a more robust continuum of care.

13 DR. CHRISTIANSON: Yeah. I support the  
14 recommendation. It's hardly necessary for me to say  
15 anything else, Glenn, but I will.

16 [Laughter.]

17 DR. CHRISTIANSON: You know, it's not news that  
18 Medicare is going to be under incredible pressure to control  
19 its costs, both for demographics and debt reduction reasons,  
20 and probably the inclination will be to do it in a kind of  
21 heavy-handed cutting across everybody in the same way. So,  
22 I think we need to take advantage of every opportunity that



1 we have to sort of show that there are wiser ways to control  
2 costs, and when there are opportunities to be more  
3 aggressive, we should do that.

4 DR. HOADLEY: So, I support the recommendation and  
5 could even be sympathetic to going lower.

6 The only comment I make will sort of mirror the  
7 first comment I made yesterday morning on sort of how we  
8 measure access, and this strikes me as one of those sectors  
9 where we don't have direct measures of access, as was said,  
10 and if we had a situation where, because of ACOs or  
11 whatever, we saw a significant shift out of these facilities  
12 into home health or wherever else, I keep trying to think  
13 about what that would mean for how we would interpret access  
14 measures, if there's a risk that we would somehow say, oh,  
15 there's an access problem because of that decline in volume.  
16 And I think some of the things you've got on here, like  
17 occupancy rate, are good ways that would still show up.  
18 There's plenty of space left in the hospitals that are open.

19 But it's just something as a thought exercise, and  
20 maybe at some point in the retreat or something we should  
21 think about how we're going to view access in these sectors  
22 where lower use may actually be interpreted as a good

1 result.

2 MR. HACKBARTH: As we go around, I'd welcome  
3 reactions to Jon's proposal that we should go lower.

4 MR. ARMSTRONG: Yeah. So, very specifically,  
5 then, I would say I think we don't go far enough. I think  
6 we should go lower with our recommended price. Again, it  
7 probably doesn't need to be said, but the frustration is  
8 we're setting a price for a service that's really inside of  
9 a system that we're trying to rationalize, and to me, the  
10 chapter does a nice job in offering a glimpse at a  
11 comparison to the MA plans' utilization of IRFs and how  
12 quite dramatically different that is when you actually have  
13 a system that's trying to rationally use this service in the  
14 context of the other alternatives. I think it just  
15 amplifies the importance of continuing that work.

16 In the meantime, we need to set these rates, and  
17 like I said, I would go further than the zero percent  
18 change.

19 DR. NAYLOR: So, I support the direction of the  
20 proposed update, and I'm trying to separate what we know  
21 about the service and how it's currently being implemented.  
22 I think for the population, which is so vastly different

1 than the LTCH -- I mean, this is a group of people who have  
2 a set of problems who can benefit from three hours of  
3 intensive services five days a week in 13 days and we are  
4 seeing pretty good outcomes from that, and using robust  
5 measures. The functional independence measures is a very  
6 robust measure.

7           So, I'm trying to separate that from how it's  
8 currently in the system and wanting to say, we don't want to  
9 lose that opportunity for that kind of service to be  
10 available because it could, in a person's trajectory,  
11 dramatically facilitate their rehabilitation. So, 80  
12 percent of the people right now are in low caseloads. They  
13 don't have lots of other chronic conditions. They are  
14 people that can really benefit from intensive rehab  
15 services.

16           That said, it is of concern that the hospital-  
17 based rehab, about a 60 percent occupancy rate right now,  
18 and so we're not maximizing on that. It's higher in  
19 freestanding.

20           So, I am not sure that I want to go lower right  
21 now based on, I think, the opportunity -- I support the  
22 recommendation as stated, but based on the opportunity, and

1 here's a great example where the CARE tool could help us,  
2 because we could know whether or not making a 13-day  
3 investment gets you to a better yield in the long term,  
4 prevents rehospitalizations, and gets people back to work  
5 more quickly. So, I'm just -- I'm concerned about going too  
6 low to disincent the service.

7 MS. UCCELLO: I would be supportive of Jon's  
8 preference for a lower update. I think, and building on  
9 what Scott said, the mailing material had some information  
10 about how IRF usage differs by fee-for-service and MA. It  
11 was, like, MA plans are much more selective on who they send  
12 there. And so I think the compliance rate is too blunt of  
13 an instrument on trying to do this.

14 So, then, kind of echoing Mary, the need more for  
15 the CARE tool, the need for us to continue exploring these  
16 bundling of the acute and post-acute services is where we  
17 need to kind of continue on this. But the top line here,  
18 though, is I would be willing to go lower.

19 MR. KUHN: I support the recommendation that's  
20 presented, probably not in the space yet where I support a  
21 lower update. I would like to see kind of a more refined  
22 proposal than just going on a straight across-the-board

1 reduction.

2 DR. SAMITT: I support the recommendation. I  
3 could also be convinced to consider a lower update yet. You  
4 know, I think that, clearly, from the MA example that Mary  
5 described, that there is more scrutiny in alternative models  
6 to really look at appropriateness of IRF versus other care  
7 models and we would not want incentives to proliferate the  
8 less-efficient models. And so I certainly could support a  
9 lower update.

10 The one area of concern that I have are the very  
11 narrow margins that exist in certain hospital settings,  
12 especially not-for-profit hospitals, and whether there are  
13 some markets, geographies, areas of the country that will be  
14 severely negatively affected by lower updates where  
15 beneficiaries would benefit from IRF facilities, especially  
16 in a hospital. We wouldn't want closures in hospitals where  
17 there really isn't another for-profit or freestanding  
18 alternative. So, that would be the only area of concern  
19 that I would have.

20 MR. BUTLER: Okay. I wouldn't support going  
21 lower, but I would support the recommendation as is and I'll  
22 make a couple comments.

1           If you could put Slide 7 on. So, this shows -- I  
2 think this is very different from home health and hospice.  
3 If you go back even four more years, in our material, it  
4 shows the spending was \$6.58 billion in 2004, actually  
5 higher than in 2008. So, unlike these other sectors, this  
6 spending has not grown -- you know, again, Mike, bottom  
7 lines isn't the only thing. This has kind of been  
8 contained, and it's been contained through the criteria used  
9 to admit patients, by pricing, and so forth.

10           So, I don't think it's kind of out of control in  
11 the same way that maybe some other sectors are, and I think  
12 that there is still opportunity to influence through pricing  
13 more specifically in criteria as opposed to kind of just  
14 simply lowering the rates, despite the obviously very high  
15 margins in some of these institutions.

16           Also, the cost of entry is so much higher, that  
17 despite some references to some new freestanding facilities,  
18 there's not like there's hundreds of them popping up. So, I  
19 feel a little differently.

20           I also would cite, and I don't have the numbers,  
21 but I believe the readmission rates from rehab versus SNF as  
22 trade-offs, the rehab units do significantly better. I'd

1 like to surface those. And if that's the case, there is a  
2 real financial benefit, and I think is partly, Mary, what  
3 you cite. The required therapy in these facilities is  
4 significant and I think it does make a difference. That  
5 doesn't mean that I'm not sensitive to the high returns that  
6 particularly the freestanding for-profits have, but I, at  
7 this time, would support just leaving things flat.

8 DR. CHERNEW: Yeah. So, I support the  
9 recommendation and I haven't come to a decision about how I  
10 would feel about being more aggressive, but I would say part  
11 of the reason is I'm not sure what happens to these patients  
12 when they don't go to the IRFs. There's a section in the  
13 chapter about quality that basically says it's about the  
14 same when they go, and there's a section about MA comparison  
15 to fee-for-service which says that the MA plans use them  
16 less. I'm not sure if they're under-using in MA or  
17 overusing in fee-for-service. So, I'm uncertain, frankly,  
18 about, for example, financially, is it way more expensive if  
19 the same person goes to an IRF? I know there's places in  
20 the country where there are no IRFs, so those patients get  
21 treated in other settings, and I'm not sure how it plays  
22 out.

1           My sense is that we're in a reasonably stable  
2 place, which is why I support the recommendation, and I  
3 understand the comments around the table about why it looks  
4 like it's conceivable we could go a tad lower, and I'm not  
5 inherently opposed to that, but I haven't thought through it  
6 well enough and I haven't thought through how to think about  
7 this in a patient-centric as opposed to site-centric way,  
8 and that's what's sort of causing the pause that I've been  
9 trying to figure out.

10           DR. BAICKER: I support the recommendation. I'd  
11 be open to thinking about lower. I, I think like Mike, was  
12 struck by the MA versus fee-for-service comparison in the  
13 chapter, which I thought was somewhat telling about  
14 potential opportunities for reducing use and changing the  
15 mix of patients in the fee-for-service group. More  
16 information about how the patients in fee-for-service look  
17 relative to the MA patients in the areas where there are  
18 IRFs, so that you're doing as much of an apples-to-apples  
19 comparison, might be helpful in supporting what the  
20 alternatives might look like for those patients and might be  
21 good input into a discussion about even lower. But I'm  
22 certainly supportive of the recommendation as it stands.



1 DR. HALL: I support the recommendation as it  
2 stands and I would need to see a lot more data to want to  
3 inflict even a lower update at this point. It's a system  
4 that seems to be working pretty well. It has promise. And  
5 I think this does send a message to the industry. I'll  
6 leave it at that.

7 DR. REDBERG: I support the recommendation as it  
8 stands. Like Mary, I do have some concerns. I think  
9 there's a lot of good that comes out of these inpatient  
10 rehab facilities that it really is a focused service that  
11 our beneficiaries benefit from.

12 I was struck by the geographic distribution, which  
13 looked a lot like the LTCH geographic distribution. Some of  
14 it certainly is the population centers, but that  
15 concentration in Texas and Louisiana that you see out of  
16 proportion to the population there is striking. But, still,  
17 I would support the recommendation as it stands.

18 DR. NERENZ: I would support the recommendation  
19 for reasons others have already stated.

20 DR. COOMBS: As well.

21 MR. GRADISON: I do, also.

22 MR. HACKBARTH: So, all three of you, let me ask

1 you a question. Does that mean you would prefer not to go  
2 lower? You like the current recommendation?

3 DR. NERENZ: At this instance, that would be  
4 accurate, although I'd certainly be open to discussion about  
5 going lower. But it reflects this balance, and others have  
6 used the Goldilocks analogy. It seems to have the right  
7 feel of, at the same time, being cautious with Medicare  
8 spending but also not disrupting a program that seems to be  
9 effective and, as Peter said, not running out of control.  
10 But I would be open to that discussion if you wanted to go  
11 that way.

12 DR. COOMBS: So, I was thinking about the notion  
13 of a maldistribution of IRFs in certain areas in conjunction  
14 with some providers who are hospital-based in certain areas  
15 and what that would mean to them. Giving a negative update  
16 could be anywhere from a minus-three to a minus-four,  
17 depending on what it was with the sequester in hand, so that  
18 was the other consideration that I had.

19 MR. GRADISON: I could be -- I can move in that  
20 direction. I'm not quite there now. And it has nothing to  
21 do with being considered Scrooge at this time of year.

22 [Laughter.]

1 DR. COOMBS: I did have one other question. Is it  
2 possible to get that titrated information regarding -- I  
3 think Peter talked about the readmissions -- but to get it  
4 in the freestanding versus the hospital-based at some point?

5 MS. SADOWNIK: Sure. That's something we can work  
6 on.

7 MR. HACKBARTH: Yeah. Okay. So, on the issue of  
8 whether to go lower, there seems to be some division of  
9 opinion. Let me think some more about that and talk to you  
10 between now and the January meeting.

11 I'm of two minds on this. On the one hand, some  
12 of the patterns -- could you put up the Slide 10, Sara,  
13 please. So, we have this difference in profitability of  
14 for-profit versus nonprofit, freestanding versus hospital-  
15 based, which is not unusual. This is a pattern frequently  
16 repeated. You know, it's always a signal to me, you know,  
17 what's going on here? Let's try to understand what might be  
18 the explanation.

19 Put up Slide 12 now. Here, we get a little bit  
20 different picture. We see even among the hospital-based  
21 that we have some that have substantial positive margins,  
22 which suggests it can be done. And we have some for-profit

1 hospital-based that are doing pretty well. You know, the  
2 not-for-profit versus for-profit seems to be the most  
3 persistent pattern.

4 But, again, we see that in acute care hospitals,  
5 as well. So, I look at acute care hospitals and we have  
6 efficient provider margins that are negative, overall  
7 average margins -- the average overall margin that's  
8 projected to be double-digit negative, and some not-for-  
9 profit/for-profit issues in there. We say we can live with  
10 that. We may want to increase the update a little bit above  
11 current law, but it's not going to make those negative  
12 margins go away.

13 And here, we're saying, oh, we see some of those  
14 not-for-profit/for-profit patterns. We're reluctant to cut  
15 an average margin that's double-digit. I'm not entirely  
16 comfortable that we're being consistent there.

17 And just for the record -- one last point, Mary,  
18 and then I'll call on you --

19 DR. NAYLOR: [Off microphone.]

20 MR. HACKBARTH: Okay. I'll get to you in just a  
21 second.

22 I do want to emphasize that I think IRFs do a lot

1 of really good, important work for patients, and I feel the  
2 same thing about home health agencies and I feel the same  
3 way about acute care hospitals. I think IRFs doing their  
4 job really well may save some spending elsewhere, like on  
5 readmissions.

6           Having said all that, I'm not sure how that  
7 justifies paying -- overpaying for each unit of service  
8 provided. I don't think if we reduce the payment rate,  
9 they're going to stop doing good things for patients. And  
10 if we have access problems like Craig identified, the  
11 solution for that is in holding up double-digit average  
12 margins for all IRFs across the country. It's if we have  
13 access problems in particular places, we need to address  
14 those more specifically.

15           So, there are some things about the patterns that  
16 make me a little bit uneasy. On the other hand, I'm really  
17 eager that we be consistent and fair across the different  
18 provider groups in how we treat them, and I need to sort of  
19 sort through in my own mind where to go with those  
20 conflicting feelings.

21           Mary.

22           DR. NAYLOR: I was just doing a quick -- back to

1 when you were talking about the margin difference, and I  
2 said it has to do with how we look at margins in the context  
3 of payment adequacy overall.

4 MR. HACKBARTH: You know, on that point, you know,  
5 I think that a negative margin is not necessarily conclusive  
6 proof that we're not paying adequately. I think it's a  
7 little more difficult to argue that a double-digit margin is  
8 not evidence that we aren't overpaying. And so some cases,  
9 I think, the margin numbers really could lead you to a  
10 strong conclusion.

11 Mike.

12 DR. CHERNEW: No, I mean, I agree with that. I  
13 think it depends on what you think the alternative to IRF  
14 was and what the cost is in the IRF versus not. So, if you  
15 said that this is a high-cost sector making a large margin,  
16 you would really have to convince me that the quality was a  
17 lot better. So, some of it is do you go in -- and I say the  
18 chapter clearly doesn't do that. The chapter has a clear  
19 tone that the quality is about the same across all of these  
20 settings, making you wonder, why would you certainly pay  
21 more in this setting versus another one, and why would you  
22 pay this much in this setting given the sense of margin?

1 And I agree with that completely.

2 But, if you told me that this was a low-cost  
3 setting and they were making a lot of margins because they  
4 were really efficient relative to some other setting, I  
5 would be more tolerant of a high margin, and I just don't  
6 think that's the particular case here, but --

7 MR. HACKBARTH: And so in that latter case, the  
8 question that I would ask, if we cut the margin from 12  
9 percent to eight percent, would the IRFs stop doing those  
10 good things --

11 DR. CHERNEW: Yeah. Absolutely.

12 MR. HACKBARTH: -- that we saw the lower total  
13 cost? I think probably no, but -- Mary.

14 DR. NAYLOR: I just wanted to, also, because this  
15 could be very helpful, so I read the quality differently,  
16 meaning I saw pretty good improvements in quality. The  
17 analysis around comparison of SNF, IRF, and home health was  
18 based on the CARE assessment, which was largely an  
19 assessment to develop the reliability and validity of the  
20 CARE tool and, oh, by the way, to take a look at what we  
21 were seeing. So, I think your point is a really good one.  
22 It has a lot to do with what we see as the evidence here

1 about vast improvements in quality and we may be  
2 interpreting that differently.

3 DR. CHERNEW: Right. So, Sara, what's your take  
4 on the quality across sectors?

5 MS. SADOWNIK: I think you summarized the findings  
6 of the CARE tool accurately, and there was other research  
7 that had been done prior to that, to a common assessment  
8 tool being developed, that did not -- that found that they  
9 were not able to make a definitive statement because of some  
10 difficulties in comparing patients across settings, and in  
11 terms of IRF patients, some questions about whether there  
12 are variables that can't -- that are harder to measure, like  
13 aptitude for doing that intensive regimen. So, overall, I  
14 think those are the points, that evidence has been either  
15 not conclusive of differences, or not differences, or  
16 finding similar short-term outcomes across different PAC  
17 settings with the CARE tool.

18 MR. HACKBARTH: One last thought on this, and I  
19 apologize for sort of rambling on, but this is part of my  
20 process of rethinking before I talk to you about the final  
21 recommendation.

22 You know, I try to imagine myself in Scott's



1 position. So, if I'm running an organization like Scott's I  
2 might think very differently about how I pay for home health  
3 or an IRF provider than I do in the Medicare siloed system.  
4 So, if I'm Scott and I'm dealing with a really high quality  
5 home health agency that I've selected, or an IRF that I've  
6 selected, and I know that they're doing a great job for my  
7 patients, and if I pay them a little bit more, they say  
8 they're going to invest in new technology or they're going  
9 to expand their operations, I might be inclined to say,  
10 yeah, that's a good investment for me to make because it'll  
11 pay dividends in the future.

12 In Medicare, where you've got this siloed,  
13 unintegrated system, you can't strike that bargain. Oh,  
14 I'll pay you a little bit more and allow you to have a  
15 higher profit on this year's business because it'll come  
16 back to me in some way in the future, or for my patients in  
17 the future. You know, it just goes out through the silos,  
18 and in some cases, there may be a future dividend. In other  
19 cases, it's going to shareholders or wherever.

20 And so long as we're thinking about Medicare in an  
21 unstructured, unmanaged system, you know, the margins --  
22 high margins, unfortunately, become a focal point.

1 DR. CHERNEW: [Off microphone.]

2 MR. ARMSTRONG: So, just to continue, if I were me

3 --

4 [Laughter.]

5 MR. ARMSTRONG: -- I would think about how I  
6 organize that, as you just described, and I would be willing  
7 to pay a premium relative to what I would pay for  
8 alternative services. But I would still work very hard to  
9 avoid contributing to 11 to 13 percent margins. That's too  
10 high.

11 MR. GEORGE MILLER: Yeah --

12 MR. HACKBARTH: Okay. Oh, George, I'm sorry.

13 MR. GEORGE MILLER: Yeah. If we look back  
14 historically, many of these services were in the hospital  
15 and they got spun out because others could do them better,  
16 notwithstanding that. But a health care delivery system  
17 that had all of those components before they were stripped  
18 out is complicated and it is very difficult to figure out  
19 the right cost. So, I think this discussion is a natural  
20 evolution of what has happened over time.

21 I'm struck by -- this conversation, I think, is  
22 appropriate and well meaning, and just the converse, though,

1 doesn't happen with many other services. We don't see a  
2 freestanding diabetes center. We don't see a freestanding  
3 emergency room center. So, these things are naturally  
4 because the reimbursement structure -- although you don't  
5 want to talk about margins, they drive this type of  
6 independent structure that doesn't need all of the  
7 complexities of a hospital and its costs as multilayers that  
8 add on additional costs.

9           So, as we strip these things out appropriately,  
10 and you have people like Scott see how to buy these  
11 services, in my mind, you've got to take consideration where  
12 they originally came from and what's a better way to price  
13 them. But the fundamental basis of health care in America  
14 right now is -- for the most part has been -- let me put it  
15 that way -- has been the hospital because of this  
16 complexity. They can take care of a wide variety and range  
17 of health care needs in a setting that provides both  
18 inpatient, outpatient, ICU services that may or may not be  
19 appropriately priced. But as you take each one of these  
20 out, we figure out the right prices at the right time for  
21 these. So, I just wanted to say that for just saying it,  
22 then, so -- to reflect on that, yeah.

1 MR. HACKBARTH: Thank you, Sara and Craig.

2 We'll now have our public comment period.

3 [No response.]

4 MR. HACKBARTH: Seeing nobody step to the

5 microphone, we are adjourned until January. See you all

6 then.

7 [Whereupon, at 11:20 a.m., the meeting was

8 adjourned.]

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