

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

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

COMMISSIONERS PRESENT:

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[9:30 a.m.]

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

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

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

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

1 generally speaking, we introduce recommendations, and then  
2 we vote on those recommendations or amended recommendations  
3 in January. These recommendations are for the payment year  
4 2017.

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

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

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

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

22 A little philosophy, Medicare, of course, is an

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

1 not change from 2015.

2           While plan bids average 94 percent of fee-for-  
3 service, that number is kept down because HMOs are bidding  
4 90 percent of fee-for-service on average. The other plan  
5 types bid much higher, and local PPOs are bidding 105  
6 percent of fee-for-service.

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

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

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

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

22           The difference in the quality increases can be

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16           MR. ZARABOZO: In this year's report, we provide  
17 some information about the market structure of the MA  
18 program, pointing out that it is relatively concentrated,  
19 and with pending mergers among the largest MA contractors,  
20 it is likely to become more concentrated. As of 2015, the  
21 top four companies have the majority of MA enrollment, at  
22 54 percent. Overall, 69 percent of MA enrollment is in the

1 top ten organizations.

2           Compared to 2007, the year after the Medicare  
3 Advantage program began, the program now has higher  
4 concentration of enrollment. But on a per county basis, in  
5 2015, there are more companies participating in MA through  
6 the offering of coordinated care plans, that is, HMOs or  
7 PPOs. In 2007, the average was 2.6 companies per county.  
8 In 2015, the average has increased to 3.2 companies per  
9 county.

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22           This concludes our presentation. We look forward

1 to your discussion. Thank you.

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

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

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

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



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

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

4 DR. CROSSON: Yeah, just a second.

5 MR. KUHN: Okay.

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

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

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

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

18 DR. CROSSON: Yes, Kathy. Sorry.

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

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

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

11 The reason that the law is invoked is that there  
12 is currently a minimum adjustment applied, and given that  
13 this new approach might change how the across-the-board  
14 adjustment, as Mark said, is what the minimum adjustment  
15 invoked by the law is addressing, we might have to change -  
16 -

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

19 DR. CROSSON: Herb.

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

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

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

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

17 DR. CROSSON: Thanks, Scott.

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

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

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

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

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

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

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

9 MR. ARMSTRONG:

10 MR. ARMSTRONG: Thanks.

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

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

18 DR. HALL: This is for Andy, I think. On Slide  
19 15, if you could put that up for a minute, on  
20 Recommendation 2, the risk adjustment model uses two years  
21 of data. Is that existing policy or is there a reason we  
22 picked two years out of it?

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

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

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

10 DR. HALL: I'll come back.

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

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

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

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

7 DR. CROSSON: Mary?

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

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

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

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

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

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



1 also pushed some plans over to bonus status.

2 DR. NAYLOR: Thank you.

3 DR. CROSSON: Warner?

4 MR. THOMAS: I just had a couple of questions.

5 One, there was a reference in the chapter about this new  
6 policy being implemented, the CMS HCC policy being  
7 implemented for multi-years. Was that -- I'm not totally  
8 familiar with that, but how do you see that impacting or  
9 does that impact any of your recommendations or areas that  
10 your recommendations could affect? I mean, is there any  
11 duplication there?

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

15 MR. THOMAS: No. There's a reference in there  
16 about there's a new CMS HCC model being implemented between  
17 2014 and 2016.

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

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

21 DR. JOHNSON: No, it's --

22 DR. MILLER: [Off microphone.]

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

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

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

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

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

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

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

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

15 MR. THOMAS: Okay.

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

19 DR. JOHNSON: Correct.

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

1 DR. JOHNSON: Lowers the difference.

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

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

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

12 DR. JOHNSON: That's correct.

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

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

22 DR. JOHNSON: That's correct.

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

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

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

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

5 MR. THOMAS: Okay.

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

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

14 DR. JOHNSON: Right.

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

18 DR. JOHNSON: True.

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

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

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

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

11 MR. THOMAS: Yep.

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

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

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

5 MR. THOMAS: With no --

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

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

11 MR. THOMAS: Nothing happens.

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

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



1 DR. MILLER: Yes. Yes.

2 MR. THOMAS: Okay. All right.

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

5 DR. CROSSON: Yes.

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

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

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

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

16 DR. HOADLEY: Okay.

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

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

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

5 DR. HARRISON: Yeah, that's correct.

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

9 DR. HARRISON: Correct.

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

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

22 DR. HOADLEY: And then my last question really

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

19 DR. CROSSON: Thank you, Jack.

20 David?

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

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

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

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

14 DR. CROSSON: But the Urban Floor counties were -  
15 -

16 DR. HARRISON: 2004.

17 DR. CROSSON: 2004.

18 DR. HARRISON: Yeah.

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

1 make?

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

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

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

14 MS. BUTO: Support.

15 MR. KUHN: I support the recommendation.

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

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

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

4 DR. CROSSON: Thank you.

5 Sue?

6 MS. THOMPSON: I support the recommendation.

7 DR. CROSSON: Bill?

8 DR. HALL: Support on the basis of equity.

9 DR. CROSSON: Okay.

10 MR. GRADISON: I do as well.

11 DR. NAYLOR: As do I.

12 DR. CROSSON: Mary. Warner?

13 MR. THOMPSON: I support it.

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

18 DR. CROSSON: Thank you.

19 Jack?

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

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

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

7 DR. CROSSON: Thank you, Rita.  
8 David?

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

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

22 DR. MILLER: We did.

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

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

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

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



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

5 DR. CROSSON: Jack, on this?

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

18 DR. CROSSON: Okay. Thank you.

19 Kate?

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

1 DR. COOMBS: I support.

2 DR. CROSSON: Jon?

3 DR. CHRISTIANSON: Yeah. I support and also  
4 acknowledge that we can bring back the map, but I think  
5 Scott's point was more about the plan than the counties, so  
6 --

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

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

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

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

22 To reiterate a point that Mark made, this is

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

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

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

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

17           DR. CROSSON: Alice?

18           DR. COOMBS: I support the recommendation.

19           DR. CROSSON: Kate?

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

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

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

4 David?

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

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

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

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

21 DR. NERENZ: Perfect.

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

1 DR. NERENZ: Perfect. that's all.

2 DR. CROSSON: Rita?

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

8 DR. CROSSON: Thank you.

9 Jack?

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

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

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

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

11 DR. CROSSON: Okay.

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

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

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

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

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

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

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

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



1 MR. THOMAS: A lot of moving pieces.

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

4 Okay. Mary.

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

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

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

21 DR. CROSSON: Bill.

22 MR. GRADISON: I support it.

1 DR. CROSSON: Bill.

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

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

20 DR. CROSSON: Thank you. Sue.

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

1 DR. CROSSON: Thank you. Scott.

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

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

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

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

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

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

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

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

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

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

1 advancements in the way care is being organized and  
2 provided.

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

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

11

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

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

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

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

14 DR. CROSSON: Thanks.

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

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

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

8 Yes, Herb.

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

12 DR. CROSSON: About the what?

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

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

17 MR. KUHN: No, no, no --

18 [Laughter.]

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

20 DR. CROSSON: Go ahead, Herb.

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



1 I've been waiting for round two --

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

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

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

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

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

19 [Laughter.]

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

1 kind of messing with right at the moment.

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

4 [Laughter.]

5 DR. CROSSON: Kathy.

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

14 DR. CROSSON: Really?

15 [Laughter.]

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

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

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

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

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

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

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

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

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

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

12           [Laughter.]

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

17           DR. CROSSON: To take the minimum, yeah.

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

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

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

5 MS. BUTO: Well, that strikes me as a little  
6 weird, because there are other things going on that I think  
7 you mentioned earlier that are going to narrow the  
8 difference between fee-for-service and MA risk adjustment -  
9 -

10 DR. MILLER: The V22, for example.

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

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

13 [Laughter.]

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

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

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

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

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

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

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

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

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

9 [Pause.]

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

13 Okay. Complex stuff. Who wants to start out?

14 Okay, Zach.

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

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

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

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

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



1 and some of the inpatient decline was also due to a shift  
2 of cases to the outpatient setting. The relatively large  
3 growth in outpatient spending was the result of a general  
4 shift of services to the outpatient setting, but it was  
5 also in part due to a policy change which began packaging  
6 lab-related payments into outpatient payments. This is how  
7 we arrive at a net 4 percent increase in hospital spending.  
8

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

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

1 occupancy.

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

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

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

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

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

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

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

12           Hospital cost growth remains relatively low. In  
13 2014, inpatient cost per case grew by just 2.2 percent,  
14 compared with 5.7 percent in the 2001-to-2008 period. This  
15 low cost growth occurred despite a sizable increase in case  
16 mix of 2 percent, most of which we believe is due to  
17 hospitals treating more complex mix of patients rather than  
18 coding changes.

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

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

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

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

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

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

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

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

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

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

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

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

5           We estimate that the overall Medicare margin will  
6 decline from -5.8 percent in 2014 to around -9 percent in  
7 2016. Although payment rate updates and case mix growth  
8 will increase payments, cost growth is expected to be  
9 larger than the payment updates.

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

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

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

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

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

14           In this year's analysis, we identified about 15  
15 percent of hospitals that we had usable data on as having  
16 been relatively efficient for three straight years, from  
17 2011 through 2013.

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

1 these hospitals to generate positive Medicare margins in  
2 2014, with a median margin of 1 percent.

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

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

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

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



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

3 Now Jeff will continue on with our discussion.

4 DR. STENSLAND: Over the last year and most  
5 recently in November, the Commission discussed how  
6 hospitals receive significant discounts on Part B drugs  
7 through the 340B program. We had initially estimated that  
8 340B hospitals receive discounts equal to about 23 percent  
9 of their Medicare Part B drugs costs.

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

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

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

5 In addition, we examined the uncompensated care  
6 costs of the 1,200 PPS hospitals in the 340B program to  
7 address this question about uncompensated care. We find  
8 that the 340B hospitals on average only provide slightly  
9 more uncompensated care than non-340B hospitals. In fact,  
10 40 percent of 340B hospitals provided less than the median  
11 level of uncompensated care.

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

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

22 And I would also want to say that this policy

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

4 Now, a key question is how the uncompensated care  
5 pool of dollars should be distributed. In 2016, the  
6 uncompensated care pool had \$6.4 billion in it and the  
7 policy change I just talked about, the 340B policy, would  
8 add about \$300 million to that pool. However, CMS  
9 currently distributes the fund based primarily on Medicaid  
10 days, and this has the effect of Medicare paying hospitals  
11 \$160 for each Medicaid day.

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

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

1 currently in use by CMS.

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

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

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

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

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

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

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

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

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

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

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

7           And the last three columns shows you that using  
8 the S-10 dollars to redistribute the uncompensated care  
9 pool will result in material declines in payments for at  
10 least 10 percent of hospitals in many of these categories.  
11 And for this reason, the Chairman recommends phasing in the  
12 policy over three years. So the reductions you see in that  
13 10 percent column and the increases you see in the 90  
14 percent column would be phased in over three years.

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

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

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

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

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



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

5 MR. LISK: There.

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

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

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

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

3 DR. NERENZ: This is going to sound like a  
4 semantic question, it is that, but I think it's got some  
5 substance underneath, and this is going to relate to Slides  
6 14, 15, 16, and also a couple pages. The terminology here  
7 slips bullet by bullet from charity care to uncompensated  
8 care, and then we talk about uncompensated care and then we  
9 talk charity care. I think everyone understands they're  
10 not interchangeable terms. They don't have the same  
11 meaning, and I think generally one is a subset of the  
12 other. Charity care is a subset of uncompensated care.

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

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

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

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

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

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

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

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

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

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

16 DR. HOADLEY: I just have a couple of questions  
17 and I really do appreciate all the work in this chapter.  
18 It's been great. It's great stuff. On Slide 3, you cited  
19 \$9 billion in uncompensated care payments in 2014, and then  
20 when you were talking about the options going forward, you  
21 talked about, I think it was, \$6.4 billion in 2016. Does  
22 that simply reflect the lowering of the number of uninsured

1 over that period of time?

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

12 DR. HOADLEY: Only to the extent that some states  
13 move forward on Medicaid expansion may move it a little  
14 bit, but we've had the big change. Yeah, that makes sense.  
15 And then you talked in broad terms about the \$9 billion in  
16 2014 offsetting the drop in inpatient payments,  
17 particularly the DSH payments, in the aggregate. How true  
18 is that sort of down at lower levels? Given that it's  
19 measured by Medicaid days and we've got Medicaid expansion  
20 states and non-expansion states, is that relatively uneven  
21 down at the hospital level or at a regional level, or does  
22 that kind of wash out or have you looked at that?

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

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

14 DR. STENSLAND: Yes.

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

22 DR. STENSLAND: And this is a very good point

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

8 DR. HOADLEY: Right.

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

22 Then you also do something similar on the bad

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

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

22           DR. CROSSON: You think?



1 [Laughter.]

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

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

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

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

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

10           [Laughter.]

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

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

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

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

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

17 DR. MILLER: Right.

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

20 DR. MILLER: Exactly.

21 DR. CROSSON: Cori, Warner.

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

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

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

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

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

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

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

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

1 is that right?

2 DR. STENSLAND: So, to get into 340B, it all  
3 depends on your DSH adjustment, and that's purely depending  
4 on your Medicaid days primarily. That's 85 percent of it.  
5 And about 15 percent of it is how many of your Medicare  
6 patients are on SSI. So, you really don't get any credit  
7 for serving the uninsured in terms of getting in the 340B  
8 program. The only thing they could say is it is true that  
9 the hospitals that serve a lot of these Medicaid patients  
10 also tend to have a little bit more uninsured, but  
11 uninsured doesn't directly help you with getting in the  
12 340B program.

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

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

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

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

8 MR. THOMAS: Absolutely.

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

15 MR. THOMAS: Mm-mm.

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

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

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

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

16 MR. THOMAS: Right.

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



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

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

11 [Laughter.]

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

14 DR. STENSLAND: But, in general --

15 DR. MILLER: Well, let's not lose the concept.

16 The concept is an insured person's bad debt is counted --

17 DR. STENSLAND: Right.

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

20 MR. THOMAS: Yeah.

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

1 on charity care.

2 MR. THOMAS: Okay. Thank you.

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

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

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

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

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

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

4 DR. NAYLOR: That's right. Exactly.

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

6 DR. NAYLOR: Right, and so --

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

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

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

1 DR. NAYLOR: I understand that. But, my -- in  
2 earlier work, we had talked about ten percent was a choice  
3 we made in terms of where to start in reducing payments for  
4 340B drugs. But we also had talked about the tremendous  
5 cost sharing burden on beneficiaries beyond the ten  
6 percent.

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

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

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

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

18 DR. STENSLAND: It would be a legislative  
19 recommendation.

20 DR. HALL: Okay.

21 DR. CROSSON: Sue.

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

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

2 DR. CROSSON: Okay. Scott.

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

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

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

19 DR. CROSSON: Thank you.

20 Herb.

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

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

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

19 MR. KUHN: Great. Thank you.

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

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

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

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

1 DR. CROSSON: Kathy?

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

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

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



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

4 MS. BUTO: Yes.

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

7 MS. BUTO: Right.

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

9 MS. BUTO: No.

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

12 MS. BUTO: Right.

13 DR. CROSSON: Okay.

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

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

1 DR. MILLER: Yeah, it is.

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

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

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

16 DR. CROSSON: Okay. Thank you.

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

20 [Laughter.]

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

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

1 hand up?

2 DR. CHRISTIANSON: No.

3 DR. CROSSON: Yeah. Because where did we start?

4 We started with -- okay, I'm sorry.

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

9 Could I have Slide 17?

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

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

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

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

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

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

21           [Hands raised.]

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

1 would be opposed, irrespective of further clarifications?

2 [Hands raised.]

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

6 DR. CROSSON: Okay. Not at this point.

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

15 DR. CROSSON: Yeah.

16 DR. NERENZ: I have serious concerns.

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

20 Warner?

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

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

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

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

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

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

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

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

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

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

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

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

9           DR. NERENZ: That's important.

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

14           A question, though. In the Medicare patients in  
15 340B hospitals, how many are dual eligible? Because in  
16 that case, they are not paying the copays. Medicaid is  
17 paying the copays. And how many of them had Medigap  
18 coverage? Because they're not paying the copays either.  
19 And I guess when we feel that we're giving some money back  
20 to the beneficiaries, I'd really like to know how often is  
21 that an individual beneficiary, and how often is that  
22 either the Medicaid program or a Medigap coverage?



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

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

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

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

1 340B program, and this recommendation is an effort to try  
2 to get it back to where it ought to be.

3 Cori.

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

13 DR. MILLER: It is true that the way this  
14 executes is that, you know, we're not mailing checks to  
15 people. We're talking about a beneficiary walks into a  
16 340B hospital. The ASP price in that hospital would be ten  
17 percent, or whatever you ultimately decide on, less, and,  
18 therefore, the beneficiary's copayment, whether it's gap or  
19 state or personally that they pay, would be lower by that  
20 amount. And, so, yes, it's a patient that's walking into  
21 that particular hospital or pharmacy that's under contract.

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

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

5 Kathy.

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

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

21 DR. CROSSON: Okay. Herb.

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

1 raise my hand when you were looking for comments.

2 DR. CROSSON: Yeah.

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

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

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

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

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

9           [Laughter.]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15           Thank you for your time.

16           DR. CROSSON: Thank you very much.

17           MR. DAVIS: Hello. My name is Jeff Davis. I am  
18 counsel with 340B Health. We represent hospitals in the  
19 340B program. It's been a great continued conversation  
20 about 340B today, and I just want to pick up on this point  
21 about the uncompensated care that 340B hospitals provide.

22           There's been conversation about different



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

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

17           Thank you.

18           DR. CROSSON: Thank you.

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

22           You may argue that there is no strong policy

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

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

12           And yes, you can do an analysis at the plan  
13 level, at the country level, and I have some examples for  
14 you. And these are all in low fee-for-service, low  
15 benchmark counties, and these are all 4.5 star plans. For  
16 example, Capital District Physicians Health Plan would lose  
17 \$3.3 million in Albany County alone. Geisinger Health  
18 Plan, well known to all of you, would lose \$2.3 million in  
19 Lackawanna County; independent Health in Buffalo, New York,  
20 \$19 million in Erie County alone. Priority Health, another  
21 4-1/2 star plan in Grand Rapids, Michigan, would lose \$10  
22 million in Kent County. And I could provide many, many

1 other examples.

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

8           Thanks very much.

9           DR. CROSSON: Thank you.

10           Okay. We are adjourned, and we'll reconvene at  
11 1:30.

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

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## AFTERNOON SESSION

[1:30 p.m.]

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2  
3 DR. CROSSON: Okay. Welcome back from lunch,  
4 everybody, and welcome to the afternoon session, those of  
5 you who have come in.

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

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

14 [Laughter.]

15 DR. CROSSON: So, take it away.

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

22 So, we start with physician and other health

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

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

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

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

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

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

14           When looking for a new physician, beneficiaries  
15 overall do not face significant problems. First, most  
16 beneficiaries aren't looking for a new doctor during the  
17 year. Seven percent seek a new primary care provider and  
18 16 percent look for a new specialist. Among that group  
19 looking, beneficiaries seeking a primary care provider face  
20 more trouble than those seeking a specialist, and these  
21 results are also consistent with prior years as well as  
22 other data sources.

1 Alice, you've asked us to look at wait times, so  
2 we've continued to track them. In 2013, a little less than  
3 half the beneficiaries reported getting an appointment in  
4 three days or less. This share has declined slightly since  
5 2010.

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

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

1 key conditions since 2010.

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

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

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

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



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

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

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

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

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

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

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

1 line shows that there was a small increase in spending per  
2 beneficiary in 2014, 1.8 percent. Several factors  
3 influenced this change: The small increase in volume in  
4 2014, the small increase in the conversion factor, the  
5 sequester, and payment updates outside of the fee schedule  
6 -- outside of the update process, excuse me.

7           The Commission has expressed concern that  
8 mispricing in the fee schedule contributes to an income  
9 disparity between primary care and specialty physicians.  
10 This chart is based on physician compensation data from  
11 2014. As in prior years, average compensation was much  
12 higher for some specialties than others. The specialty  
13 groups with the highest compensation were the non-surgical  
14 procedural group and radiology. The average for each group  
15 was over \$500,000. By contrast, average compensation for  
16 primary care was about \$250,000. Previous Commission work  
17 has shown that such disparities also existed when  
18 compensation was analyzed on an hourly basis.

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

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

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

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

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

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

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

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

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

16           It is important to compare ASCs with hospital  
17 outpatient departments because OPDs are the setting most  
18 similar to ASCs and the ASC payment system is based on the  
19 hospital outpatient prospective payment system. A benefit  
20 of ASCs is that they offer efficiencies over OPDs, such as  
21 shorter waiting times for patients and greater control over  
22 work environment for physicians. In addition, ASCs have

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

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

7 A final issue is that relative to OPD patients,  
8 ASC patients are less likely to be dual-eligible, minority,  
9 under age 65, or age 85 or older. Factors that may  
10 contribute to these differences include that ASC patients  
11 have better average health status than OPD patients,  
12 minorities may be less likely to receive care in ASCs  
13 because they are more likely to be dual-eligible, and ASCs  
14 may tend to be in higher-income areas.

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

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

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

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

1 borrowed at least \$1 billion.

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

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

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

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



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

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

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

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

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

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

7           Spending implications are that ASCs are poised to  
8 receive an update in 2017 equal to the projected CPI-U of  
9 1.9 percent minus a multifactor productivity of 0.5  
10 percent, for a net update of 1.4 percent. Therefore, this  
11 recommendation would produce small budget savings.

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

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

1 update and the ASC update.

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

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

7 Bill.

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

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

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

1 that all works out.

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

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

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

4 Is that --

5 MR. WINTER: That's correct.

6 DR. ZABINSKI: Okay.

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

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

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

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

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

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

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

22 DR. MILLER: I think I distracted it.

1 MR. GRADISON: That's okay.

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

6 MR. GRADISON: Is it for just one year?

7 MR. WINTER: It can express for two years.

8 DR. ZABINSKI: For two years? Okay.

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

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

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

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

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

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

11 [Laughter.]

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

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

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

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

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

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

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



1 more tests.

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

4 [Laughter.]

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

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

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

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

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

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

12 DR. CROSSON: Kathy.

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

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

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

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

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

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

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

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

22 DR. CHRISTIANSON: This is not on the slides but

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

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

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

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

3 MS. BLONIARZ: No.

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

7 MS. BLONIARZ: Yeah, point taken.

8 DR. CROSSON: Alice.

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

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

15 MS. BLONIARZ: On the bottom of page 39?

16 DR. COOMBS: Mm-hmm.

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

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

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

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

10 DR. COOMBS: Just that transforming clinical  
11 practices initiative.

12 MS. BLONJARZ: That's right.

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

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

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

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

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

13 DR. CROSSON: Clarifying questions?

14 [No response.]

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

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

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

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

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



1           So, Mary.

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

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

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

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

13           Thank you.

14           DR. CROSSON: Okay. Alice?

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

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

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

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

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

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

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

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

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

22           DR. CROSSON: Alice, thank you for making that

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

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

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

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

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

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

22           So here's what I think based on the questions

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

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

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

10 Let's turn to the second recommendation on Page  
11 26, which is a repeat of previous recommendation from the  
12 Commission, Congress eliminate the update for the payment  
13 rates for ambulatory surgery centers for calendar year  
14 2017, in this case. Congress should also require  
15 ambulatory surgical centers to submit cost data. I would  
16 add an editorial comment, that all things being equal, I  
17 think it may be difficult for the Commission in the future  
18 to recommend positive updates in the absence of cost data.

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

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

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

6 DR. CROSSON: Oh, yeah.

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

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

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

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



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

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

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

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

11           MR. WINTER: Yeah, the --

12           DR. MILLER: Yeah.

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

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

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

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

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

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

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

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

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

22           DR. CROSSON: Right.

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

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

5 DR. COOMBS: More likely high.

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

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

14 [Pause.]

15 DR. CROSSON: Kim, welcome.

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

21 As you know, the hospice benefit provides  
22 palliative and supportive services for beneficiaries who

1 choose to enroll. To be eligible, a beneficiary must have  
2 a life expectancy of six months or less if the disease runs  
3 its normal course. At the start of each hospice benefit  
4 period, a physician must certify that the beneficiary's  
5 life expectancy meets this criteria. There is no limit on  
6 how long a beneficiary can be in hospice as long as he or  
7 she continues to meet the life expectancy criteria.

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

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

15           Back in 2009, the Commission found that there had  
16 been substantial entry of for-profit hospices, increases in  
17 length of stay for patients with the longest stays, and  
18 higher lengths of stay among for-profit hospices compared  
19 to nonprofits across all diagnoses. This pattern suggested  
20 that there were new actors entering the hospice field with  
21 revenue generation strategies.

22           So, we looked at the payment system and found

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

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

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

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

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

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



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

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

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

13 The next chart shows the growth in hospice use  
14 among Medicare decedents. Between 2013 and 2014, the share  
15 of Medicare decedents who used hospice increased from 47.3  
16 percent to 47.8 percent. Hospice use has grown most  
17 rapidly for beneficiaries age 85 and older. In 2014, 56  
18 percent of decedents in this age group used hospice at the  
19 end of life. Minorities and beneficiaries in rural areas  
20 continue to have lower hospice use than other  
21 beneficiaries, although hospice use has been increasing for  
22 these groups, as well.

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

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

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

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

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

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

22           In 2014, about 17.2 percent of hospice discharges

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

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

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

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

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

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

11 So, this brings us to Medicare margins.  
12 Different from other sectors, we have historical margin  
13 data through 2013 because 2014 margins are incomplete. So,  
14 for 2013, the aggregate Medicare margin for hospices was  
15 8.6 percent, down from ten percent in 2012. The margin  
16 decline in 2013 partly reflects the effect of the  
17 sequester. The sequester reduced Medicare payments to  
18 hospices by 1.3 percent during the 2013 cost report year.

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

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

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

10           The chart also shows margins by type of  
11 ownership. For-profit hospices have very strong margins,  
12 14.7 percent. The overall margin for nonprofits is lower,  
13 1.2 percent. But when we look just at freestanding  
14 providers, the nonprofit margin is 5.2 percent.

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

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

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

3

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

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

1 reports. Putting all that together, we project a margin in  
2 2016 of 7.7 percent.

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

13 So, this brings us to the Chairman's draft  
14 recommendation. It reads, "The Congress should eliminate  
15 the update to the hospice payment rates for fiscal year  
16 2017."

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



1 for Medicare beneficiaries.

2 So, that concludes the presentation.

3 DR. CROSSON: Thank you, Kim.

4 We are open for questions, comments. Bill.

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

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

1 counselor, or volunteer.

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

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

13           MR. GRADISON: Thank you.

14           MS. NEUMAN: Yes.

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

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

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

1 point they are in sort of implementing the enrollment, but  
2 --

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

5 MS. NEUMAN: Yeah.

6 DR. HOADLEY: -- so whenever thereafter.

7 MS. NEUMAN: Yeah.

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

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

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

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

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

8

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

11 DR. CROSSON: Rita, and then John.

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

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

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

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

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

21 DR. CROSSON: Jon.

22 DR. CHRISTIANSON: Kim, this refers to some

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

8 MS. NEUMAN: No, just analysis.

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

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

20 DR. CHRISTIANSON: Just curious.

21 DR. CROSSON: Mary.

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

1 interrupt. There was no legislative activity around this.

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

3 DR. MILLER: Okay.

4 DR. CROSSON: Mary.

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

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

1 and see.

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

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

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



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

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

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

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

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

4 DR. CROSSON: David.

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

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

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

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

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

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

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

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

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

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

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

1 you know, there's certain diagnoses that we're paying  
2 correctly for or incorrectly for, that type of thing. And  
3 that led to this U-shaped curve, to try and take the  
4 incentive out of like just keep them in there as long as  
5 you possibly can. There was a ton of this work around  
6 2007-2008, 2009, somewhere in there.

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

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

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

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

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

16 DR. CROSSON: Okay. Thank you, Kim.

17 [Pause.]

18

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

21 DR. CARTER: Are we ready?

22 DR. CROSSON: No. I can't find mine.

1 DR. CARTER: No? Okay.

2 DR. MILLER: What do you want, the schedule or  
3 the --

4 DR. CROSSON: No. I'm looking for the SNF  
5 handout here. Give me one second. I've got it here  
6 somewhere. I'll find it.

7 I'm sorry. We're going to talk about SNFs.  
8 Carol?

9 DR. CARTER: Great. Before I get started, I  
10 wanted to thank Anna Harty for her help with this chapter.

11 Today I'll be presenting an overview of the SNF  
12 industry and then present some information related to the  
13 update and end with a summary of the Medicaid trends that  
14 we are required to report.

15 To start with a sketch of the industry, there are  
16 just under 15,000 providers that participate in the  
17 Medicare program. About 1.7 million, or about 4.5 percent  
18 of beneficiaries, use SNF services. Program spending was  
19 just under \$29 billion in 2014, and Medicare makes up 12  
20 percent of days but 21 percent of revenues.

21 I will be using our update framework, which we're  
22 all now very familiar with. I'll go through the material

1 quickly, but there's more detail in the chapter.

2           Access to SNF services is adequate and stable.

3 Supply was steady between 2013 and 2014. About 90 percent  
4 of beneficiaries live in counties with at least three SNFs,  
5 and the majority live in counties with 10 or more.

6 Occupancy rates were unchanged in 2014 but remained  
7 relatively high at 86 percent. However, about one-quarter  
8 of facilities have occupancy rates below 76 percent.

9           Between 2013 and 2014, covered admissions and  
10 days declined, consistent with the decline in inpatient  
11 hospital stays, which is a prerequisite for SNF coverage by  
12 Medicare. However, the decline in SNF volume was smaller  
13 because, as the complexity of cases in hospitals increased,  
14 a larger share of hospital stays were discharged to SNFs.

15           The mix of days reflects the biases of the PPS  
16 design. Since the SNF PPS was implemented, there has been  
17 a steady increase in the share of days classified into the  
18 intensive rehab therapy case-mix groups. In 2014, 81  
19 percent of the days were assigned to these groups.

20           Even though the number case-mix groups for  
21 medically complex patients was expanded, their share of  
22 days remains low.



1           The high growth in the amount of therapy  
2 furnished is not related to patient characteristics.  
3 Rather, the growth reflects three design features of the  
4 payment system. First, the amount of therapy drives  
5 payments. Second, that as more therapy is furnished,  
6 providers' costs increase, but payments increase even more.  
7 Furnishing more therapy is more profitable than furnishing  
8 less therapy. And last, payments for non-therapy ancillary  
9 services, such as drugs, do not track these services'  
10 costs, and as a result, the payments for these services are  
11 poorly targeted.

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

17           The average facility rates of discharge back to  
18 the community and potentially avoidable readmissions during  
19 the SNF stay show small improvements between 2013 and 2014,  
20 although the community discharge rate was -- the increase  
21 was not statistically significant -- no, I got that wrong.  
22 The one that during the SNF stay was not statistically

1 significant.

2           So we have improvements in two measures, but the  
3 increase in readmissions after the stay show a worsening of  
4 that quality measure, and the two function measures show no  
5 change and were essentially unchanged between the two  
6 years.

7           In terms of access to capital, industry analysts  
8 report that capital is generally available and expected to  
9 continue during 2016. Some lenders are reluctant to lend  
10 to nursing homes, but this reflects uncertainties about the  
11 federal budget, lower volume in the sector, and future  
12 Medicare policies, not the level of Medicare payments.  
13 Medicare continues to be a payer of choice.

14           In 2014, the average margin for freestanding  
15 facilities was 12.5 percent. This was the 15th year in a  
16 row that the average was above 10 percent, and these  
17 margins reflect the impact of the sequester.

18           Across facilities, margins vary eight-fold. One-  
19 quarter of SNFs had margins of 2.4 percent or lower, and  
20 one quarter had margins of at least 21.2 percent. There  
21 continued to be large differences between non-profit and  
22 for-profit facilities in part due to the mix of their

1 patients and therapy practices, but also because on average  
2 they are smaller, they have higher costs per day, and  
3 recently have had higher cost growth compared with for-  
4 profit facilities. The marginal profit in this sector was  
5 20 percent, indicating that facilities with free beds would  
6 have an incentive to admit Medicare patients.

7           We also compared margins in the top and bottom  
8 quartiles of the distribution of Medicare margins.  
9 Compared to lower-margin SNFs, high-margin SNFs had  
10 considerably lower cost per day after adjusting for  
11 differences in case-mix and wages in part because they have  
12 higher average daily census and they have longer stays over  
13 which that yield more economies of scale. They have lower  
14 routine and ancillary costs per day.

15           And on the revenue side, high-margin SNFs have  
16 higher revenues per day in part because they provide more  
17 intensive therapy and have fewer medically complex days.

18           In assessing the level of payments, we also look  
19 at the rates that some MA and managed care plans pay for  
20 SNF care. In the four publicly traded firms, fee-for-  
21 service rates average 23 percent higher than MA/managed  
22 care rates, yet our analysis of patient assessment data

1 indicate that the characteristics of the users enrolled in  
2 MA and fee-for-service are not that different and would not  
3 explain the differences in payments. The publicly traded  
4 firms also report seeking managed care business, suggesting  
5 that the rates are attractive.

6           Each year we look at efficient providers, using  
7 three years of performance to identify SNFs with relatively  
8 low cost and high quality. In 2014, there were almost 900  
9 SNFs, and that was 8 percent of the SNFs included in the  
10 analysis that were relatively efficient.

11           Compared to other SNFs, they had standardized  
12 costs that were 8 percent lower, community discharge rates  
13 that were 27 percent higher, and readmission rates that  
14 were 16 percent lower. They were also larger, allowing  
15 them to achieve greater economies of scale. The  
16 combination of their low cost and high revenues per day  
17 results in an average Medicare margin for this group of 20  
18 percent.

19           To estimate the average 2016 margin, we assumed  
20 that costs would grow at the market basket between 2014 and  
21 2016.

22 To estimate payments, we updated the payments by the market

1 basket updates, net of productivity and the sequester. For  
2 2015, we also reduced payments to account for the last year  
3 of changes to the bad debt policies, and in 2016, there is  
4 a forecast error correction. The estimated average  
5 Medicare margin in 2016 is 10.7 percent, and this also  
6 includes the impact of the sequester.

7           In considering how Medicare payments should  
8 change for 2017, the broad circumstances of the this  
9 industry have not changed. The PPS continues to favor  
10 therapy over medically complex care. The level of  
11 Medicare's payments remains too high. The wide variation  
12 of Medicare margins reflects differences in patient  
13 selection, the mix and amount of services furnished, and  
14 cost control. The Commission has recommended that the SNF  
15 PPS be revised and the level of payments be rebased, and  
16 we'd like to review the evidence for each of those.

17           The Commission first recommended revising the PPS  
18 in 2008, and since then, we have continued to evaluate the  
19 accuracy of this payment system. Our work with the  
20 researchers at the Urban Institute has found that over  
21 time, payments for therapy and non-therapy services has  
22 gotten worse, despite the many changes made to the payment

1 system.

2           The overpayments for therapy services are larger,  
3 and there is increased evidence that unnecessary therapy  
4 services are furnished and payments for NTA services are  
5 poorly targeted.

6           Although there are not widespread access  
7 problems, we continue to hear that certain types of  
8 patients can be difficult to place at discharge from the  
9 hospital. The large difference in Medicare margins partly  
10 reflects the systematic biases of the PPS that at this  
11 point are well known and need to be corrected.

12           Without increasing total spending, the design we  
13 proposed would shift payments within the industry. We  
14 estimated that payments would decrease for SNFs that  
15 furnish a lot of intensive therapy and would increase for  
16 SNFs that treat a high share of medically complex patients.

17           Based on a facility's mix of cases and therapy  
18 practices, payments would shift from freestanding SNFs to  
19 hospital-based facilities and from for-profit to non-profit  
20 SNFs -- and you can see the numbers on the slide --  
21 basically from the highest margin providers to lower margin  
22 providers. Payments would also increase for rural

1 facilities.

2           Now let's consider why to rebase the payments.

3 The average Medicare margin has been above 10 percent since  
4 2000. In 2014, the Medicare margin was 12.5 percent, and  
5 the marginal profit was 20 percent. We project the  
6 Medicare margin in 2016 to remain above 10 percent.

7           Our analysis of efficient providers shows that it  
8 is possible to furnish relatively low-cost, high-quality  
9 care and remain highly profitable. And, finally, fee-for-  
10 service payments are considerably higher than some  
11 MA/managed payment rates.

12           The evidence for the need to revise and to rebase  
13 the PPS is compelling, yet there has been little movement  
14 from CMS and the Congress on reforming the payment system.  
15 Last year, the Commission expressed growing impatience with  
16 the lack of progress. The structure of our recommendation  
17 may contribute to the delay because we call for the PPS to  
18 be first revised and then for rebasing to occur.

19           We did this to protect low-margin, typically non-  
20 profit SNFs. The large disparities in margins -- that's  
21 kind of in the neighborhood of 10-percentage-point spread  
22 between for-profit and not-for-profit facilities -- made us

1 reluctant to take large reductions in payments without  
2 first revising the PPS to redirect payments to the low-  
3 margin SNFs. An alternative strategy would be to set much  
4 smaller rebasing steps in motion while the PPS is revised.

5           This leads us to the Chairman's draft  
6 recommendation, and it reads: The Congress should  
7 eliminate the market basket for 2017 and 2018 and direct  
8 the Secretary to revise the prospective payment system for  
9 skilled nursing facilities. In 2019, the Secretary should  
10 report to the Congress on the impacts of the reformed PPS  
11 and make any additional adjustments to payments needed to  
12 more closely align payments with cost.

13           The propose rebasing would be done in two small  
14 steps, with no update in 2017 and 2018, and a final  
15 adjustment, perhaps, in 2019 after the Secretary has  
16 evaluated the need for further adjustments.

17           In terms of implications relative to current law,  
18 program spending would decrease. For beneficiaries, access  
19 for medically complex patients will increase, and for  
20 providers, the recommendation will reduce the disparities  
21 in Medicare margins across providers. The impact on  
22 individual providers will vary based on their mix of cases



1 and their current practice patterns.

2           Finally, as required by PPACA, we examine  
3 Medicaid trends in spending and financial performance for  
4 nursing homes. About 15,000 facilities participated in  
5 Medicaid, and that was a small decrease from 2014.  
6 Medicaid spending is estimated to be \$52 billion in 2014,  
7 and that's a small increase -- I mean, that was from '15 --  
8 and that's a small increase form '14, and spending is  
9 projected again to increase in 2016.

10           The non-Medicare margin for 2014 was a negative  
11 1.5 percent, and that was a slight improvement from last  
12 year. And the total margin remained at 1.9 percent.

13           And with that, I look forward to your discussion.

14           DR. CHRISTIANSON: So we'll start with questions,  
15 clarifications. Bill?

16           MR. GRADISON: On page 20, we're told that  
17 hospitals are increasingly establishing preferred provider  
18 networks with higher quality SNFs, hoping to lower their  
19 own readmission rates --

20           DR. CARTER: Yes.

21           MR. GRADISON: -- in exchange and so forth. I  
22 thought they weren't permitted to steer. What's going on

1 there?

2 DR. CARTER: I think they're explicitly not, but  
3 I think that -- what we've heard is there is some soft  
4 steering that goes on; that is, hospitals have to provide a  
5 list of post-acute care providers to a patient, but they  
6 can recommend providers to a patient, either because of  
7 their experience with a patient or kind of the practice  
8 patterns that they know that they're comfortable with.

9 So I think -- I mean, I use the term "soft  
10 steering," but I think that that does go on.

11 MR. GRADISON: Thank you.

12 DR. CARTER: Mm-hmm.

13 MR. KUHN: So, Carol, a quick question on your  
14 identification of the efficient skilled nursing facilities.  
15 Are they pretty much random across the country, or are they  
16 clustered in any particular areas? And I guess my point is  
17 -- I'm curious -- areas that are more mature in terms of  
18 care coordination, per diem payments, or at-risk payments.  
19 Are they more efficient and clustered in certain areas, or  
20 is that pretty much all over the country?

21 DR. CARTER: They are all over the country, and  
22 we even had two in Frontier areas, but I haven't looked

1 kind of by market type. But I have seen them. They are  
2 across the country.

3 MR. ARMSTRONG: I'm looking at Slide 17, and I  
4 understand the case for advancing this kind of rebasing,  
5 but I'm wondering why 7 percent?

6 DR. MILLER: So here, if I understand your  
7 question, maybe I'll start off.

8 MR. ARMSTRONG: Okay.

9 DR. MILLER: This is not a proposed number or  
10 policy number. What Carol did with the Urban Institute  
11 folks is said if you re-torqued the PPS system to pay on a  
12 patient characteristic base for therapy services -- and  
13 there's more to it than that, but that's the big driver --  
14 this is what happens.

15 MR. ARMSTRONG: Oh, this is the outcome of it.

16 DR. MILLER: Right.

17 MR. ARMSTRONG: Okay.

18 DR. MILLER: And then just to round it out, the  
19 rebase or the payments that are policy steps and we're  
20 proposing instead of what we've said previously take a 4  
21 percent reduction, we're saying take a softer two-year  
22 freeze while this is happening, and it's because of the

1 concerns raised by the Commissioners the last time of,  
2 like, how do we build a fire here.

3 MR. ARMSTRONG: So I get the two to three year  
4 process you just described, and you used the word "re-  
5 torquing." I'm not sure if that's exactly the right word,  
6 but I'll use it.

7 [Laughter.]

8 MR. ARMSTRONG: So let's assume re-torquing the  
9 payment structure ends up with these kinds of shifts. Do  
10 we think that that's the right place to get to, these  
11 shifts? Because looking at some other data, it was quite  
12 dramatic, the amount of intensive therapy compared with the  
13 other kinds of services, and this is, frankly, a more  
14 subtle shift.

15 DR. CARTER: Right. And, actually, if you look  
16 at sort of more patient categories as opposed to -- these  
17 are sort of provider groups. But, for example, providers  
18 that have furnished low amounts of therapy, their payments  
19 would increase 16 percent, or if you concentrate in low  
20 intensive, so you don't have a lot of the high, ultra-high  
21 payments to those guys would go up 32 percent. So these  
22 are provider-level characteristics, and maybe I'll include

1 some of these other impacts.

2           It was in our report with Urban Institute last  
3 year, but there is more movement of money around, and as  
4 Mark said, these are budget-neutral. So this is agnostic  
5 about what's the level. If we kept the level the same, how  
6 does money move around?

7           DR. CHRISTIANSON: Sue? Bill, anything? Bill  
8 Hall? No? Mary.

9           DR. NAYLOR: Briefly, on Slide 8, in equality  
10 work -- first of all, great report. Can you give us a  
11 sense of -- this is the performance of skilled nursing for  
12 -- and then you had all the common diagnoses -- hip, joint,  
13 heart failure, shock. But can you give us a sense of how -  
14 - what the performance of skilled nursing is relative to  
15 alternative sectors, home care, so if someone goes home  
16 with the same diagnosis? Do we have that kind of -- I  
17 mean, this is a shift year to year in this sector, but do  
18 we have a sense of how overall quality measures relate from  
19 one sector to another?

20           DR. CARTER: Well, interesting you ask that  
21 because we're working -- because we are working on a  
22 consistently defined readmission measure across the post-

1 acute care settings.

2 Right now, the SNF sector, the IRF sector, the  
3 home health sector all use readmission rates in measuring  
4 quality, and we all define it just a little bit  
5 differently. And you can't really compare the rates. I  
6 could say the home health rates are higher, but they  
7 actually -- they are defined differently.

8 So I'm reluctant to kind of characterize that,  
9 but we are hoping to bring forward -- not for next month,  
10 but in the future because we are actively working on a  
11 common readmission measure across the settings.

12 DR. CROSSON: Warner. Pass. Cori.

13 MS. UCCELLO: Can I just get clarification on  
14 kind of what it is we're saying here. So, in the past,  
15 we've said we wanted to shift the way the payments are  
16 made, and then the thought that, well, maybe the way we're  
17 saying this isn't getting us anywhere, so maybe we should  
18 kind of figure out a different way to do this. So, now --  
19 so, what is this saying? So, we're just keeping payments  
20 flat, but at the same time saying, but move ahead with this  
21 redoing the way the payment system works.

22 DR. CROSSON: Both with reforming the structure

1 of the payment system and examining whether or not there  
2 should be further reductions, as well. Two things.  
3 Simultaneous.

4 MS. UCCELLO: At the same time?

5 DR. CROSSON: At the same time.

6 DR. MILLER: So, the way I would characterize it  
7 is there was always great concern to going to a rebasing,  
8 and in that instance, and maybe we do -- speaking of  
9 terminology, maybe we need some other terminology here. We  
10 were saying, given that these margins are so high, we  
11 should actually take the rate down, and we were saying at  
12 the time as much as four percent in the first step and then  
13 figure out from there. And that's a healthy step.

14 But we said, given that that's so healthy and  
15 we're concerned about the disparities, first, reform the  
16 PPS, which is a -- and Kathy drives on this point a lot --  
17 that's a Secretarial activity.

18 And, so, here we are. You know, we've been  
19 saying this for a few years, and I think, among others, but  
20 Kathy, I think, raised this last time, is there anything we  
21 can do to get to more forward motion. And, so, now what  
22 we're saying is, you should do this now. You should reform

1 the PPS, and by the way, your rates are frozen now for two  
2 years.

3           And just to make sure you understand the math  
4 here, this is not taking the rate down four points  
5 immediately, obviously. But to the extent that it's frozen  
6 for two years and they have any cost growth, they're going  
7 to have to deal with that without a rate increase. So,  
8 you're putting pressure on them and saying, we're moving  
9 ahead, but not as aggressively, but we're moving ahead, and  
10 you need to reform this PPS, and then we're trying to put a  
11 back-end piece and say, Mr. or Ms. Secretary, you need to  
12 report out on what you've done here.

13           We can obviously report out on it, too. That  
14 would just be a matter of course for us to do that as part  
15 of our work. But we're trying to send some clear signals.  
16 Move ahead. Secretary, you need to report a stronger  
17 message. This should move. That's how we're trying to  
18 accommodate the comments we heard.

19           MS. UCCELLO: Okay. Thank you for that  
20 clarification. I had forgotten the way that we had ordered  
21 it before. So, this makes complete sense. I think our  
22 priority -- the priority should be restructuring the PPS,



1 because I am very concerned about particular types of  
2 beneficiaries who are having trouble getting access. So, I  
3 think this gets at that, and if this helps us get there  
4 faster, fabulous.

5 DR. CROSSON: Thank you. Moving up this way,  
6 clarifying comments. So, I think -- I'm sorry. Kathy.

7 MS. BUTO: What, roughly, do we think our  
8 recommendation would have been for the updates in the  
9 absence of recommending that they be frozen for two years  
10 to put increased pressure on --

11 DR. CARTER: Well, we have --

12 MS. BUTO: Would we have been at zero anyway?  
13 I'm just curious --

14 DR. CARTER: Well, we have a -- I guess the  
15 question would be, our standing recommendation was to  
16 freeze the rates in one year --

17 MS. BUTO: Yeah.

18 DR. CARTER: -- which I guess would be this year,  
19 and to take a four percent cut next year. So, one question  
20 would be, if we weren't doing this, would we fall back to  
21 our standing recommendation or would we consider something  
22 else.

1 MS. BUTO: Right. I'm just trying to figure out  
2 why a two-year freeze, then, as opposed to a freeze and a  
3 reduction --

4 DR. MILLER: [Off microphone.] Well, that's kind  
5 of what we were doing before --

6 MS. BUTO: The freeze and the reduction, yeah.  
7 And why --

8 DR. CROSSON: A freeze and a significant  
9 reduction.

10 MS. BUTO: Right. So, why would this  
11 recommendation put more pressure on?

12 DR. MILLER: I mean, the real shift in the  
13 pressure is we're no longer saying -- assuming you guys  
14 agree, and we're trying to respond to what we thought you  
15 guys were saying -- don't wait around to take the rebasing.  
16 But at the same time, you have expressions over here, but  
17 I'm concerned that we don't sink the not-for-profits or  
18 whoever, and so it's a way to kind of move a little more  
19 cautiously in the short run, but to move as opposed to wait  
20 and then move. So, it's a subtle difference, but we're  
21 trying to balance the concern that it not put one part of  
22 the industry underwater, but to have forward motion.

1           And before, we dealt with that concern by saying,  
2 don't rebase until you have reformed the PPA. Now, we're  
3 saying we're moving ahead, but we're moving ahead less  
4 aggressively. You might not view that as yet aggressive  
5 enough, but --

6           The only other thing I would say is we made the  
7 original recommendation before the sequester came into  
8 effect, and so that might be another reason to sort of --

9           DR. CROSSON: Jack.

10          DR. HOADLEY: What's the current statutory  
11 scheduled reduction, or, I mean, update factor for --

12          DR. CARTER: They get the marketbasket minus  
13 productivity.

14          DR. HOADLEY: And what does that amount to in  
15 this --

16          DR. CARTER: Two and change.

17          DR. HOADLEY: So --

18          DR. CARTER: I mean, it varies. The productivity  
19 factor has ranged from kind of 0.4 to 0.8 over time --

20          DR. HOADLEY: So, it's still to be determined --

21          DR. CARTER: -- and it's kind of in the two, two-  
22 plus range in terms of update.

1 DR. HOADLEY: But, presumably, if -- so, to go to  
2 a no update, Congress would have to act to do that, but  
3 even if Congress didn't act to do that, the Secretary could  
4 respond to this recommendation and say, start the process  
5 of changing the PPS things. Without the pressure of a zero  
6 update, it would still start to move things around in the  
7 direction we thought would be useful.

8 DR. MILLER: Which she could have always --

9 DR. HOADLEY: Could always do.

10 DR. MILLER: -- could have always done. I think  
11 -- and again, this is maybe too subtle to have the effect,  
12 but the other thing this is saying to that portion of the  
13 industry that's on the lower side of the margins, you know,  
14 if the Congress acts here and starts to freeze for two  
15 years, your margins, or your payments, are going to be the  
16 first that -- you're going to feel it the fastest.

17 And, so, the other way to look at this is maybe  
18 it gets that portion of the industry to go to CMS and say,  
19 why aren't you moving on the reforms, and I think this was  
20 some of --

21 MS. BUTO: [Off microphone.] That's more of what  
22 -- yeah.

1 DR. MILLER: -- what was being said a year ago  
2 about this topic.

3 DR. CROSSON: Okay. I think -- this is obviously  
4 a new recommendation. This is not a repeat of a  
5 recommendation from before. So, we can either bring this  
6 back in January again, and I'm willing to do that, or not,  
7 but rather than do an informal thing, I'd like, on this  
8 particular case, I'd like to go around and hear from  
9 everybody in terms of whether this is supported, if so,  
10 why, briefly, or if not, why not, so we can get a sense of  
11 where we are.

12 Jon, do you want to start.

13 DR. CHRISTIANSON: Yeah. I think the Commission  
14 has been very frustrated by this for a while and some new  
15 strategy is needed and I think this is a reasonable new  
16 strategy, so I would support it.

17 DR. CROSSON: Sorry. Alice.

18 DR. COOMBS: I would agree with supporting this,  
19 given the data that we have with the margins and that we  
20 fulfill all of our questions in terms of access and access  
21 to capital and how the industry has been doing. So, I  
22 would support it.

1 DR. CROSSON: Thank you. Kate.

2 DR. BAICKER: I am supportive, as well. I think  
3 the retorquing is particularly important.

4 DR. MILLER: Thank you.

5 DR. BAICKER: It's our collective favorite word  
6 of the day. It's particularly important in balancing  
7 payments equitably. The right strategy for then dialing up  
8 or down simultaneously is a little less clear to me and  
9 this seems like a perfectly good strategy, but I don't feel  
10 strongly that others wouldn't also potentially work. But  
11 with the rebalancing, it seems like the important first  
12 step.

13 DR. CROSSON: Thank you. David.

14 DR. NERENZ: Yeah. I can support. I  
15 particularly like the emphasis on the reformed PPS and then  
16 the subsequent effects on sort of the differential wins and  
17 losses.

18 DR. REDBERG: I also support the recommendation  
19 and the retorquing of the PPS.

20 DR. CROSSON: Are we inventing new words?

21 DR. MILLER: Now I think they're just piling on.

22 [Laughter.]

1 DR. MILLER: And I would encourage --

2 DR. CROSSON: I'm getting a little confused here  
3 between tweeting, twerking, twocking --

4 DR. MILLER: Don't go there --

5 [Laughter.]

6 DR. HOADLEY: So, I support the retorquing and I  
7 support the recommendation, and I think, if nothing else,  
8 the fact that we will have a new recommendation and we're  
9 not just sort of reprinting in and of itself is a statement  
10 that we're making, and I think that's very useful.

11 DR. CROSSON: Cori.

12 MS. UCCELLO: As long as I understand this  
13 correctly, which is a big "if" --

14 [Laughter.]

15 MS. UCCELLO: -- I strongly support this. And, I  
16 just -- I just really think the priority needs to be  
17 restructuring the PPS on this. So, however way that is  
18 made clear, I am a hundred percent behind it. As long as I  
19 understand it.

20 MR. THOMAS: I support the recommendation.

21 DR. CROSSON: Thanks. Mary.

22 DR. NAYLOR: I support Cori. As long as I

1 understand what she understands, I'm good.

2 [Laughter.]

3 MR. GRADISON: Way to go.

4 DR. CROSSON: Bill?

5 DR. HALL: I support the recommendation.

6 DR. CROSSON: We can't put two Bills --

7 MS. THOMPSON: As do I.

8 DR. CROSSON: Sue. Scott.

9 MR. ARMSTRONG: Yeah. I support this direction,  
10 too. I think the -- it's one of those great examples -- by  
11 the way, I also endorse this idea of impatience and would  
12 second that emotion, I guess.

13 [Laughter.]

14 MR. ARMSTRONG: But, this is also one of those  
15 where a part of the tricky part is that skilled --  
16 investing in skilled nursing facility services is good. I  
17 mean, we like this. And yet, it's kind of out of context  
18 when you're just looking at the payment for that  
19 experience. And, so, it's one of those where you want to  
20 solve it. There are probably better solutions than  
21 retorquing PPS, but given that we're working inside of  
22 that, I really think that's the right approach to take.



1 DR. CROSSON: Thank you. Herb.

2 MR. KUHN: I support the recommendation for many  
3 things, as I said, but I do really like the fact that this  
4 is an updated and refinement of past policies and I think  
5 that makes it fresh and current and will be helpful.

6 DR. CROSSON: Good. Thanks. Kathy.

7 MS. BUTO: Yeah. I strongly support this, in the  
8 spirit of inpatients. I would like to -- would encourage  
9 us to think about adding some language that encourages the  
10 Secretary to move ahead on the retorquing or refinement of  
11 the PPS, even as Congress deliberates as to what to do  
12 about the update factor. So, I'd just like to see  
13 something like that that, again, acknowledges that we know  
14 she has some flexibility to move ahead.

15 DR. CROSSON: I'm just a little confused, though.  
16 We're saying direct the Secretary to revise the PPS. Are  
17 you saying we need stronger language than that, or am I  
18 missing something?

19 MS. BUTO: Well, it's -- because that direct  
20 relates to Congress directing the Secretary, right?

21 DR. CROSSON: Oh, you want us to directly direct?

22 MS. BUTO: To point out -- or not so much that,

1 but to encourage the Secretary to move ahead even as  
2 Congress thinks about this, or doesn't do anything, or  
3 whatever it is they're going to do.

4 DR. CROSSON: We need some wordsmithing here.  
5 Herb, you got it?

6 MR. KUHN: I don't know if I have it. The only  
7 thing I would just say is kind of a friendly amendment to  
8 what Kathy is saying, is if we were to go that direction,  
9 the other thing we do need to kind of assert here, and  
10 maybe in the other recommendations where we're asking for  
11 more energy and activity with the Secretary, CMS does need  
12 the resources to implement this stuff. I mean, these are  
13 not easy to put in place. You've got to get contractors.  
14 There's a lot of work. So, if we do add something like  
15 Kathy is speaking about, let's also make sure that we  
16 reiterate the need for CMS to have sufficient resources to  
17 implement.

18 DR. MILLER: And to your question is would it be  
19 -- and particularly if it's going to be more commentary,  
20 about them, you know, the Secretary and CMS getting this  
21 done, I wonder if that sits better in the text following  
22 the recommendation, where we say, again, more eloquently

1 than this is about to happen, but, you know, we've made  
2 this recommendation for many years. We are very concerned  
3 about the disparities. Urge you again, if there are  
4 resources, you know, that kind of thing. And it allows you  
5 a lot more flexibility than trying to get this, where it  
6 could be kind of brutal trying to get all that in there.

7 MS. BUTO: One last comment. Because we are also  
8 thinking in the larger context of things like waiving the  
9 three-day prior hospitalization requirement, things like  
10 that, I think we can acknowledge, or maybe we do this but  
11 it's more subtle than I think, that we think these  
12 institutions are going to play an incredibly important role  
13 going forward, and the Commission has looked at a number of  
14 ways in which that role may expand. And, so, it's really,  
15 really important to get it right, or get it better, in  
16 terms of the way they're paid and paid fairly and  
17 equitably. So, some language like that, without getting  
18 too emotional about it, I think that's where we're headed,  
19 is that we think these institutions are going to play a  
20 much more significant role going forward, even vis-a-vis  
21 IRFs and other entities.

22 DR. CROSSON: Right.

1 DR. MILLER: And I think I can see, you know,  
2 three, four paragraphs following the recommendation that  
3 kind of captures what just happened here.

4 DR. CROSSON: Right. Very well said.  
5 Okay. Thank you, Carol.

6 And we come to our dialysis services update.

7 [Pause.]

8 DR. CROSSON: Okay. Nancy and Andrew. Nancy, it  
9 looks like you're going to start off?

10 MS. RAY: Yeah.

11 DR. CROSSON: Go ahead.

12 MS. RAY: Good afternoon.

13 Outpatient dialysis services are used to treat  
14 most patients with end-stage renal disease. In 2014, there  
15 were about 383,000 Medicare fee-for-service dialysis  
16 beneficiaries treated at roughly 6,300 facilities. Total  
17 Medicare spending on dialysis services was \$11.2 billion in  
18 2014.

19 This presentation is composed of three parts.  
20 First, I will proceed with the adequacy analysis and  
21 provide you with information to help support your  
22 assessment of the adequacy of Medicare's payments for

1 dialysis services and the Chairman's draft recommendation  
2 for the 2017 payment rate. Next, Andy will discuss  
3 regulatory changes to the dialysis prospective payment  
4 system that CMS will implement in 2016 and two aspects of  
5 the PPS that may continue to need attention.

6           So moving to our payment adequacy analysis, here  
7 are the factors listed on this slide that you've seen for  
8 the other sectors.

9           We look at beneficiaries' access to care by  
10 examining industry's capacity to furnish care as measured  
11 by the growth in dialysis stations, treatment stations.  
12 Between 2013 and 2014, growth in dialysis treatment  
13 stations grew slightly faster than beneficiary growth.  
14 Between 2013 and 2014, there was a net increase of about  
15 235 facilities. Few facilities, roughly 40, closed in  
16 2013., and the closed facilities were smaller, more likely  
17 to be hospital-based and non-profit compared to all other  
18 facilities.

19           Few patients, less than 1 percent, were affected  
20 by these closures, and there is no indication that affected  
21 patients were unable to obtain care elsewhere.

22           Another indicator of access to care is the growth

1 in the volume of services. We track volume growth by  
2 assessing trends in the number of dialysis treatments and  
3 dialysis beneficiaries. Between 2013 and 2014, the total  
4 number of dialysis beneficiaries and treatments grew by 2  
5 percent. Treatments per beneficiary remained steady in  
6 both years.

7 We also look at volume changes by measuring  
8 growth in the volume of dialysis drugs furnished. Dialysis  
9 drugs are an important component of care. Since the PPS  
10 was implemented in 2011, dialysis drugs have been included  
11 in the payment bundle. Consequently, providers' incentive  
12 to furnish them, in particular the two erythropoietin  
13 stimulating agents, ESAs, has changed. ESAs are the  
14 leading dialysis drug class in terms of utilization.

15 Before implementation of the dialysis PPS in  
16 2011, there were both clinical and financial reasons for  
17 their overuse. As anticipated, after the PPS, ESA use went  
18 down significantly. Between 2010 and 2014, their use  
19 declined by about 45 percent per treatment. This outcome  
20 was expected and has occurred without any sustained change  
21 to beneficiaries' health status.

22 As you can see from the figure, most of the

1 decline occurred during the initial years of the PPS.  
2 Between 2013 and '14, use has remained relatively constant.

3           Next, we look at dialysis quality by examining  
4 changes between 2010, the year prior to the dialysis PPS,  
5 and 2014. CMS compiled these data. Mortality and hospital  
6 admissions are trending down while emergency department use  
7 has modestly increased.

8           The percent of dialysis beneficiaries using home  
9 dialysis, which is associated with improved quality of life  
10 and patient satisfaction, has modestly increased between  
11 2010 and 2014.

12           Your mailing materials discuss a shortage that  
13 began in fall of 2014 of the solutions necessary to perform  
14 one type of home dialysis. We will be watching the effect  
15 of this shortage on patients' access to home dialysis.

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

20           So moving to our analysis of payments and costs,  
21 in 2014, the Medicare margin is 2.1 percent. This reflects  
22 the sequester in 2014.

1           The biggest difference across freestanding  
2 facilities is the difference between rural and urban  
3 facilities. The aggregate Medicare margin for rural  
4 facilities, which account for about 20 percent of  
5 facilities, is negative 2.7 percent.

6           The lower Medicare margin for rural facilities is  
7 related to their capacity and treatment volume. Rural  
8 facilities are on average smaller than urban facilities.  
9 They have fewer stations and provide fewer treatments. And  
10 smaller facilities on average have higher cost per  
11 treatment than larger facilities.

12           Like the other sectors, we also calculated the  
13 rate of marginal profit; that is, the rate at which  
14 Medicare payments exceed providers' marginal cost.

15           In 2014, the marginal profit is nearly 18  
16 percent, suggesting facilities with available capacity have  
17 an incentive to treat Medicare beneficiaries.

18           So the 2016 Medicare margin is projected at 0.8  
19 percent. This margin reflects statutory changes in 2015  
20 and 2016 that are listed on the slide and regulatory  
21 changes implemented by CMS in 2015. It also includes the  
22 small estimated reduction in total payments due to the ESRD



1 Quality Incentive Program, the QIP. This projection  
2 reflects the sequester.

3 Policy changes to occur in 2017 include the  
4 statutory update of the base payment rate reduced by the  
5 productivity adjustment less 1.25 percentage points. They  
6 were also -- in 2017, CMS estimates a small reduction in  
7 total payments due to the ESRD QIP.

8 So here is a quick summary of the payment  
9 adequacy findings. Access to care indicators are  
10 favorable. Quality is improving for some measures. The  
11 nearly 18 percent marginal profit suggests that facilities  
12 with available capacity have an incentive to treat Medicare  
13 beneficiaries. The 2016 Medicare margin is projected at  
14 0.8 percent.

15 The Chairman's draft recommendation reads that  
16 the Congress should increase the outpatient dialysis  
17 payment rate be by the update specified in current law for  
18 calendar year 2017. Under current estimates of the market  
19 basket index and productivity adjustment, this would result  
20 in an update of 0.75 percent.

21 This draft recommendation has no effect on  
22 spending relative to the statutory update. There may be

1 increased financial pressure on some providers, but we do  
2 not anticipate that it will impact their willingness or  
3 ability to furnish care. We do not anticipate this  
4 recommendation impacting beneficiaries.

5 So now we are going to shift gears and discuss  
6 changes that CMS has finalized to the dialysis PPS and two  
7 continuing concerns.

8 DR. JOHNSON: Thanks, Nancy.

9 In 2016, CMS will implement a revised version of  
10 the ESRD PPS for the first time since the expanded ESRD  
11 bundle was introduced in 2011. The American Taxpayer  
12 Relief Act required the Secretary to analyze the case mix  
13 adjustment and make changes as necessary. These changes do  
14 not affect the Commission's consideration of a payment  
15 update because they will be implemented in a budget-neutral  
16 manner.

17 The revised PPS will include recalibrated  
18 adjustment factors based on data from 2012 and 2013 as well  
19 as three significant changes to the structure of the  
20 adjustment factors. Overall, the recalibration and  
21 refinement of the PPS will reallocate about 4 percent of  
22 total facility payments from the base rate per treatment

1 amount to the aggregate payment amounts generated by the  
2 adjustment factors.

3           Dialysis providers have expressed many concerns  
4 with the PPS revision. We generally share these concerns  
5 and in August provided further detail in a comment letter  
6 to CMS.

7           For the structural changes, first, CMS will drop  
8 two of the six comorbid conditions identified for ESRD  
9 patients. CMS found that the documentation required for  
10 facilities to receive the adjustment did not match the  
11 diagnostic and clinical practices related to those  
12 conditions. Dialysis providers have told us that the other  
13 comorbid conditions remaining in the PPS may have a similar  
14 situation.

15           Second, CMS is making adjustments to the facility  
16 low-volume adjustment, which applies to facilities with  
17 fewer than 4,000 treatments in each of the 3 prior years.

18           And, third, CMS will also implement a new  
19 adjustment for rural status, which will increase the  
20 payment amount for all facilities located outside of an  
21 MSA. We expand on these last two changes on the next  
22 slide.

1           The adjustment for facility low volume is the  
2 first of two ongoing PPS issues we will discuss today that  
3 have open recommendations from the Commission. These two  
4 recommendations will be reprinted in this year's update  
5 chapter.

6           The Commission has long held that an adjustment  
7 for facility low volume should protect facilities that are  
8 critical for beneficiary access to dialysis.

9           For 2016, CMS will make changes that affect the  
10 targeting of this adjustment. When determining low-volume  
11 status, CMS will now take into account whether facilities  
12 under common ownership are within five miles of one  
13 another. However, for facilities under different  
14 ownership, CMS does not consider distance to the nearest  
15 facility. Although we believe this is an improvement over  
16 the prior policy, further changes are needed to better  
17 target the low-volume adjustment. We reiterate our prior  
18 recommendation that the Secretary should consider distance  
19 to nearest facility when determining status for the low-  
20 volume adjustment.

21           Finally, in creating an adjustment for rural  
22 facilities, CMS cited the Commission's support of

1 protecting isolated facilities that are critical for  
2 beneficiary access. The rural adjustment, however, will be  
3 applied to all facilities located outside an MSA. Again,  
4 we believe this adjustment has good motivation but does not  
5 properly target isolated facilities.

6 The second PPS issue with an open Commission  
7 recommendation concerns that accuracy of cost reports.  
8 This sector has experienced major policy changes in the  
9 past few years, and the accuracy of cost reports has not  
10 been examined under the new PPS. The last audit was  
11 conducted more than 10 years ago.

12 Prior ESRD audits have found that facilities'  
13 allowable costs ranged from 90 to 96 percent of submitted  
14 costs. If providers' costs are overstated, then the  
15 Medicare margin would be understated and policymakers may  
16 be willing to increase payments as a result of the faulty  
17 data. It would be good fiscal management to assess the  
18 accuracy of cost reports under the new PPS.

19 This concludes our presentation, and we look  
20 forward to your discussion. Thank you.

21 DR. CROSSON: Thank you, Nancy and Andrew.

22 Let's take clarifying questions. I see Bill.

1 MR. GRADISON: On page 16, you referred to the  
2 change in the use of certain medications from 2013 to 2014,  
3 and you referred to that in your presentation as well. I  
4 don't mean to quibble, but I wouldn't use the word  
5 "modestly increase," as this does with something that one  
6 went up 33 percent and one went up 59 percent. What am I  
7 missing?

8 MS. RAY: The units are small, so it makes the  
9 change look bigger. So for one of the drugs, which is  
10 darbepoetin, for example, that increased by 33 percent, it  
11 went up from .56 mcg, which is that drug's unit, to .75.

12 MR. GRADISON: Yes.

13 MS. RAY: So, yeah, we can change the text  
14 accordingly.

15 MR. GRADISON: Thank you.

16 And the prior page, one other thing. It refers  
17 to the average number of treatments per beneficiary, 117.  
18 That puzzles me because the typical treatment is three  
19 times a week. Is that not adjusted for -- does this take  
20 into account beneficiaries that aren't necessarily entered  
21 for the full year or what?

22 MS. RAY: It does not. So beneficiaries who are

1 not in it for the full year, who start dialysis late in the  
2 year, who pass away, whatever, when they're admitted, it  
3 does not take that into account. You're correct. It would  
4 be about, what, 156 treatments a year?

5 MR. GRADISON: It would be 156, yes.

6 MS. RAY: Yes.

7 MR. GRADISON: Why is not -- it's closer to 156  
8 than 117.

9 MS. RAY: Right. Again, because it's not -- it's  
10 not annualized.

11 MR. GRADISON: Oh, okay.

12 MS. RAY: And we can add a footnote to that.

13 MR. GRADISON: Thank you.

14 DR. CROSSON: Yes, Alice.

15 DR. COOMBS: Thank you very much. I was very  
16 interested in this.

17 On page 25, you talk about the ESRD comprehensive  
18 care initiative, and I've been kind of curious as to what  
19 the breakout is. The renal folks have given estimates of  
20 80 grand a year for care of an end-stage dialysis patient.  
21 what I was thinking about is if they do the nephrologist in  
22 with this bundled payment here, do we have a breakout of

1 the cost, the dialysis separate? I mean, there must be a  
2 way in which you can actually appropriate cost to the  
3 individual components of the bundle.

4 DR. MILLER: I would take another pass at the  
5 question.

6 DR. COOMBS: So if you were to look at the cost  
7 that you've actually mentioned on page 1 of the chapter  
8 summary when you talk about \$11.2 billion as a part of the  
9 dialysis piece.

10 MS. RAY: Yes. That's just dialysis.

11 DR. COOMBS: Right.

12 MS. RAY: Right.

13 DR. COOMBS: So when we look at that, commonly  
14 you'll see a wedge that says dialysis patient, this, but  
15 the true cost of dialysis patients include their  
16 comprehensive physician fees and nursing fees and things  
17 like that. With that ESRD bundle project, are we able to  
18 separate that out to see what additional costs do to the  
19 other components of the bundle?

20 DR. CROSSON: Alice, are you asking how much is  
21 paid to the physician or physicians and other caregivers,  
22 or is it the facility?



1 DR. COOMBS: Well, yes. What are the non-  
2 dialysis costs of a dialysis patient?

3 MS. RAY: Right. So, in your briefing material  
4 on page 43, we gave -- I provided some information at least  
5 for Parts A and B on the breakout of services by type of  
6 service.

7 DR. COOMBS: Right. So I was just wondering if  
8 we had -- from this initiative, we had some dollar amounts  
9 in terms of --

10 MS. RAY: I don't have any dollar figures from  
11 the ESCO initiative yet.

12 DR. CROSSON: So would that be specified, or  
13 would that be up to the individual institution to decide  
14 how that money is divided?

15 DR. MILLER: Yeah. I have to admit -- I'm  
16 looking at Nancy -- I'm confused by the -- well, you don't  
17 need this on the record. I'm confused.

18 [Laughter.]

19 DR. MILLER: I need you to re-torque that  
20 question.

21 DR. COOMBS: Okay. So --

22 DR. MILLER: So let me take one shot.

1 DR. COOMBS: Okay.

2 DR. MILLER: There may be two pieces of questions  
3 floating around. One question, which I do think is very  
4 answerable, if this is what you're asking -- and I'm not  
5 clear on this -- what's the total cost of an ESRD patient?  
6 There is the ESRD portion, but they go to the hospital;  
7 they see a physician. We can produce that. In fact, I  
8 think we've got the breakout here, and we could sign the  
9 dollar amounts to each piece and make it much more clear.  
10 If that's one of your questions, we can do that. If that's  
11 not your question, then I'm confused.

12 DR. CROSSON: I thought she was asking in the  
13 bundled payment.

14 DR. COOMBS: So, within the bundled payment, what  
15 the breakout is, which is similar to what you're saying,  
16 but the reason why I'm asking that question is because I  
17 have another question that I want to follow up with.

18 DR. CROSSON: Do we have to answer the first one?

19 [Laughter.]

20 DR. CROSSON: Yes. Kathy?

21 MS. BUTO: I don't know if this might help, but  
22 in constructing the bundle in the first place, CMS had to

1 make certain assumptions about what's in the bundle and  
2 roughly what the allocation is, and that might be  
3 informative, if we can get that information.

4 I don't think it's possible. The concept of the  
5 bundle was that given a fair bundle, if you will, of what  
6 was to be included, the actual expenditure within that  
7 bundle would be up to the provider.

8 DR. CROSSON: The entity --

9 MS. BUTO: The entity that's managing that ESRD  
10 patient, but you could probably figure out what they  
11 assumed going into a bundling -- initially a bundling  
12 demonstration.

13 DR. CROSSON: Is it possible, Nancy, to get a  
14 couple of examples? I mean, do you have a connection with  
15 the --

16 MS. RAY: So just to clarify just a little bit,  
17 the ESCO, the end-stage renal disease -- it's also called  
18 the CAC and referred to in the paper -- it's like, it's  
19 similar to other of CMS's ACOs and shared savings programs,  
20 and that an ESCO, which is composed of a dialysis provider  
21 and a nephrologist agree -- have submitted applications,  
22 and CMS has proceeded, beginning this past October. And

1 they will be responsible for the care of the -- held  
2 responsible for all of the spending of their dialysis  
3 beneficiaries.

4           And it's described in the paper in a little bit  
5 more detail. If a beneficiary gets attributed to a  
6 facility based on a first touch, prospectively first touch,  
7 and then the three large dialysis organizations will be  
8 held at both gain and -- or are taking full gain -- a gain  
9 and -- it's a two-sided design. Whereas, the one small  
10 dialysis provider, it's only shared savings.

11           DR. CROSSON: So, Nancy, let me try this because  
12 I think the question is, so what does the physician get or  
13 other providers and what does the facility get? And I  
14 think -- tell me if I'm right here, that fundamentally,  
15 specifying that ahead of time is kind of the opposite of a  
16 bundled payment, right?

17           MS. RAY: Right.

18           DR. CROSSON: Isn't the essence of a bundled  
19 payment that you provide the money to this, in this case, a  
20 physician and facility and then they determine, based on  
21 the nature of the patient or whatever business arrangements  
22 they have, how that money is divided? Or am I wrong?

1 MS. RAY: That's correct, and to be clear, both  
2 the dialysis organization and the one or more nephrologists  
3 are at shared or at risk for shared savings, and the three  
4 big large dialysis organizations are also -- and their  
5 nephrologist partners are also on the hook for shared risk  
6 loss.

7 DR. COOMBS: And that's the question because you  
8 could have a conceivable bundle demonstration wherein you  
9 have fee-for-service within that.

10 DR. CROSSON: I see what you're saying.

11 DR. MILLER: And that's why I was kind of going  
12 back to the claims point. Like an ACO, in an ACO, and I  
13 need you to do the ESCO piece, but in an ACO, it's fee-for-  
14 service and your actual fee-for-service level depends on  
15 what you draw-off patients are. And so, you know, it would  
16 be whatever the fee-for-service on average is for the group  
17 of patients that you took. And so, we need to do it  
18 specifically for any ACO or ESCO would depend on it  
19 happening and then us being able to say, Oh, you had these  
20 ten patients. So doing it in advance, I think, would be  
21 somewhat difficult until we knew who was attributed and who  
22 was in.

1           But the concept would still be, I think, that  
2 whoever is in, you would be looking at the totality of  
3 their ESRD, their hospital, their physician, that type of  
4 thing.

5           MS. RAY: Right. It's all A and B spending and  
6 then it will be compared to the benchmark spending and then  
7 they determine potential savings or losses and then it will  
8 be adjusted by their quality score and that ends up as  
9 their final. Either they get shared savings or not.

10          DR. CROSSON: And you had a second question,  
11 Alice.

12          DR. COOMBS: Well, my second question related to  
13 the risk of the nephrologist within the --

14          DR. CROSSON: And that would presumably depend  
15 upon the methodology of payment in that particular setting.  
16 Okay. Rita, Jack

17          DR. REDBERG: Thank you. Very nice chapter. I  
18 was struck that it looks like mortality is going down,  
19 which is good, and ESA drugs, the bundle, seems to be  
20 working. We're using less and patients are doing better,  
21 although I would comment that I think internationally, our  
22 mortality rates are higher than anywhere else and that we

1 spend more on dialysis.

2           But I wanted to understand better what was going  
3 on with the Part D drugs and why they're outside of the  
4 bundle. In Page 30 in the mailing materials, the  
5 calcimimetics and phosphate binders, which we spent \$1.3  
6 billion on, which was an increase of 22 percent per year,  
7 I'm not aware of data. I don't know if anyone is showing  
8 improved quality of life or outcomes associated with. It  
9 seems like a lot.

10           And it went on to say, the Secretary intended  
11 that these drugs be included in the bundle, but the Stephen  
12 Beck, Jr. Achieving a Better Life Experience Act of 2014  
13 delayed bundling these drugs until 2025. What was going on  
14 there?

15           MS. RAY: That's what Congress --

16           DR. MILLER: I'm going to let you guys go ahead.  
17 You know the look that you guys give me where you go --

18           MS. RAY: Well, that's what the Congress decided  
19 to do.

20           DR. REDBERG: And this was done for what reason?

21           DR. MILLER: Remember the tactic here, right?

22 You just reiterate the facts. Okay? So, you know, I think

1 in building the bundle, and also, Nancy, remind me. I  
2 think we made comments to this effect when this was all  
3 kind of being churned around. What you want in a system  
4 like this is capture what relates to the care, and I know  
5 you guys all know this, care to the patient because if  
6 there's some important part that's not included in the  
7 bundle, then obviously you can just kind of shift the cost  
8 to the bundle outside the bundle, a cost outside the  
9 bundle.

10 So there was some thought that decisions were  
11 going to be made, there was going to be a capture and these  
12 drugs would go into the bundle. My recollection is CMS  
13 kind of came along and said, Okay, this is what we think  
14 happens. There were strenuous objections and decisions  
15 were made.

16 DR. CROSSON: Rita.

17 MS. RAY: So when CMS, in proposing the broader  
18 bundle in 2010, proposed to put the oral-only dialysis  
19 drugs, the phosphate binders and the calcimimetics, into  
20 the bundle. Based on comments they got in the rule-making  
21 process, they decided to defer including them in the bundle  
22 until they had obtained more utilization data and they said



1 that they would put them in the bundle beginning in 2014.

2 In the meantime, Congress then acted to delay  
3 including those oral-only drugs in the bundle at least on  
4 two different opportunities.

5 DR. CROSSON: So, Rita, just to check in, you and  
6 I are both in Washington right now. We're not where we  
7 live. Cathy?

8 MS. BLONJARZ: Jay, I just want to point out that  
9 Part D drugs are also not in the ACO. I think we all know  
10 that, right? So that's to me a much bigger deal in the  
11 sense that we're talking about comprehensive care for many  
12 more beneficiaries, and that's not been done.

13 DR. CROSSON: Right.

14 MS. BLONJARZ: So it doesn't surprise me that it  
15 didn't make it into the ESRD bundle.

16 DR. CROSSON: Jack

17 DR. REDBERG: On the two wrongs don't make a  
18 right.

19 DR. HOADLEY: I mean, at the very least, there  
20 are practical questions on how do you take drugs out of a  
21 Part D where there's a lump -- you're taking just the drugs  
22 for this treatment out and then what do you do to adjust

1 the Part D plans? So, I mean, same issue comes on ACOs.  
2 How do you go about doing it? It's a problem that could be  
3 figured out, but it is not as simple as some of the other  
4 pieces.

5 That wasn't actually what I was going to comment  
6 on. Did you want to add more?

7 MS. RAY: I just want to say one other point. In  
8 the rule that CMS just finalized, they did finalize the  
9 process of one and oral-only drug is not oral-only. And  
10 so, if an injectable form of that drug is approved by the  
11 FDA, then that will be -- both the injectable and the oral-  
12 only will be included in the bundle.

13 DR. HOADLEY: Interesting. So the question I was  
14 going to ask is much smaller. You mentioned in that same  
15 section that Alice was talking about, that there are some  
16 ESRD special needs plans, and I was just curious how many  
17 of these SNPs are there? Are there any significant number  
18 of people in them, do we know?

19 MS. RAY: You know, it's not a huge number.

20 DR. HOADLEY: That's what I was assuming.

21 MS. RAY: And they're in specific geographic  
22 areas, I believe, California. I can get back to you on

1 that for sure.

2 DR. HOADLEY: Yeah, thanks.

3 DR. CROSSON: Other clarifying questions? So  
4 here we again, we have a recommendation which is  
5 essentially unchanged. I think we've had -- we have a  
6 couple of considerations going on here that led to this.  
7 Number one is that there are already regulations in place  
8 that are being enacted in 2016 that are going to change the  
9 landscape. We don't know how yet.

10 And then we have this underlying concern about  
11 the accuracy of the cost reports and whether or not the  
12 margins that we actually are looking at are accurate or  
13 not. So that has led us to suggest that we essentially  
14 stick with current law at the moment. So I'm not hearing  
15 in the discussion a whole lot of discussion about that  
16 itself. So I'm again taking this as support for the  
17 recommendation and hearing no objection will move this  
18 forward also in January through the expedited process.  
19 Good. Thank you, Nancy. Thank you, Andrew.

20 So we have come once again to the time for public  
21 comment. If there are any in the audience who would wish  
22 to make a comment, please step to the microphone so we can

1 see who you are.

2           Seeing none, we are adjourned until 8:30 tomorrow  
3 morning. Thank you very much.

4           [Whereupon, at 4:04 p.m., the meeting was  
5 recessed, to reconvene at 8:30 a.m. on Friday, December 11,  
6 2015.]

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MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, December 11, 2015  
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
KATHERINE BAICKER, PhD  
KATHY BUTO, MPA  
ALICE COOMBS, MD  
WILLIS D. GRADISON, JR., MBA, DCS  
WILLIAM J. HALL, MD, MACP  
JACK HOADLEY, PhD  
HERB B. KUHN  
MARY NAYLOR, PhD, FAAN, RN  
DAVID NERENZ, PhD  
RITA REDBERG, MD, MSc  
WARNER THOMAS, MBA  
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P R O C E E D I N G S

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[8:30 a.m.]

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DR. CROSSON: Okay. I think, if everybody can take their seat, we can get started.

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This morning, we finish up the initial update discussions, and we are going to start off with home health care.

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Evan, you have the microphone.

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MR. CHRISTMAN: Good morning. Now we will review the framework as it relates to home health, and before I dive into that, a quick overview of this presentation. It's going to have three parts. I'll take you through a brief summary of the benefit, a review of the current issues, and then I'll dive into the payment adequacy framework.

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As an overview, Medicare spent \$17.7 billion on home health services in 2014. There were over 12,400 agencies, and the program provided about 6.6 million episodes to 3.4 million beneficiaries.

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Before we look at the framework, I just want to remind you of some of our standing issues with the home health benefit. Home health is an effective service when

1 appropriately targeted and can be an important service for  
2 frail community-dwelling Medicare beneficiaries. However,  
3 eligibility for the benefit is poorly designed and does not  
4 encourage efficient use.

5           As I will note in a minute, there has been rapid  
6 growth in episode volume, which raises particular concerns  
7 in the current fee-for-service environment that rewards  
8 providers for additional volume.

9           The benefit also has an unfortunate history of  
10 program integrity problems. The Secretary and the Attorney  
11 General have made a number of efforts to address fraud in  
12 the benefit, but many patterns of unusual utilization  
13 remain.

14           We have also noted significant geographic  
15 variation in the use of this benefit, which program  
16 integrity and the poor definition likely contribute to.

17           In terms of the payment system, the Commission  
18 has noted two problems. First is an issue with the  
19 incentive in the current system. The current PPS uses the  
20 number of therapy visits provided in an episode as a  
21 payment factor. Payments increase as more therapy visits  
22 are provided in an episode, sometimes increasing by



1 hundreds of dollars for a single additional visit.

2           The share of episodes qualifying for these  
3 payments has increased every year in the PPS. This trend  
4 and the fact that more profitable home health agencies tend  
5 to favor therapy episodes raise concerns that financial  
6 incentives of the payment system may be influencing the  
7 type of care provided.

8           The second issue is the high level of payments.  
9 Medicare has overpaid for home health since the PPS was  
10 established. The fact that home health can be a high-value  
11 service does not justify the excessive overpayments. As  
12 discussed in the paper, Medicare margins average better  
13 than 16 percent in the 2001-to-2014 period. These  
14 overpayments do not benefit the beneficiary or the  
15 taxpayer.

16           The Commission has made a few recommendations to  
17 address some of these problems in prior reports. We  
18 recommended a copayment for home health episodes not  
19 preceded by a hospitalization. The Commission recommended  
20 this because the standards for the use of home health  
21 appear to be less clear when it is not being used as a  
22 post-acute service. These types of episodes have also

1 grown rapidly in the last decade, and again, as noted in  
2 the paper, they now constitute the majority of home health  
3 episodes.

4 We also recommended that CMS expand its fraud  
5 efforts. CMS has taken action, but several areas with  
6 questionable patterns of use remain.

7 As a reminder, here is our framework. It is the  
8 same one you saw yesterday for the other sectors

9 We begin with supply. As in previous years, the  
10 supply of providers and the access to home health appears  
11 to be adequate. Ninety-nine percent of beneficiaries live  
12 in an area served by one home health agency. Eighty-two  
13 percent live in an area served by five or more.

14 Turning from access to supply, the number of  
15 agencies was over 12,600 by the end of 2012. There was a  
16 net decline of 152 agencies in 2014, but we're still near  
17 the all-time supply of agencies hit in 2013.

18 The decline in 2014 is concentrated in a few  
19 areas, such as Texas, Florida, and Michigan. I would note  
20 that these areas experienced rapid growth and utilization  
21 and supply in prior years. And, overall, the supply of  
22 agencies in 2014 is 65 percent higher than 2004.

1           Next, we look at volume. Episode volume in 2014  
2 declined slightly, relative to the prior year. However,  
3 this comes after several years of rapid growth, and the  
4 decline is primarily concentrated in five states that had  
5 disproportionately fast utilization growth in earlier years  
6 and have been the focus of activities to reduce fraud.

7           I will say more about these five areas in a  
8 minute, but turning back to 2014, we note that the number  
9 of users and episodes per user decreased slightly. The  
10 share of fee-for-service beneficiaries was 9.1 percent in  
11 2014, a slight downtick from the previous year, and though  
12 we have seen a recent slowdown in utilization and spending,  
13 I would note that over the 2002-through-2013 period, you  
14 can see that all of these measures have increased  
15 significantly. Spending has almost doubled, and  
16 utilization has increased by 60 percent.

17           This figure gives you a better sense as to how  
18 utilization has changed since 2002. Turning first to the  
19 yellow line in the middle, the national average, you can  
20 see that utilization increased through 2011 on a national  
21 basis and has declined slightly in subsequent years.

22           I would note that this decline occurred at the

1 time that several other downward pressures on volume hit,  
2 including an economy-wide slowdown in health care spending  
3 for most payers, continuing declines in hospital  
4 discharges, and an increased effort to fight fraud, waste,  
5 and abuse in home health.

6 In addition, it appears that states that  
7 experienced the most rapid declines since 2011 had higher  
8 growth than other areas prior to 2011, as shown by the  
9 orange dashed line at the top. While many factors  
10 contributed to this decline, it is notably that these five  
11 states have been the focus of efforts to fight fraud,  
12 waste, and abuse.

13 The dotted line at the bottom shows utilization  
14 in the other 45 states. As you can see, utilization grew  
15 relatively fast through 2011 and since then has remained  
16 level. Overall, this graph suggests that the decline in  
17 volume since 2011 has been relatively concentrated, and  
18 home health utilization in most parts of the country has  
19 remained pretty steady since 2011.

20 Our next indicator is quality, and I just want to  
21 note for the Commissioners that some of these rates have  
22 been updated since we sent you mailing materials.

1           This table shows the risk-adjusted rates of  
2 functional improvement among those patients not  
3 hospitalized at the end of their home health episodes.  
4 Patients are assessed at discharge by the home health  
5 agency for their functional improvement.

6           As you can see, across the three years, you can  
7 see that the rates of improvement for transferring and  
8 walking have increased.

9           In contrast, hospitalization rates remained  
10 mostly unchanged. The lack of progress in lowering the  
11 hospitalization rate was one of the factors that motivated  
12 the Commission to recommend a rehospitalization incentive  
13 for agencies with very high rates.

14           Next, we look at capital. It is worth noting  
15 that home health agencies are less capital intensive than  
16 other health care providers. Also, few are part of  
17 publicly traded companies. Financial analysts have  
18 concluded that the publicly traded agencies have adequate  
19 access to capital.

20           We have seen a recent uptick in acquisition  
21 activity, with two health care firms buying home health  
22 providers to expand their capacity in this sector.

1           Next, we turn our attention to margins for 2014.  
2 You can see that overall margins for freestanding providers  
3 were 10.8 percent. For-profits had higher margins than  
4 non-profits, and urban agencies had higher profits than  
5 rural. And these margins include the effect of the  
6 sequester that went into effect in 2013.

7           I would also note that these data rely upon the  
8 home health cost report. CMS audited a sample of 2011 home  
9 health cost reports and found that costs were overstated by  
10 8 percent in 2011. If reported margins were adjusted for  
11 this error, our home health Medicare margins reported for  
12 2011 would have exceeded 20 percent. While it is  
13 speculative to apply the 8 percent to other years, the  
14 results suggest that the margins we report for home health  
15 could be higher.

16           Similar to the other providers you heard about  
17 yesterday, we computed the marginal profit for home health  
18 agencies, which equaled 13.3 percent in 2014, and this  
19 indicates that agencies have an economic incentive to serve  
20 additional patients.

21           This year, we also examined the performance of  
22 relatively efficient home health agencies compared to other

1 agencies. Recall that we define relatively efficient  
2 providers as those that are in the lowest third on cost and  
3 the best performing third of quality for three consecutive  
4 years and never in the worst performing third on either  
5 measure. About 15 percent of agencies met this standard.

6 Relatively efficient providers had a median cost  
7 per visit that was 11 percent lower than other agencies and  
8 Medicare margins that were about 10 percentage points  
9 higher. Relatively efficient providers were typically  
10 larger in size, with the median efficient provider about 28  
11 percent larger than the median for other agencies.

12 The relatively efficient provider had lower  
13 hospitalization rates, and they provided about the same mix  
14 of nursing, therapy, and aide services to their patients.  
15 And they served similar numbers of dual-eligible patients,  
16 and their beneficiaries were about the same average age.  
17 However, the efficient providers tended to serve more urban  
18 patients than rural ones.

19 We estimate margins of 8.8 percent in 2016. This  
20 is a result of several payment and cost changes. There is  
21 a 3 percent add-on in effect for rural areas in both years.  
22 Payments will decrease slightly to reflect rebasing,

1 currently required by the PPACA, and we assume cost growth  
2 of less than 1 percent in 2015 and '16 in line with  
3 historical rates of growth. And we also assume some  
4 nominal case-mix growth, and these estimates assume the  
5 sequester remains in effect.

6 As a reminder, rebasing is a payment reduction  
7 for home health and PPACA designed to bring payments more  
8 in line with costs. As I noted earlier, home health  
9 margins have averaged 16 percent a year since 2001. While  
10 PPACA intends to lower payments, we have been concerned  
11 that the reductions are too small, and this table shows  
12 why.

13 Every year, rebasing will reduce payments by  
14 about 2.8 percent. However, this decrease will be offset  
15 each year by a payment update of 1.9 to 2.3 percent each  
16 year that will add much of what is cut. Across the years,  
17 the net payment reduction for the 60-day episode will be  
18 about 3 percent.

19 Turning back to our framework, here is a summary  
20 of our indicators. Beneficiaries have good access to care  
21 in most areas. The number of agencies continues to  
22 increase, reaching over 12,600 agencies in 2014. The



1 number of episodes declined slightly after several years of  
2 rapid increases, and the number of users decreased  
3 slightly.

4           Quality measures have not changed significantly.  
5 Access to capital is adequate, and the margins for 2015 are  
6 projected to equal 10.8 percent. The marginal profit is  
7 estimated to be 13.3 percent, and the estimated margins for  
8 2016 are 8.8 percent.

9           And I would note that these are average margins,  
10 and our review of the quality and financial performance for  
11 relatively efficient providers suggest that better  
12 performing agencies can achieve good outcomes with profit  
13 margins that are higher than other agencies.

14           Since our indicators are positive, the Chairman  
15 has proposed that we recommend no update for 2013 and  
16 further rebasing. The recommendation includes a provision  
17 to eliminate the use of therapy visits as a payment factor.  
18 The recommendation reads: The Congress should direct the  
19 Secretary to eliminate the payment update for 2017 and  
20 implement a two-year rebasing of the payment system  
21 beginning in 2018. Congress should direct the Secretary to  
22 revise the PPS to eliminate the use of therapy visits as a

1 factor in payment determinations concurrent with rebasing.

2           The impact of this change would be to lower  
3 spending relative to current law. The impact of  
4 beneficiaries should be limited. They should not affect  
5 provider willingness to serve them. Eliminating therapy as  
6 a payment factor would be budget-neutral in the aggregate  
7 but redistributive among providers. Non-profit agencies  
8 would see their aggregate payments increase, while for-  
9 profit agencies would see a decrease.

10           This completes my presentation, and I look  
11 forward to your questions.

12           DR. CROSSON: Thank you, Evan.

13           And just to be clear to the Commission, this is a  
14 rerun of our previous set of recommendations.

15           So we'll take clarifying questions. Mary and  
16 then Bill.

17           DR. NAYLOR: Thanks, Evan, for a great report,  
18 reminding us of all the work of the Commission over the  
19 last couple of years.

20           I was interested in page 29 of the report. You  
21 talked about lower margins for hospital-based home health  
22 agencies, and one of the factors might be reallocation of

1 cost to home health agencies, but the other that you  
2 indicated was some evidence of shorter lengths of stays in  
3 hospitals that might be moving patients more quickly to  
4 home health. And I'm wondering if you could comment on  
5 that, whether or not you're seeing that, how much we're  
6 seeing in hospital-based systems and whether or not that's  
7 also evidence in any of the other freestanding or other  
8 owned home health agencies.

9 MR. CHRISTMAN: I guess the -- I'm trying to --  
10 I'm not quite sure. Is there a part of the paper where we  
11 implied that was shorter stays?

12 DR. NAYLOR: Yes. It says the lower inpatient  
13 cost --

14 MR. CHRISTMAN: Oh, okay. Yes. I think --

15 DR. NAYLOR: -- due to shorter hospital stays --

16 MR. CHRISTMAN: Right.

17 DR. NAYLOR: -- compensates for losses from  
18 operating.

19 MR. CHRISTMAN: Right. So I guess the thinking  
20 is that it's better to lose money on a day of home health  
21 than a day of inpatient care. To the extent that hospitals  
22 can -- even if they're losing money on the home health

1 side, if they can avoid further losses, if they have to  
2 hold somebody in the hospital longer, the --

3 DR. NAYLOR: So there's no evidence that this is  
4 happening?

5 MR. CHRISTMAN: Right.

6 DR. NAYLOR: This is a kind of hypothesis.

7 MR. CHRISTMAN: Right. Yes.

8 DR. NAYLOR: You may just want to change the  
9 wording because it led me --

10 MR. CHRISTMAN: Okay.

11 DR. MILLER: And we can change that.

12 I think you've heard this dynamic come up in  
13 other conversations where you'll find the hospital base,  
14 and you find a freestanding industry that seems to have  
15 costs that are -- or does consistently have costs that are  
16 lower and then hospital-based that's higher. Some of it is  
17 the cost of hospitals and the allocation issue.

18 But the other thing that we've done, although I'm  
19 not quite sure in the home health setting, but I know in  
20 the SNF setting, we've shown that even though there are  
21 what appear to be high losses on a line of business in SNF,  
22 you have higher margins on your inpatient side. And the

1 thinking is that having the hospital-based SNFs helps them  
2 manage their costs on the inpatient side.

3 DR. NAYLOR: I understand.

4 In the SNF work, though, there was no evidence at  
5 all that hospitals are shortening lengths of stay to move  
6 people more quickly to SNFs, and I was just wondering if we  
7 were beginning to see this in home health based on what --

8 DR. MILLER: I think it's inference rather than  
9 anything else, and we can make that clear.

10 DR. CROSSON: Bill.

11 DR. HALL: Evan, a very nice report, as usual.

12 Could we look at page 11?

13 MR. CHRISTMAN: Slide 11?

14 DR. HALL: Slide 11. I'm sorry. In your  
15 handout.

16 So, a couple of things, when we start talking  
17 about the use of quality measures, when we're going to be  
18 reducing incentives for therapy services, which is what the  
19 recommendation is offering. So we look at those, and we  
20 look at things that look pretty good. Transferring and  
21 walking seems to have improved quite a bit over a short  
22 period of time. What do those percentages mean?

1           Let's take walking, which is the biggest one.  
2 Does that mean that 63 percent of the patients were  
3 walking? And maybe they were walking before they went into  
4 the facility? I think this is more than academic.

5           MR. CHRISTMAN: Sure. Yeah, the language makes  
6 it a little tricky to do succinctly, but it's improvement  
7 in walking. So you'll get assessed on, say, a five-point  
8 scale at the beginning of your home health stay, and then  
9 this is saying that in 2014, wherever they started on that  
10 five-point scale, 63 percent were at the -- at least the  
11 next rung up on the scale when they were discharged.

12           Now, these numbers, there's a few things to know  
13 about them. First of all is that, obviously, you can only  
14 assess a patient at discharge for function if they're  
15 there. So patients that have been hospitalized are not  
16 reflected in this data. It flushes out a lot of the bad  
17 cases.

18           Now, the other summary level of responses are a  
19 patient could have no improvement, which is about the other  
20 remaining 35 percent. The number of patients that have a  
21 reported functional decline in these measures is tiny, and  
22 so I think that that's sort of how this measure worked.

1 DR. HALL: Okay.

2 MR. CHRISTMAN: Does this answer your question?

3 DR. HALL: Yeah. We're going to be using  
4 measures like this with increasing frequency, and so I  
5 think it's very important that we qualify what we're  
6 talking about. I think that helps.

7 In terms of the readmissions, is there any chance  
8 that we could look at what the attribution is, what were  
9 people readmitted for?

10 MR. CHRISTMAN: We can -- I can definitely pull  
11 that. I don't have it off the top of my head. It is a lot  
12 of the usual suspects, and it's been a while since I've  
13 looked at that, though.

14 DR. HALL: I would bet that what we'll see, as is  
15 true with almost all readmission data, is that at least  
16 half of the readmissions have nothing to do with the  
17 primary diagnosis, and I think those clarifications might  
18 help us if we are going to use these measures.

19 MR. CHRISTMAN: Yeah. I agree with that.

20 I think the challenge to a certain extent with  
21 home health is it builds itself as a multidisciplinary  
22 benefit, and they're certainly trying to keep somebody out

1 of the hospital for their primary diagnosis, assuming there  
2 was an acute trigger to the episode, but they essentially  
3 are trying to -- they certainly can't control for  
4 everything. But I think they're usually trying to treat  
5 whatever the broad range of issues are the patient has and  
6 not just their primary indication.

7 DR. CROSSON: Okay. Let's start this way.  
8 Alice, David, Rita -- no, Alice, Rita.

9 DR. COOMBS: So, I had a similar question that  
10 Bill had, and I thought we did something a few years ago,  
11 Evan, that actually looked at hospitalizations from home  
12 health. I'm not sure that we did at that time. Maybe it  
13 was one of the other industries. But my question was, you  
14 know, hospitalizations to acute care versus PACs and what  
15 the differential is in terms of what the different  
16 diagnosis. Is there a different type of hospitalization  
17 for the PACs in this group?

18 MR. CHRISTMAN: I'm sorry. Are you speaking of  
19 hospitalization rates for sort of the community-admitted  
20 patients versus the post-acute patients?

21 DR. COOMBS: For the community-admitted patients.

22 MR. CHRISTMAN: Yeah. They're not that



1 different, as I recall. They're usually within two to  
2 three percentage points of each other, sort of the national  
3 rates. The biggest difference, the community-admit  
4 patients tend to have a few fewer chronic conditions, on  
5 average, but a little bit more of the sort of the  
6 degenerative- Alzheimer's-dementia type of conditions.

7 DR. CROSSON: Rita.

8 DR. REDBERG: I was going to build more on --  
9 Bill got me thinking about the quality measures, and in the  
10 walking, can you tell us who does the assessment of the  
11 walking.

12 MR. CHRISTMAN: It's done by the home health  
13 agency. It'll be, you know, by generally a nurse be doing  
14 the discharge, and there'll be an assessment at admission  
15 and an assessment at discharge and they're both done by the  
16 home health nurse, generally.

17 DR. REDBERG: So -- and do you know a little bit  
18 more about what scale it was, and also, is this just for  
19 people who the reason for home health admission was for  
20 walking, or --

21 MR. CHRISTMAN: No, this will be all patients.  
22 This is an all patients measure. It uses -- you know,

1 again, it's a five-point scale. It's been a while since  
2 I've looked at it, but I can get you some more on that.

3 DR. REDBERG: And, just, if we want to look at  
4 quality measures, we probably should think a little more  
5 about what makes the most sense. It is very helpful.

6 And the other point that you mentioned, about  
7 when you take everyone out of the denominator who isn't  
8 there, not usually the way we look at outcomes.

9 MR. CHRISTMAN: Well, and that's a fair point. I  
10 guess it's just something to keep in mind, that functional  
11 measures are such an important part of post-acute care.  
12 That's a difficult problem in all settings. You know, you  
13 can't assess somebody that isn't there, but it certainly --  
14 I think it is something to think about, whether there's a  
15 way to control for that. You know, if an agency loses a  
16 lot of patients, do you somehow adjust the functional  
17 measure.

18 DR. REDBERG: Or at least add it to the measures,  
19 you know, X-percent were not there, or --

20 DR. MILLER: It's probably real obvious. I mean,  
21 I think part of the reason that we also look at  
22 hospitalization out of -- is for that very reason, and that

1 at least has the characteristic of being identifiable in  
2 the claims data and so it's not as subject to some of these  
3 other issues that you guys are going back and forth on.

4 DR. CROSSON: Warner.

5 MR. THOMAS: So, I just had a couple of questions  
6 on the quality measures and the compensation that's tied to  
7 quality measures. How large is that in the scale of their  
8 payments, roughly? Is it a percent? Is it three percent?  
9 Is it any --

10 MR. CHRISTMAN: It'll start at three percent, and  
11 by the end of the current effort, it scales up each year.  
12 So I believe it starts at three percent of their base  
13 payment kind of goes into the pool beginning in 2018, and  
14 then by the end, which I think is 2022, it's gone up to  
15 eight percent.

16 MR. THOMAS: And it seems like with the measures  
17 you're talking about, walking, I mean, those are self-  
18 assessed measures. Are there specific outcome measures  
19 that you think are more appropriate to be --

20 MR. CHRISTMAN: Well, I guess the, you know, the  
21 hospitalization measures. There's also an ED use measure.  
22 There's even a hospitalization measure that kind of

1 controls for ED use and so you're not double-counting it.  
2 Because those are such key parts of home health, I've  
3 always thought that if there was a way to kind of emphasize  
4 those measures in an approach, this would be good. Those  
5 are definitely signs of something that beneficiaries should  
6 seek to avoid. I think it's something that the home health  
7 industry generally agrees is a primary reason for the  
8 benefit.

9           You know, it's difficult, because I think the  
10 functional measures are also important. As one advocate  
11 put it to us, you don't want it to keep people out of the  
12 hospital by discharging to their couch --

13           MR. THOMAS: Right.

14           MR. CHRISTMAN: -- so, they do have to be in  
15 there. But there are other measures that CMS, under this  
16 one -- I can't even list them all off the top of my head,  
17 something like two dozen measures, including things like  
18 immunization and things like that, but something that  
19 focused -- I think when we've commented, you know,  
20 something that focuses more on the outcome measures like  
21 hospitalization --

22           MR. THOMAS: Right.

1 MR. CHRISTMAN: -- and ED use would be best.

2 MR. THOMAS: Right. And then, seeing how I'm  
3 from Louisiana, it's probably up there as one of the high  
4 utilizers --

5 [Laughter.]

6 MR. THOMAS: It strikes me, at least what I see  
7 in our state, is that there's a wide variability in quality  
8 in these entities and a lot of it has to do with size and  
9 scale. And I don't know if you can comment on that or if  
10 you could comment on, as you look at the efficient  
11 providers, is there a certain break point of size where you  
12 see performance change in these entities?

13 MR. CHRISTMAN: I mean, I guess -- you know, I've  
14 never really gotten down to sort of a precise  
15 quantification of when there's some sort of delta where you  
16 just see things snap.

17 MR. THOMAS: Right.

18 MR. CHRISTMAN: But, it definitely is true that  
19 bigger is generally better. The larger agencies generally  
20 have lower costs per visit and better quality. And the  
21 market design of home health agencies really varies widely  
22 across the country. If I recall correctly, Louisiana is

1 generally a state where I see more but smaller agencies --

2 MR. THOMAS: Right.

3 MR. CHRISTMAN: -- and I can see the reverse in  
4 other areas, like Massachusetts.

5 MR. THOMAS: Right.

6 MR. CHRISTMAN: And, so, to the extent that the  
7 Medicare program could do anything about this, I think that  
8 the quality incentive is the way to do it in the sense that  
9 it rewards providers who are providing better outcomes,  
10 ideally, and that would -- you know, if the data is  
11 correct, that would probably shake out some of the smaller  
12 agencies and reward those that were providing better  
13 quality, generally, the bigger ones.

14 MR. THOMAS: Have we assessed or looked  
15 specifically at -- just targeted small agencies and looked  
16 at their performance specifically?

17 MR. CHRISTMAN: Not in great detail, no.

18 MR. THOMAS: Okay. All right. Thank you.

19 DR. CROSSON: Jon.

20 DR. CHRISTIANSON: I guess this is just sort of a  
21 tangential question. On these agency-assessed measures,  
22 does CMS have any process for auditing, or is that even

1 feasible to think about?

2 MR. CHRISTMAN: They primarily count on provider  
3 education. They, you know, will put out materials designed  
4 to help agencies understand what the correct way to code a  
5 patient is, and that's, to the extent of my knowledge,  
6 that's sort of what they rely up. And to the extent that  
7 these issues are addressed directly, I think when CMS will  
8 do field sessions of different types with agencies and have  
9 conversations with them and say, you know, when we see  
10 this, you do that, and I'm sure there's a conversation  
11 about whether they're actually doing that. So, it's 13,000  
12 agencies, so it's tough to do any other way.

13 MS. BUTO: Evan, I noticed in the paper on page  
14 six that right from the get-go when they established the  
15 PPS, there was a flawed assumption about the average number  
16 of visits per episode that would decline. Is that a major  
17 factor in the need for rebasing? I mean, how big a factor  
18 is that? And I guess I'm wondering whether we should call  
19 out those key issues where -- and I'm also wondering  
20 whether CMS could -- has the authority already to at least  
21 go back and adjust that assumption.

22 MR. CHRISTMAN: Yeah. I mean, I think that the,

1 you know, the -- I guess the way I would answer this  
2 question, as you're probably well aware, the late 1990s  
3 were a period of rapid change for the home health industry  
4 --

5 MS. BUTO: Yeah.

6 MR. CHRISTMAN: -- when they had to form up this  
7 payment system, and so they had data for 1998 and they kind  
8 of had to guess how much it was going to change between  
9 1998 and October 1, when the payment system was supposed to  
10 go live. And they, if I've got all this right in my head,  
11 they assumed the utilization would drop down by 15 percent.  
12 And, again, it was anybody's guess at that point, and it  
13 was about double that amount.

14 And, so, in 2001, there were also some payment  
15 policies running, but they had margins of 23 percent, so  
16 they kind of just completely overshot what the costs of a  
17 typical service were going to be.

18 We've made this point for several years, and  
19 instead of sort of going back -- and again, I hope I'm not  
20 trying to talk around your question here -- instead of  
21 going back and rearguing what they should have done in  
22 2000, we're saying, you know, take the latest data, take



1 the latest costs, take the latest payments and align  
2 payments with those costs, you know, instead of trying to  
3 get into this original sin kind of argument --

4 MS. BUTO: Right.

5 MR. CHRISTMAN: -- about what happened in 1999.

6 MS. BUTO: No, I think that's -- you know, that's  
7 appropriate for us. I'm just thinking -- and we can get  
8 into this in round two -- but sometimes it's easier to  
9 adjust a flawed assumption than it is to rebase the whole  
10 system. That's my --

11 MR. CHRISTMAN: Right, and they don't have --  
12 they're basically -- I think the budget neutrality  
13 requirements don't let them go any lower unless the law  
14 opens it up.

15 MS. BUTO: Okay.

16 MR. CHRISTMAN: They've got a little bit of  
17 authority in PPACA to lower rates, but as we point out, we  
18 don't think it's enough. So, I guess, if you're asking if  
19 they have the administrative authority to go further, they  
20 don't.

21 DR. CROSSON: Other clarifying questions? So --  
22 sorry.

1 DR. MILLER: Can I just say one thing? There is  
2 -- a lot of your questions on the quality are this  
3 underlying tension of, you know, sizes of measure sets and  
4 types of measures that has gone on in this Commission a lot  
5 of times. The exchange between Warner -- I think it was  
6 Warner and Evan, you know, we tend to say if there are a  
7 smaller set of outcomes that have less game-ability to  
8 them, that that's the direction to move in. So, just as a  
9 philosophical and a larger issue, it hangs over lots of  
10 these conversations.

11 But, the other little thing that got implicated  
12 there was, well, how much flexibility in coding when it  
13 happens on the ground and how do you deal with that, and I  
14 would just give you a heads up. We're going to get into  
15 that in the next section when we talk about IRF, because  
16 there are some patterns there that start to look odd. So,  
17 that was just a commercial.

18 [Laughter.]

19 DR. CROSSON: Stay tuned. So, similar to some of  
20 the discussions we had yesterday, most of the questions,  
21 although excellent, were tangential to the recommendations.  
22 So -- except for Kathy's. So, what I was going to propose

1 -- in a minute or two, I'm going to propose that we, if we  
2 have a consensus to move forward with the previous and now  
3 current recommendations, that we put this into expedited  
4 voting in January. But, Kathy, I want to give you another  
5 chance to, if you want, to elaborate on your suggestion,  
6 because it might affect the recommendation.

7 MS. BUTO: I would just, since we'll probably  
8 come back to this in January, I assume, even though in a  
9 probably expedited way, something Jon mentioned. I think -  
10 - I'm assuming we're picking up the prior recommendations -  
11 -

12 DR. CROSSON: That's correct.

13 MS. BUTO: -- about fraud and abuse, that it  
14 would be good to elaborate a bit more, rather than expand  
15 efforts to reduce fraud, abuse, and waste, and similarly on  
16 the issue of rebasing, we do point out some areas that need  
17 to be particularly looked at. I just think the specificity  
18 helps, because there may be pieces of this that can be  
19 adopted more easily and Congress would be more willing to  
20 take them. And then, of course, the copay for episodes not  
21 preceded by -- that's a big deal.

22 So, I think we could do a lot more in the fraud

1 and abuse area, targeting the states where there's high  
2 volume growth, and maybe even going so far as to recommend  
3 that there be a more targeted review of kind of medical  
4 necessity that goes along with the cost report audit that's  
5 done periodically, because I don't think we have a handle  
6 on that. Putting quality aside, I don't think we know if a  
7 lot of these visits are even -- the individuals really  
8 quality for home health services.

9 DR. CROSSON: So, it strikes me, Kathy, that some  
10 of what you said could be an elaboration within the text  
11 and some might be a little more specificity in the  
12 recommendations?

13 MS. BUTO: Without changing the recommendations.

14 DR. CROSSON: Yeah.

15 MS. BUTO: I would just get more specific.

16 DR. MILLER: And I know Warner has his hand up --

17 DR. CROSSON: I'm sorry.

18 DR. MILLER: -- but when we say, take the fraud  
19 and abuse recommendation, I mean, here, obviously, we're  
20 being extremely terse just in the interest of presentation,  
21 and I'm trying to reconstruct when we made the  
22 recommendation. We were saying, the Secretary has these

1 new authorities. The Secretary got some new authorities in  
2 the PPACA law, and Evan knows this better than me, and what  
3 our recommendation said is, she has these authorities and  
4 we are urging her to use them. And then we presented data  
5 in the chapter, which I'm not sure we recapitulated all  
6 that here, and said, here are patterns around the country.  
7 We would suggest these are places, as long as you've got  
8 this new authority, you should look first.

9           Then the other thing I'll say, to Evan's credit  
10 and the work that he's done, is some of the geographic  
11 variation stuff he's presented and we ended up publishing  
12 in the chapter, and it does draw attention on the Hill.  
13 The staff regularly refer to parts of the country based on  
14 the work here.

15           So, there is -- what I want to say to you is  
16 there is more of an elaboration when we put the  
17 recommendation together. We summarize it in this chapter,  
18 but we can certainly put more of that back in there to make  
19 it clear.

20           DR. CROSSON: Warner.

21           MR. THOMAS: And this, once again, may just be an  
22 elaboration, but I just think tying more dollars to outcome

1 measures may help to raise the bar on some of these smaller  
2 entities. Or maybe they need to demonstrate a certain  
3 proficiency before they're -- I mean, I know, and I'm not  
4 comparing home health to transplant, but, like, in  
5 transplant, you have to demonstrate a certain proficiency  
6 before you're Medicare-eligible, period.

7           And, I just wonder if -- because it seems like  
8 these very, very small entities are, I think, a challenge  
9 from a utilization perspective. And once again, if they're  
10 hitting great outcome quality measures, fine, but I wonder  
11 if that's necessarily the case. So, that could just be in  
12 the text, but that's just a comment about the general  
13 direction of the payments.

14           DR. CROSSON: So, let me ask Evan, then. Is what  
15 Warner is suggesting, that is, it sounds to me like more  
16 specificity in the conditions of participation or whatever  
17 the entry criteria is, is that something that's been  
18 explored?

19           MR. CHRISTMAN: That's certainly been talked  
20 about. I mean, I think I initially heard him to say,  
21 definitely, VBP incentive that focuses on outcomes starts  
22 to take you down this road by itself. But then another

1 question becomes, you know, do you have a -- to be in the  
2 program, do you say, you know, after your first three  
3 years, you've got to be at this level of performance to  
4 remain, and that's something we could certainly talk about.  
5 I think the only -- I think there's some language in there,  
6 you always want to assure access, but once that concern is  
7 addressed, I think you could certainly say it might be  
8 worth exploring minimum quality standards, particularly in  
9 markets that are saturated.

10 DR. CROSSON: Yeah. So, it sounds like perhaps  
11 for January you might take a look at that for us.

12 And Mary.

13 DR. NAYLOR: So, I support continuing the  
14 recommendations, all of them. Where Evan started was --  
15 and we talked about this yesterday related to skilled  
16 nursing facilities, how critically important home health  
17 is, and I think somebody used the language yesterday, we  
18 want to get the payment right and so on. But, on the  
19 quality measures, I'm wondering if the chapter in  
20 elaboration could really push the effort to use measures  
21 across the sectors -- skilled nursing, home health. I know  
22 this is more than an update, but it is the work -- I'm

1 wondering if the efforts to say, for example, promoting  
2 measurement of function or mobility using the care  
3 continuity tool, for example, gives us a chance to look  
4 differently across sectors.

5           So, I think this effort to think about the work  
6 that's going on in post-acute care and trying to get a  
7 whole system of post-acute care might be something that  
8 could be brought in in support of our recommendations.

9           DR. CROSSON: I think that is doable, yes. Okay.  
10 Given those additions that we'll see in January, do I see  
11 general comfort with taking this to the expedited voting  
12 process in January? Okay. Good.

13           Thanks very much, Evan. Very nice.

14           [Pause.]

15           DR. CROSSON: Okay. Now we're going to take on  
16 the issue of the update for inpatient rehabilitation  
17 facilities, the IRF world, and Dana, take it away.

18           MS. KELLEY: Okay. Good morning.

19           After illness, injury or surgery, many patients  
20 need intensive rehabilitative care, including physical,  
21 occupational, or speech therapy. Sometimes these services  
22 are provided in inpatient rehabilitation facilities. In



1 2014, Medicare spent \$7 billion on IRF care provided in  
2 almost 1,200 IRFs nationwide. There were about 375,000 IRF  
3 stays in 2014, and on average, Medicare paid more than  
4 \$18,000 per case. Per case payments vary based on  
5 patient's condition, level of impairment, age, and co-  
6 morbidity. Medicare accounted for about 60 percent of  
7 IRF's discharges.

8           To qualify as an IRF a facility first must meet  
9 Medicare's conditions of participation for acute care  
10 hospitals. In addition, IRFs must have a medical director  
11 of rehabilitation and a pre-admission screening process to  
12 determine that each patient is likely to benefit  
13 significantly from an intensive inpatient rehabilitation  
14 program.

15           An IRF also must demonstrate that it's primarily  
16 focused on treating conditions that typically require  
17 intensive rehab. To that end, IRFs must meet the  
18 compliance threshold known as the 60 percent rule. Under  
19 this rule, at least 60 percent of all patients admitted to  
20 an IRF must have one of 13 conditions specified by CMS.  
21 These include stroke, brain or spinal cord injury, hip  
22 fracture, and neurological disorders. If an IRF does not

1 meet the compliance threshold, Medicare pays for all its  
2 cases on the basis of the inpatient hospital PPS rather  
3 than the IRF PPS.

4           For beneficiaries to qualify for a covered IRF  
5 stay, they must be able to tolerate and benefit from  
6 intensive therapy and must have a condition that requires  
7 frequent and face-to-face supervision by a rehabilitation  
8 physician. Beneficiaries also must need at least two types  
9 of therapy.

10           As always, we reviewed payment adequacy for IRFs  
11 using our established framework. We'll start by  
12 considering access to care. We first looked at the supply  
13 of IRFs. In 2014, there were about 1,180 IRFs nationwide  
14 with more than 39,000 beds. IRFs tend to be concentrated  
15 in states that have large Medicare populations, but each  
16 state and the District of Columbia has at least one IRF.

17           As you can see in the facilities column on the  
18 chart, only 21 percent were free-standing facilities. The  
19 vast majority of IRFs, 79 percent, were distinct units  
20 located in acute care hospitals. However, because  
21 hospital-based units tend to have fewer beds, they  
22 accounted for just about half of Medicare discharges from

1 IRFs in 2014.

2 As you can see in the last two columns, the  
3 number of hospital-based and non-profit IRFs has been  
4 declining, but both these categories saw a small increase  
5 in numbers between 2013 and 2014. Growth in the number of  
6 free-standing and for-profit IRFs, which has been ongoing,  
7 picked up in 2014. The average occupancy rate has been  
8 steady for several years at about 64 percent, indicating  
9 that overall capacity is more than adequate to meet demand.

10 This slide shows the number of IRF cases on a  
11 fee-for-service basis. Beginning in 2004, tighter  
12 enforcement of the 60 percent rule resulted in a  
13 substantial drop in IRF volume. The decline in the number  
14 of hip and knee replacement cases was particularly steep.  
15 But since 2008, you can see that use of IRF services has  
16 been very stable.

17 To assess the quality of care furnished in IRFs,  
18 we used six risk-adjusted measures developed for MedPAC by  
19 a contractor. Overall, we found that the measures have  
20 been stable. On average, IRF patients continue to gain  
21 about 23 points in motor function during the IRF stay and  
22 about four points in measured cognition. The risk-adjusted

1 community discharge rate was about 76 percent, while the  
2 rate of discharge to SNF was almost 7 percent.

3           The risk-adjusted rate of potentially avoidable  
4 readmissions during the IRF stay was 2.4 percent in 2014  
5 and 4.5 percent during the 30 days after discharge. These  
6 rehospitalization rates are low compared with those of  
7 other PAC settings, but that's not unexpected. Remember  
8 that IRF patients are selected because they can tolerate  
9 and benefit from intensive therapy, which means they tend  
10 to be less frail than, say, SNF patients, and IRFs  
11 themselves are certified as hospitals.

12           Turning now to access to capital, as I noted  
13 earlier, more than three-quarters of IRFs are hospital-  
14 based units which access needed capital through their  
15 parent institutions. As you heard yesterday, hospitals  
16 maintained good access to capital markets in 2014 and 2015  
17 due to hospitals' high level of profitability and continued  
18 low interest rates. Hospital construction has recently  
19 shifted away from inpatient and towards outpatient ones,  
20 but about-inpatient projects and toward outpatient ones,  
21 but about 25 new hospital-based IRFs did open in 2014.

22           As for free-standing IRFs, one large chain

1 dominates the free-standing market, accounting for 41  
2 percent of all free-standing facilities. Continued  
3 acquisitions of other post-acute care providers and  
4 expansion of capacity through construction of new IRFs  
5 reflect good access to capital for this chain. Most other  
6 free-standing IRFs are independent or are local chains with  
7 a small number of facilities, and the extent to which these  
8 providers can access capital is less clear.

9           In 2014, the Medicare margin increased almost 1  
10 point to 12.5 percent. As you can see, financial  
11 performance varies across IRFs. The aggregate margin for  
12 free-standing IRFs, which again accounted for about half of  
13 all Medicare discharges, was 25.3 percent. Hospital-based  
14 IRFs had an aggregate margin of 1 percent. There was a  
15 similar spread between non-profit and for-profit IRFs. Of  
16 course, these two categories are highly correlated. The  
17 aggregate marginal profit was 30.4 percent.

18           The disparity between hospital-based and free-  
19 standing IRF margins could be caused by a number of  
20 factors. First, we see higher costs across the board in  
21 hospital-based IRFs with the biggest difference in routine  
22 patient care costs. We don't believe that allocation of

1 overhead is much of a factor in hospital-based IRFs' higher  
2 costs. In fact, as a share of total cost, hospital-based  
3 IRFs have lower indirect costs than free-standing IRFs do.

4 Hospital-based IRFs are, as I said, far more  
5 likely than free-standing IRFs to be non-profit, and so may  
6 be less focused on reducing costs to maximize returns to  
7 investors. Economies of scale are also likely a factor.  
8 hospital-based IRFs tend to be much smaller and have fewer  
9 total cases. Their occupancy rates are also somewhat  
10 lower.

11 But we can't rule out unmeasured differences in  
12 case complexity. We've noted differences in the mix of  
13 cases in hospital and free-standing IRFs. Hospital-based  
14 IRFs also have many more high cost outliers which could, in  
15 part, reflect unmeasured case complexity. Despite their  
16 comparatively low margins, Medicare payments to hospital-  
17 based IRFs exceed marginal costs by a substantial amount,  
18 19 percent in 2014. This compares to a marginal profit of  
19 over 40 percent for free-standing IRFs.

20 We project an aggregate Medicare margin of 13.9  
21 for 2016. This projection includes the effects of current  
22 law such as the sequester and PPACA adjustments, as well as

1 statutory updates and changes to high-cost outlier payments  
2 in 2015 and 2016. We assumed a historical rate of cost  
3 growth that has been below market basket levels. Overall,  
4 we project that payment growth will continue to exceed cost  
5 growth in this industry.

6           So to summarize, we observed capacity that  
7 appears to be adequate to meet demand. Our risk-adjusted  
8 outcome measures are stable. Access to capital appears  
9 adequate. We estimate that the margin was 12.5 percent in  
10 2014 while marginal profit was 30.4 percent. We project a  
11 margin of 13.9 percent in 2016.

12           The Chairman's draft recommendation reads as  
13 follows: The Congress should eliminate the update to  
14 payment rates for inpatient rehabilitation facilities for  
15 fiscal year 2017. Eliminating the update for 2017 will  
16 reduce spending relative to the expected statutory update.  
17 We don't anticipate this recommendation would have any  
18 adverse impact on beneficiaries or on providers'  
19 willingness and ability to care for patients. Even without  
20 an update, we expect providers will have more than enough  
21 revenue to cover costs.

22           Before I conclude my presentation, I want to

1 address some concerns we have about the IRF PPS. As you've  
2 seen, the aggregate margin is high and projected to  
3 increase. This situation often prompts discussion of the  
4 need for rebasing. However, in the case of IRFs, the wide  
5 variation of margins gives us some pause. As I mentioned  
6 previously, the low margins we see among hospital-based  
7 IRFs may be because they are less efficient. If that's the  
8 case, one might be less troubled by their low margins.

9           But given the differences we've observed and the  
10 mix of cases in hospital-based and free-standing IRFs, we  
11 wanted to dig further and determine if there was any reason  
12 to think that other factors might be behind those margins  
13 such as patient selection or coding.

14           We first wanted to look more closely at the  
15 relationship between IRF's mix of case types and financial  
16 performance. We sorted IRFs into five equal sized groups,  
17 or quintiles, based on their margins. The IRFs in quintile  
18 five have the highest margins, while those in quintile one  
19 have the lowest margins. There are both hospital-based and  
20 free-standing IRFs in every quintile, although quintile one  
21 is predominantly hospital-based.

22           As you can see here, the shares of cases with



1 stroke and neurological disorders varied considerably  
2 across the margin quintiles. Looking at the red bars, IRFs  
3 with the highest margins have a smaller share of stroke  
4 cases. Perhaps more striking, they have a much larger  
5 share of cases with neurological disorders, shown here in  
6 green. It's not shown on the chart, but we also found  
7 differences across the margin quintiles in the types of  
8 stroke and neurological cases they admitted.

9 I want to note that this analysis looks only at  
10 post-acute cases, those that were discharged from the acute  
11 care hospital to the IRF. We've also noted differences  
12 across IRFs in the shares and types of cases that are  
13 admitted from the community without a preceding acute care  
14 stay, and that's something we plan to look into further.

15 We also noted some interesting patterns of coding  
16 in IRFs. When we looked at IRF patients' preceding acute  
17 care hospital claims, we found that patients in high margin  
18 IRFs appeared to be less severely ill during their  
19 preceding hospital stay compared with patients in low  
20 margin IRFs. High margin IRFs cared for patients who had  
21 lower average hospital case mix index. Their patients were  
22 less likely to have been in an ICU or CCU. Patients who

1 had been in an ICU had shorter stays there, on average,  
2 than patients in low margin IRFs. Patients in high margin  
3 IRFs were also less likely to have been high-cost outliers  
4 during their preceding hospital stay.

5 But once patients were admitted to and assessed  
6 by IRFs, the patient profile appeared to change, with  
7 patients in high margin IRFs appearing to be more impaired  
8 on average. Patients in high margin IRFs had lower motor  
9 and cognition scores and they were more likely to be coded  
10 with co-morbidities that increased payment. In fact, we  
11 found that at any level of patient severity, as measured in  
12 the acute care hospital, patients in high margin IRFs were  
13 coded with greater impairment.

14 This slide helps to illustrate the kinds of  
15 differences in coding we're seeing. Here we're looking at  
16 average motor function scores at IRF admission for patients  
17 with three types of stroke, stroke with left body  
18 involvement, right body involvement, and stroke with no  
19 paralysis. For ease of reading, I've removed the middle  
20 quintiles to show data only for the lowest margin quintile  
21 and the highest margin quintile.

22 If you look at the scores for the lowest margin

1 IRFs, quintile one in the middle column now in yellow, you  
2 can see that patients with strokes with left body and right  
3 body involvement have average motor scores of 28.6 and  
4 29.7, while stroke patients with no paralysis have a higher  
5 average motor score of 35.3, indicating better function.  
6 This is not surprising because we would expect stroke  
7 patients with no paralysis to have better motor function  
8 than patients with paralysis.

9           Now look at the scores on the right-hand column  
10 for quintile five, the highest margin IRFs. In the highest  
11 margin IRFs, just as in the lowest margin IRFs, we see that  
12 patients with no paralysis have a higher average motor  
13 score than patients with left body and right body  
14 involvement. But note, in the highest margin IRFs, stroke  
15 patients with no paralysis have an average motor score of  
16 29, which is almost exactly the same as the average motor  
17 score for patients with paralysis in the lowest margin  
18 IRFs. Assuming no differences in co-morbidities,  
19 Medicare's payment for these stroke cases would be the  
20 same.

21           We also note, as I mentioned before, that stroke  
22 cases -- that there are differences in the type of stroke

1 cases admitted to these facilities. Stroke cases with no  
2 paralysis are more than twice as common in IRFs with the  
3 highest margins.

4           These findings raise concerns about assessment  
5 and coding in IRFs. If similar patients are being assessed  
6 and coded differently, then payments for some cases may be  
7 higher than warranted. Historically, CMS has addressed  
8 unwarranted coding changes in its payment systems by making  
9 across-the-board adjustments to payments. CMS made coding  
10 adjustments to the IRF-based payment rate in 2006 and 2007.

11           But here, our concerns about coding practices are  
12 not industry-wide. Making an across-the-board adjustment  
13 to payments would affect all IRFs, not just those who are  
14 engaging in up-coding. More work is needed to assess  
15 whether and how a targeted adjustment could be implemented.

16           Our findings also raise concerns about patient  
17 selection. Some IRFs may be selecting patients who they  
18 anticipate will be less costly to care for. There also may  
19 be variation in the relative profitability of the IRF case  
20 mix groups. These are issues staff plans to explore over  
21 the coming months.

22           In the near term, Commissioners may wish to

1 consider another option that would help redistribute  
2 payments within the IRF PPS. Because high margin IRFs have  
3 very few outlier cases, expanding the outlier pool while  
4 keeping total payments budget-neutral, would have the  
5 effect of directing additional payments to IRFs with the  
6 costliest cases. Commissioners may also wish to discuss  
7 the need for additional program oversight in this area.

8 That concludes my presentation and I'm happy to  
9 take any questions.

10 DR. CROSSON: Thank you very much, Dana. Now  
11 we'll be open for questions. David, would you?

12 DR. NERENZ: Yes, thank you. This is great.  
13 Slide 15, please. This is just absolutely striking to me,  
14 particularly the bar on the right. I notice in the  
15 footnote that we're talking here in the high margin places  
16 a relatively high fraction of patients with MS, Parkinson's  
17 disease, ALS, and polyneuropathy. I don't know this area  
18 very well clinically. What do the rehab facilities do for  
19 patients with these conditions? Because clearly, they're  
20 not recovering from an acute event or, at least, I'm  
21 presuming so. What's going on day-to-day in session-by-  
22 session there?

1 MS. KELLEY: So all these patients in this  
2 analysis were post-acute patients, so they had had an acute  
3 care hospital stay before being admitted to the IRF.

4 DR. NERENZ: Now, does that mean that actually an  
5 acute clinical event necessarily or just that they were in  
6 that site of care? Do we have any way to know that?

7 MS. KELLEY: These were IRF claims matched to a  
8 preceding acute care hospital claim.

9 DR. NERENZ: Well, but just because you're in the  
10 hospital doesn't mean you've had an acute clinical --

11 MS. KELLEY: True.

12 DR. NERENZ: -- emergency.

13 MS. KELLEY: Most of the neurological cases had  
14 preceding acute care hospital stays for conditions that, in  
15 my non-clinical opinion, did not seem to be associated  
16 necessarily with their neurological condition. For  
17 example-

18 DR. HALL: I would guess that a lot of those  
19 acute admissions were for respiratory problems.

20 DR. NERENZ: Okay. Then sort of back to the  
21 original question, if those patients then with that reason  
22 for the acute hospitalization go to IRF, what is done for

1 them? Because again, it's just so visually striking here.  
2 The high margin places are taking care of a lot of these  
3 folks relative to the low margin places, and it begs the  
4 question, you know, what are they doing?

5 MS. KELLEY: So that's something we need to look  
6 into further, I think. The other thing to note that may be  
7 of interest to you is that, as I said, there's differences  
8 in the types of neurological cases that are accepted across  
9 these margin quintiles. The highest margin IRFs, the  
10 quintile five margins, the majority of their neurological  
11 cases are cases with neuromuscular disorders, with ALS or  
12 muscular dystrophy, things like that. I think we need to  
13 look further into the types of therapy that's provided for  
14 those patients.

15 DR. COOMBS: So thinking along those lines, a lot  
16 of patients that we may admit to an IRF may have had  
17 pneumonia or some other kind of factor that is actually  
18 worsened by their prevailing chronic neurologic problem  
19 that they have. So the diagnosis for which they were  
20 admitted to the acute care hospital is going to become very  
21 important in dictating, is this just an anchoring diagnosis  
22 that is put in because it carries a certain degree of

1 threshold for morbidity or resource utilization.

2           Because there are some patients with MS that,  
3 because of the very nature of MS, they might even be in  
4 remission, but they still have the diagnosis of MS. And  
5 so, I think it's really important for -- because patients  
6 will be admitted to an IRF with a multiplicity of  
7 diagnoses. They may even be post-procedural and they may  
8 be in the phase of rehabilitation and needing some therapy  
9 after a certain type of procedure as well.

10           DR. CHRISTIANSON: On this side, let's --

11           MR. KELLEY: Could I just respond to Alice?

12           DR. CHRISTIANSON: Oh, sorry. Go ahead.

13           MS. KELLEY: I just wanted to remind you that  
14 when Carol and I spoke with clinicians and discharge  
15 planners at hospitals, at a number of hospitals around the  
16 country last spring, we reported to you that we heard very  
17 different things about when an IRF is appropriate, and  
18 there were parts of -- regions where it seemed that IRFs  
19 were used much more for cases with high medical needs  
20 because of the greater -- the skill mix in IRFs; whereas,  
21 in other places that we spoke to, it was much more focused  
22 on rehabilitation. So, to some extent, this may be a



1 regional phenomenon too.

2 DR. CHRISTIANSON: Kate.

3 DR. BAICKER: Thanks.

4 I thought the information on the variability of  
5 costs as well as profitability across the different types  
6 of IRFs was really helpful. I also thought the information  
7 on quality was helpful.

8 I don't remember seeing in the chapter a  
9 breakdown of quality by those high margin versus low margin  
10 or for-profit versus not-for-profit or high-cost versus  
11 low-cost IRFs, and it would be -- I infer that they're  
12 pretty similar, but it would be helpful. Obviously, the  
13 case-mix adjustment would be really important in light of  
14 what you've shown us about the very different people  
15 showing up, and I understand that it might be harder to  
16 interpret if you think the coding is really different, so  
17 that you're comparing apples and oranges, even after you  
18 risk-adjust. But it would still, I think, be helpful to at  
19 least, if not see whole charges, have a few sentences on  
20 what those functional improvement metrics look like in  
21 those two different types of sites.

22 DR. CROSSON: Clarifying questions?

1 Cori.

2 MS. UCCELLO: Is there any auditing done  
3 currently in terms of coding?

4 MS. KELLEY: Yes. IRFs are subject to medical  
5 review by the MACs, as any other provider might be. There  
6 are sometimes questions of whether -- for example, if an  
7 IRF looks to be having difficulty in meeting the 60 percent  
8 rule, there will be a more focused medical record review  
9 for those IRFs.

10 But there hasn't been sort of a kind of wholesale  
11 investigation of the type I think you're --

12 MR. KUHN: So on the coding behavior or perhaps  
13 coding intensity, don't you know what's going on there yet?  
14 Typically, at times when we see something that you kind of  
15 describe or is kind of more isolated and not kind of  
16 system-wide, it means that you either have one particular  
17 consultant who has come up with something and moving in  
18 that direction or perhaps a particular health care system  
19 has devised something and moving in this direction.

20 And so when something like that happens, you'll  
21 see maybe assertions. When they do earnings reports on  
22 Wall Street, they'll talk about this new way of coding, or

1 consultants will even put on their websites that this is  
2 what they're doing, here is how to sell their service. Are  
3 we detecting anything like that in terms of conversations  
4 and earnings performance, or in any consultants talking  
5 about this new opportunity for coding and behaviors?

6 MS. KELLEY: I have not seen that, but I can look  
7 more deeply into that.

8 DR. MILLER: I thought you were going to give us  
9 a name.

10 [Laughter.]

11 DR. MILLER: But you are absolutely right, and  
12 it's just bandwidth, and Dana has other things she has to  
13 do. But there have been times, actually now that I think  
14 about it, in other settings where we kind of went out and  
15 looked at websites, and you could see statements here. And  
16 we can go and do some of that.

17 DR. CROSSON: And just to be clear, nothing here  
18 is to be taken as investment advice.

19 Jon.

20 DR. CHRISTIANSON: Well, that was my -- no.

21 [Laughter.]

22 DR. CHRISTIANSON: So I am -- back to your last

1 slide.

2           So there was the Chairman's recommendation, and  
3 then I'm not quite sure I follow what's going on here. So,  
4 on the possible short-term fixes, so is short term. Are  
5 you going to come back in January and say the Chairman's  
6 recommendation plus some of these fixes?

7           DR. CROSSON: I'm sorry. I probably should have  
8 clarified that.

9           So we kind of have a split thing going on here.  
10 We have this recommendation, which we will bring back in  
11 January, but the intention is to come back with more  
12 information, particularly about the coding issues, the  
13 difference in coding between the level of the case mix at  
14 the discharge from the acute care hospital and the apparent  
15 case mix on admission to the IRF as well as other coding  
16 issues that may be referable to, as Herb said, one or more  
17 organizations or one or more techniques, and bring forward  
18 additional recommendations.

19           So, when we're finished with the clarifying  
20 questions, what I'd like to do here is to have a more  
21 traditional Round 2 to pick up ideas about where we might  
22 focus that, and of course, Dana has already given a couple

1 of suggestions here. Sorry.

2 DR. MILLER: I'm sorry. If I can just say one  
3 thing, just to make sure that I understand what you just  
4 said there.

5 January is -- and particularly for turning the  
6 papers around for us -- is just a couple of weeks away, and  
7 then -- so we'll bring additional information.

8 There's probably other work and other  
9 recommendations at some point down the road that are  
10 probably deeper than we're going to be able to get back on  
11 the table in January. So the thing I would focus you on --  
12 and particularly with the last slide -- is we can always  
13 urge the Secretary -- and it is not inconsistent with  
14 things you were just saying a minute ago, Kathy -- on  
15 there's some areas here we think you should look at these  
16 types of -- as opposed to just a general admonishment, "Go  
17 do some stuff, we could say, "We see these patterns. We  
18 would urge the Secretary to look there," and if she was  
19 going to engage in medial review.

20 And then what we were trying to say on an outlier  
21 pool, that is something that I do think I could bring back  
22 in January, and I think give you at least some sense of the

1 distributional impact. And what you'd just be doing there  
2 -- not just, but what you would be doing there is if you  
3 have 3 percent of the dollars go into the outlier, which I  
4 think is the right number, somewhere in there, and you  
5 start with 3, you distributed on that basis -- and 3  
6 percent of the dollars tend to go to the low margin and of  
7 the IRF providers. If you were to take that percentage and  
8 expand it, then more of those dollars would travel out  
9 through the outlier and, given current behavior, go to the  
10 low-margin IRFs. And that's redistributive, budget-  
11 neutral, and relatively simple to bring for January.

12           If you wanted to fix the PPS, understand all the  
13 coding issues, that's not going to happen by January and  
14 then have a recommendation attached to it, that type of  
15 thing.

16           DR. CROSSON: Right. But just to be clear,  
17 because of this, this one, IRFs, we're not going to do an  
18 expedited voting. We will come back and have a discussion.

19           Mary.

20           DR. NAYLOR: Just one question on the outlier  
21 pool. I was looking for it now, but can you help -- what's  
22 the difference in length of stay in low-margin versus high-

1 margin IRFs? I'm assuming length of stay contributed to  
2 cost.

3 MS. KELLEY: On average?

4 DR. NAYLOR: On average.

5 MS. KELLEY: They're actually quite similar.

6 DR. NAYLOR: They're quite similar. So the cost  
7 then is what's happening in those days.

8 MS. KELLEY: Yes.

9 DR. NAYLOR: Thank you.

10 DR. CROSSON: Still on clarifying questions.

11 [No response.]

12 DR. CROSSON: Seeing none, to the extent that  
13 people want to discuss particularly what Mark described or  
14 have more elaboration on how changing the outlier pool  
15 might help the situation that we've got in terms of these  
16 widely divergent margins or other ideas, either on that  
17 topic specifically or topics for future work -- for  
18 example, one idea that had occurred to me would be whether  
19 -- and this is not for January recommendation, but whether  
20 it would be possible to look at that and actually measure  
21 that difference by institution between the average case mix  
22 of the discharged patients and then the case mix, average

1 case mix of what the admission criteria is to the IRF and  
2 understand whether an adjustment -- similar to the  
3 inpatient readmission policy, whether an adjustment could  
4 be made there. That's just one notion that may be  
5 administratively -- it is, administratively, much more  
6 complex than simply expanding the outlier pool.

7 But to those of you who have had more experience  
8 in post-acute care, if you have some additional thoughts as  
9 to where we might go, either in the short run or long run,  
10 this would be the time to do that. And there will be  
11 another opportunity in January.

12 MS. BUTO: I don't have more experience in the  
13 post-acute care, but I do have experience in looking at  
14 distortions in payment, and it strikes me that the  
15 neurological disorders category is more game-able. It  
16 looks like you can add -- and the high margins IRFs have  
17 added, comorbidities or lower cognitive skills, scores, or  
18 whatever it is. And I think that bears some looking at by  
19 the agency. I don't think we could do it necessarily, but  
20 it's just a game-ability and the fact that there's so much  
21 one can do to enhance payment by adding in this category  
22 that's already somewhat amorphous.



1 MS. KELLEY: Right. And I think the other  
2 complicating factor there is that neurological cases also  
3 count towards the 60 percent rule. So it's -- I think it  
4 could be a category of patients that, as you suggest, might  
5 be more game-able, might be sometimes more profitable to  
6 care for, and also satisfy the compliance criteria.

7 MS. BUTO: Right.

8 I just think there's some work that could be done  
9 there to tighten the accountability to what those patients  
10 are, and I don't know what it is, but I know the CMS staff  
11 could probably do a better job.

12 DR. CROSSON: Other comments? Bill.

13 DR. HALL: I suspect what we'd find when we do  
14 that is that, you know, people with a stroke have a  
15 permanent disability that they didn't have before. They're  
16 going to require more care, and they're not going to  
17 recover as quickly. All the neuromuscular disorders are  
18 kind of a -- not a wastebasket, but they're kind of a  
19 generic diagnosis, which is in the backdrop of why they  
20 were admitted to a hospital.

21 So the question is, are we, in some way or  
22 another, disenfranchising people with stroke by saying that

1 you will have to be at a hospital-based inpatient facility  
2 as opposed to freestanding or for-profit? I don't know the  
3 answer to that, but I think it's going to be fairly simple.

4 Another thing we might want to look at is, are we  
5 in any way disenfranchising rural areas and smaller  
6 communities? The for-profits tend to aggregate in large  
7 communities; is that right?

8 MS. KELLEY: There are not a lot of rural or  
9 IRFs, it's true. Off the top of my head, I don't know how  
10 the profit status works out rural-wise. I'd have to look  
11 into that. I'm sorry.

12 DR. CROSSON: Other comments? Jon.

13 DR. CHRISTIANSON: Well, I guess I would like to  
14 see us try to come to some recommendation in January that's  
15 beyond just freezing the payment. I mean, we've got more  
16 information about the problem. We've known about the  
17 problem for a while, and you've gone and done the research.  
18 And I don't know whether it's something like Mark was  
19 raising in terms of the outlier pool, but it seems to me we  
20 could put a little more oomph behind this than just saying  
21 freeze the payment at the past levels. At least that would  
22 be my preference right now.

1 DR. CROSSON: Yes. And I think I would  
2 definitely agree with that, and I think Mark pretty much  
3 implied that we would do that.

4 Let me just ask Mark. Would we be looking at a  
5 range of expansion of the outlier pool and the impact of  
6 that?

7 DR. MILLER: Yeah. And I wasn't meaning to imply  
8 that decision for you. I just wanted to avoid the heart  
9 attack of somebody saying "Let's do this" and me not being  
10 able to show up in January, so I want to just say --

11 DR. CROSSON: You were trying to get me under  
12 control.

13 DR. MILLER: Yes. Yes, I was.

14 [Laughter.]

15 DR. MILLER: In addition to these guys.

16 So, yes, that is what I'm saying, and I am trying  
17 to point out to you that there is some relatively remedial  
18 fixes we believe we could come back to in a rationale way  
19 in January, put on the table. You guys could take a vote  
20 on it. We can continue a longer run research.

21 To try and directly answer your question -- and  
22 again, I'm looking at Dana, and we've having a discussion

1 about her workload in public, so this will be awkward.

2 [Laughter.]

3 DR. MILLER: And I will pay for it.

4 MS. KELLEY: It's the holidays, Mark.

5 DR. MILLER: So I could imagine us coming back  
6 with, all right, if you move from 3 to 5, 3 to 10 --

7 MS. KELLEY: Yeah.

8 DR. MILLER: -- you know, here's the amount of  
9 dollars, here's the rough distributional impacts across the  
10 categories, that type of thing, in addition to trying to  
11 answer the more detailed questions that you asked as best  
12 as possible, and then some language for -- I don't know why  
13 I keep referring to Kathy, but some language for the  
14 secretary about more directed program integrity activities  
15 would be the idea.

16 DR. CROSSON: Okay. Jack.

17 DR. HOADLEY: I guess I was trying to think  
18 through a little bit a hear you think a little bit more  
19 about the kinds of information you'd be able to give on  
20 this sort of expanding outlier pool options.

21 I mean, is it -- there's one thing that it would  
22 be an effect on different kinds of institutions, and you've

1 hinted at that already, and another is sort of the kinds of  
2 cases. And you may have already given us at some point --  
3 and I don't remember at the moment -- sort of what are the  
4 cases that tend to fall in the outlier pool. And, again,  
5 somebody talked about the game-ability of it and trying to  
6 understand which cases tend to fall there, if that's just  
7 more of the above if you expand the pool or at some point  
8 do you get into a different type of case. That might help  
9 us think through the things like the game-ability.

10 MS. KELLEY: Yeah. I think we can get that as  
11 well.

12 DR. HOADLEY: Okay.

13 DR. CROSSON: Okay. If there are no more  
14 comments, then thank you very much, Dana, and we'll return  
15 to this topic again in January.

16 So our last presentation is Stephanie.

17 [Pause.]

18 DR. CROSSON: Good. Our last presentation for  
19 our December meeting is on long-term care hospitals,  
20 updates. Stephanie.

21 MS. CAMERON: Good morning. Today, we are here  
22 to discuss how payments to LTCHs should be updated for

1 fiscal year 2017. We will discuss changes in policy that  
2 are current law. Then, using the established framework, we  
3 will evaluate the adequacy of Medicare payments and LTCHs.

4 First, I will summarize some background  
5 information that was included in your mailing materials.  
6 To qualify as an LTCH under Medicare, a facility must meet  
7 Medicare's conditions of participation for acute care  
8 hospitals and have an average Medicare length of stay of  
9 greater than 25 days.

10 Care provided in LTCHs is expensive. The average  
11 Medicare payment in 2014 was over \$40,000. Similar to a  
12 short-stay acute care hospital, Medicare pays LTCHs on a  
13 per discharge basis with an upwards adjustment for cases  
14 with extraordinarily high costs. Unlike acute care  
15 hospitals, LTCHs also have a downward payment adjustment  
16 for cases with extremely short lengths of stay.

17 Beginning this year, an LTCH discharge must meet  
18 several criteria to qualify to receive the full LTCH  
19 payment rate. First, the case must not have a principal  
20 diagnosis relating to a psychiatric diagnosis or to  
21 rehabilitation. Second, the LTCH admission must be  
22 immediately preceded by an acute care hospital stay.

1 Third, the discharge either needs to have three or more  
2 days in the referring hospital's ICU or receive an LTCH  
3 principal diagnosis that includes prolonged mechanical  
4 ventilation.

5 Discharges that don't meet these criteria will  
6 receive a site neutral payment equal to the lesser of an  
7 IPPS comparable rate or 100 percent of the costs. As  
8 you'll recall, the criteria to qualify for the full LTCH  
9 standard payment rate are consistent with the direction of  
10 the Commission's 2014 and 2015 recommendation for  
11 chronically critically ill beneficiaries.

12 The Pathway to SGR Reform Act also changes the  
13 calculation of the 25 day average length of stay  
14 requirement to exclude cases paid the site neutral rate as  
15 well as cases paid by Medicare Advantage. The legislation  
16 also created a moratorium on facilities and additional  
17 beds, with some exceptions, through September of 2017.

18 Although this policy begins in 2016, most  
19 hospitals will not be affected until the latter half of the  
20 fiscal year. We don't expect to see changes in the claims  
21 data reflecting the start of this policy for several years.

22 I will now turn to the question of how payments

1 to LTCHs should be updated for fiscal year 2017. To  
2 determine the update recommendation, we review payment  
3 adequacy using our established framework you've seen  
4 throughout the last day and a half.

5           We have no direct indicators of beneficiaries'  
6 access to needed LTCH services, so we focus on changes in  
7 capacity and use. As you know, historically, this product  
8 has not been well defined and it's often not clear what  
9 Medicare is purchasing with its higher payments. The  
10 absence of LTCHs in many areas of the country makes it  
11 particularly difficult to access the adequacy of supply.

12           While about 60 percent of fee-for-service  
13 beneficiaries live in counties without LTCHs, over 95  
14 percent of beneficiaries live in counties with at least  
15 some LTCH use. There is extreme variation in the number of  
16 LTCH days per fee-for-service beneficiary by county. For  
17 example, the median utilization for LTCH care is six days  
18 per 100 fee-for-service beneficiaries, where the top ten  
19 percent of counties use 21 days per 100 fee-for-service  
20 beneficiaries. Further, almost three-quarters of these  
21 counties are located in just three states.

22           Given this high concentration of LTCH use, most



1 beneficiaries receive care at acute care hospitals.  
2 Research has shown that outcomes for the most medically  
3 complex beneficiaries who receive care in LTCHs are no  
4 better than those for similar patients that do not have an  
5 LTCH stay.

6           To gauge access to services, we typically look at  
7 capacity. Capacity is difficult to determine, given the  
8 variation across markets and LTCH occupancy rates that  
9 average 65 percent. Here, we show the cumulative growth  
10 rates that average -- excuse me. Here, we show the  
11 cumulative growth rate of LTCHs in beds since 2006. The  
12 moratorium began in 2007, but took several years to slow  
13 the growth of LTCH expansion given the exceptions provided  
14 by law. We found a reduction in the rate of growth of  
15 LTCHs starting in 2009.

16           You'll note the dash lines between 2012 and 2014.  
17 Because of inconsistencies in the cost report data, we  
18 analyzed Medicare's Provider of Services file. We estimate  
19 that the number of both facilities and beds decreased by  
20 about one percent between 2012 and 2013 and further  
21 estimate that there was a 1.7 decrease in beds and a 2.2  
22 percent decrease in facilities between 2013 and 2014.

1           This chart shows what's happening with LTCH cases  
2 per 10,000 fee-for-service beneficiaries. After rapid  
3 growth through 2005, volume continued to grow, but at a  
4 slower pace. Controlling for the number of beneficiaries,  
5 the number of LTCH cases declined after 2011, when volume  
6 peaked at 38.3 cases per 10,000 beneficiaries. Volume  
7 further declined 2.6 percent between 2013 and 2014 to equal  
8 35.7 cases per 10,000 fee-for-service beneficiaries. As  
9 you've seen, this decrease in volume has been observed  
10 across other inpatient settings, as well.

11           In terms of quality, LTCHs began submitting  
12 quality data on a limited number of measures to CMS using  
13 the LTCH care data set and the CDC's National Health Safety  
14 Network on October 1st of 2012. None of these data are  
15 currently available for analysis. However, we expect CMS  
16 to begin releasing this data publicly beginning in the fall  
17 of next year. In the meantime, we continue to rely on  
18 claims data to assess gross changes in quality of care in  
19 LTCHs.

20           Between 2010 and 2014, mortality and readmission  
21 rates were stable or declining for most of the common  
22 diagnoses. The aggregate mortality rate shown here reminds

1 us of how sick some patients in LTCHs are. On average,  
2 about one-quarter of LTCH patients die in the facilities or  
3 within 30 days of discharge. Among the top 25 conditions  
4 in LTCHs, this ranges from a high of 46 percent for  
5 patients with septicemia and prolonged mechanical  
6 ventilation to a low of three percent for patients treated  
7 with after-care with major complication or comorbidity.

8           Access to capital allows LTCHs to maintain and  
9 modernize their facilities. If LTCHs were unable to access  
10 capital, it might reflect problems with the adequacy of  
11 Medicare payments, since Medicare accounts for about half  
12 of LTCH total revenues. Historically, however, the  
13 availability of capital said more about the uncertainty  
14 regarding the regulations governing LTCHs as well as the  
15 effect of the prior moratorium than it did about payment  
16 rates.

17           Since the phase-in of the payment criteria began  
18 in October, we expect LTCHs to be working toward patient  
19 compliance over the next several years. Ultimately, we  
20 expect LTCHs to adapt their costs and case mix to mitigate  
21 the effect of the payment reduction for cases that don't  
22 meet the new criteria.

1           While the increased certainty of rules governing  
2 the LTCH payment policy would typically increase the  
3 availability of capital, the new moratorium significantly  
4 reduces opportunities for expansion and, thus, the need for  
5 capital.

6           Turning now to LTCHs' per case payments and  
7 costs, you can see why we have reason to believe that LTCHs  
8 will adapt to the upcoming regulatory changes. LTCHs  
9 historically have been very responsive to changes in  
10 payment, adjusting their costs per case when payments per  
11 case change. As you can see here, payment per case  
12 increased rapidly after the PPS was implemented.

13           After 2007, the growth in cost per case  
14 stabilized, to less than three percent per year. Between  
15 2013 and 2014, the average cost per case increased 2.2  
16 percent. Starting in 2012, Medicare payments increased  
17 more slowly than the rate of increase of provider costs.  
18 This slow payment growth can be attributed to the second  
19 year of the application of a budget neutrality adjustment  
20 and to sequestration.

21           Margins tracked the trends you see here, rising  
22 rapidly after the implementation of the PPS to a high of 12

1 percent in 2005. At that point, as growth in payments  
2 leveled off, margins began to fall. However, after 2008,  
3 with cost growth well under control, LTCH margins began to  
4 increase again until 2013. In 2013 and 2014, cost growth  
5 exceeded payment growth. The reduction in cost growth  
6 between 2013 and 2014 resulted in a 2014 aggregate Medicare  
7 margin of 4.9 percent, reflecting the effect of  
8 sequestration.

9           As you've heard from other presentations, this  
10 year, we are providing another piece of information to  
11 consider in evaluating the adequacy of payments, the  
12 marginal profit. This measure assesses whether providers  
13 have a financial incentive to expand the number of Medicare  
14 beneficiaries they serve. Because the average LTCH  
15 marginal profit was 20 percent in 2014, we contend that  
16 LTCHs have a financial incentive to increase their  
17 occupancy rates with Medicare beneficiaries.

18           Now, to provide more detail regarding the  
19 aggregate Medicare margin. As you can see, there is a wide  
20 variation in the Medicare margins similar to what we see in  
21 other settings, with the bottom quartile of LTCHs having an  
22 average margin of minus-15.3 percent and the top quarter

1 having an average margin of 18.9 percent.

2 In contrast to other sectors, the average margins  
3 are similar between rural and urban facilities this year.  
4 However, consistent with other sectors, the for-profit  
5 facilities have the highest average margin, at 6.9 percent,  
6 while nonprofit facilities have the lowest average margin,  
7 at negative-2.8 percent. There are a number of reasons why  
8 LTCHs have lower costs and higher margins that we will  
9 discuss on the next slide.

10 We look more closely at the characteristics of  
11 established LTCHs with the highest and lowest margins.  
12 This slide compares LTCHs in the top quartile for 2014  
13 margins with those in the bottom quartile. As you can see  
14 in the top line, high-margin LTCHs tend to be larger and  
15 have higher occupancy rates. They also likely benefit more  
16 from economies of scale. Low-margin LTCHs have  
17 standardized costs per discharge that were 35 percent  
18 higher than the high-margin LTCHs.

19 High-cost outlier payments make up a larger share  
20 of the average payment per discharge for low-margin LTCHs.  
21 High-margin LTCHs have fewer high-cost outlier cases and  
22 fewer short-stay cases. As you remember, these short-stay

1 cases often have reduced payment. Lastly, high-margin  
2 LTCHs are much more likely to be for-profit.

3 We previously discussed the 2014 margin for all  
4 Medicare LTCH claims. Now, we turn to a second margin  
5 calculation that includes only cases that would qualify to  
6 receive the full LTCH standard payment rate. To calculate  
7 a margin for only qualifying cases, we use the most  
8 recently available claims data combined with revenue center  
9 specific cost-to-charge ratios for each LTCH.

10 Using this methodology, we calculated a pro forma  
11 2014 margin of 7.4 percent. While this finding may seem  
12 counterintuitive when compared to the 4.9 percent aggregate  
13 margin we reported earlier in this presentation, these  
14 findings are consistent with an RTI and Kennell Associates  
15 report on the chronically critically ill LTCH population.  
16 Nonetheless, we will continue to evaluate our methodology  
17 over the policy's transition period.

18 We project that this LTCH margin will decline in  
19 2016. Updates to payments in 2015 and 2016 were reduced by  
20 a PPACA-mandated adjustment. CMS also made a budget  
21 neutrality adjustment in 2015 that further reduced the  
22 payment update.

1           There is a high degree of uncertainty regarding  
2 changes in admission patterns and cost per case associated  
3 with implementing the new patient-specific criteria.  
4 Because of this, we will be providing a margin range as  
5 part of our analysis. We expect cost growth to be higher  
6 than current law payment growth for the qualifying cases as  
7 the LTCH dual payment structure is implemented.

8           Using the projected growth in the LTCH  
9 marketbasket, we project that LTCHs' Medicaid margin for  
10 qualifying cases paid under the LTCH PPS will be between  
11 3.2 percent and 5.8 percent in 2016. Again, this margin  
12 projection reflects only cases that qualify to receive the  
13 full standard payment amount. LTCHs' aggregate Medicaid  
14 margin could differ to the extent that providers continue  
15 to provide care to beneficiaries who do not qualify to  
16 receive the full LTCH standard payment.

17           In sum, growth in the volume of LTCH services per  
18 fee-for-service beneficiary declined by about two percent.  
19 We have little information about quality in LTCHs, but  
20 mortality and readmission rates appear to be stable or  
21 improving. The effect of the current moratorium combined  
22 with adjustments to meet the patient specified criteria



1 will likely limit growth at this time. Our projected  
2 margin for qualifying cases paid under the LTCH PPS in 2016  
3 is between 3.2 and 5.8 percent.

4 We make our recommendation to the Secretary  
5 because there is no statutory update to the LTCH PPS. As a  
6 reminder, this recommendation applies to the LTCH standard  
7 payment rate.

8 With that said, the Chairman's draft  
9 recommendation reads, "The Secretary should eliminate the  
10 update to the payment rates for long-term care hospitals  
11 for fiscal year 2017."

12 CMS historically has used the marketbasket as a  
13 starting point for establishing updates to LTCH payments.  
14 Thus, eliminating the update for 2017 will produce savings  
15 relative to the expected regulatory update, even assuming  
16 the PPACA-mandated reductions. We anticipate that LTCHs  
17 can continue to provide Medicare beneficiaries with access  
18 to safe and effective care and accommodate changes in cost  
19 with no update to the payment rates for qualifying cases in  
20 LTCHs for fiscal year 2017.

21 With that, I turn it back to you.

22 DR. CROSSON: Thank you, Stephanie. Very clear.

1           Can I just ask one question? Compared to what we  
2 often look at, which is savings relative to current law,  
3 savings relative to expected regulatory update is,  
4 obviously, different. Is that a scorable thing, or is that  
5 just not?

6           MS. CAMERON: It is. So, CBO sets its baseline  
7 based on historical patterns of what the Secretary or the  
8 statute has done. Because the Secretary has given LTCHs an  
9 update and has a marketbasket update for the LTCHs, that is  
10 part of the baseline. So, CBO does assume the Secretary  
11 will provide LTCHs with an update with, of course, the  
12 marketbasket update adjusted for productivity as well as  
13 the additional PPACA adjustment. So, it would result in  
14 scorable savings.

15          DR. CROSSON: Thanks. Thanks very much.

16          Okay, clarifying questions. David, Warner, Jack.

17          DR. NERENZ: Thanks, Stephanie. A couple times,  
18 I think you used the phrase "higher payment." Can you just  
19 clarify, what are we comparing to what there under that  
20 phrase?

21          MS. CAMERON: So, in context of the cases that  
22 qualify relative to the cases that would be paid the site

1 neutral rate, cases that qualify receive the -- qualify to  
2 receive the LTCH standard payment amount.

3 DR. NERENZ: Yes.

4 MS. CAMERON: Cases that don't receive an IPPS  
5 comparable amount or 100 percent of cost, and that is  
6 typically much lower than the LTCH standard payment rate.

7 DR. NERENZ: Okay, so in -- all right. So, that  
8 is good. So, it is those two things being compared.

9 MS. CAMERON: That's right.

10 DR. NERENZ: Thank you. Okay.

11 DR. CROSSON: Warner, and then Jack.

12 MR. THOMAS: So, just a couple of questions.  
13 One, so you had mentioned that there's quality metrics that  
14 have been reported, but they're not public yet, is that  
15 correct?

16 MS. CAMERON: That is correct. In the last rule  
17 that CMS published, they said that there was an expectation  
18 that the quality data would become available in the fall of  
19 2016. That said, I think we will have to see what is  
20 released at that time to determine if we can work that into  
21 future analyses.

22 MR. THOMAS: So, at this point, there's really no

1 payments in LTCH tied to any sort of quality metrics?

2 MS. CAMERON: There are payments tied to quality  
3 reporting. There's a 2 percent reduction to facilities  
4 that don't report on a series of quality measures.

5 MR. THOMAS: But are those outcome-oriented  
6 measures?

7 MS. CAMERON: They are not. It is pay for  
8 reporting.

9 MR. THOMAS: Okay.

10 And then on page 13, where you talk about the  
11 revised Medicare margin based upon this new payment  
12 methodology, have we projected, or do we have any sort of  
13 understanding of what the impact would be on the overall  
14 profitability of -- because it looks like this is Medicare  
15 profitability, correct?

16 MS. CAMERON: That is right.

17 So, on Slide 13, the margins presented there are  
18 Medicare margins specific to the cases that the 2014 data  
19 would have met the criteria to qualify for the full LTCH  
20 standard payment rates.

21 Given the amount of uncertainty in the industry,  
22 we don't know at this point exactly how the LTCH, either

1 admitting behavior or changes in cost, will ultimately end  
2 up, and therefore, we have a lot of -- there's a lot of  
3 uncertainty of where that margin would be. So we felt more  
4 comfortable providing a margin for the cases that we  
5 assumed would continue at the costs that have been  
6 historically reported.

7 MR. THOMAS: So, at this point, it's difficult to  
8 really project an overall Medicare margin or an overall  
9 industry margin at this point?

10 MS. CAMERON: For 2016, that's right. Yeah.

11 MR. THOMAS: Or even going forward with this new  
12 payment methodology. It sounds like this is a pretty  
13 material change.

14 MS. CAMERON: It's a very material change for the  
15 industry. Over time, I think once this policy has been  
16 implemented, once the behavior has been -- and once LTCHs  
17 have adapted to this new change in payment, I suspect we  
18 will be able to again provide you the total margin and  
19 project on the total margin going forward, but in this  
20 transition, our focus has been the cases that qualify for  
21 the full standard payment rate.

22 MR. THOMAS: Great. Thanks.

1           Mr. Chairman, will we have a Round 2 or not on  
2 this topic?

3           DR. CROSSON: Good question, Warner. I wanted to  
4 sort of get a sense of where we're going in terms of  
5 whether the questions are material to the recommendation or  
6 not. Some have -- we just started, but yours is. So I  
7 think if you want to expand on this question and suggest a  
8 different update, then we'll have a Round 2.

9           MR. THOMAS: I have a separate comment not  
10 related to the recommendation.

11          DR. CROSSON: Then we'll do that at Round 2.

12          MR. THOMAS: Okay. Thank you.

13          DR. CROSSON: Jack?

14          DR. HOADLEY: Yeah. You gave us a lot of text  
15 boxes and things in the chapter to talk about our past  
16 recommendations in the legislation. What's the main thing  
17 that is in our past recommendations that has not been  
18 incorporated in the legislative changes? What's still on  
19 the agenda of our old recommendations?

20          MS. CAMERON: So I think there were two kind of  
21 fairly significant differences between the legislation and  
22 a recommendation. The first was the legislation provided

1 for three days of ICU use where our recommendation was  
2 eight days.

3 On the other side, our recommendation did not tie  
4 the cases that did not meet the criteria to a lesser-of  
5 calculation of payment. So we had said that the cases  
6 should be paid in IPPS comparable rate, not this lesser of  
7 IPPS or cost.

8 The third tier to our recommendation was that  
9 there would be an increase in payments for these CCI cases  
10 in the acute care hospitals, and that was not written into  
11 law either.

12 DR. HOADLEY: Thank you.

13 DR. CROSSON: Bill Gradison and then Kathy.

14 MR. GRADISON: I found it very helpful in the  
15 preceding presentation with regard to the IRFs, the  
16 appendix, which compared the use of that type of facility  
17 by MA plans versus fee-for-service.

18 Is it possible, not necessarily by January, but  
19 is it possible to develop, looking forward, comparable  
20 information by comparing MA use versus fee-for-service use  
21 in the counties which have LTCHs?

22 DR. MILLER: The way we did that, if I remember,

1 we had to kind of go out and especially find that  
2 information, if I remember.

3 Do you want to come over here, Dana? Talk into  
4 the microphone.

5 MS. KELLEY: So the IRF analysis uses the  
6 assessment tool, the IRF pie, which facilities are required  
7 to perform for both Medicare Advantage and fee-for-service  
8 patients. So we have full information on Medicare  
9 Advantage use of IRFs. We don't have any assessment tool  
10 in the LTCH, and so any use by LTCHs would be -- any use of  
11 LTCHs for Medicare Advantage would be in the encounter  
12 data, I guess.

13 And the other thing I would add is that in the  
14 past -- this is a while ago -- we spoke with a number of  
15 Medicare Advantage plans about their use of LTCHs and  
16 generally found that they use them relatively rarely and  
17 predominantly for ventilator-dependent patients.

18 MR. GRADISON: Thank you very much. Thank you  
19 both.

20 MS. CAMERON: And we'll add to that as well.  
21 Where we do know Medicare Advantage uses LTCHs, the  
22 publicly available data we have on this, it's very low,



1 about 10 percent.

2 DR. CROSSON: I'm sorry. It's 10 percent of  
3 what?

4 MS. CAMERON: Medicare Advantage makes up about  
5 10 percent of some LTCH days.

6 DR. CROSSON: I see. Thank you. Okay.  
7 Kathy?

8 MS. BUTO: I'm just trying to understand the  
9 recommendation a little bit. If the Secretary eliminates  
10 the update -- first of all, our margin, the range that  
11 we've estimated the margins would be would obviously be  
12 lower, correct?

13 MS. CAMERON: That's right.

14 MS. BUTO: I mean, this assumes current law, so  
15 you've taken whatever the Secretary has done in the past  
16 and tried to estimate what that margin would be.

17 MS. CAMERON: Right. And for 2017, the data  
18 indicate that LTCHs would have otherwise received about a  
19 1.7 percent update.

20 MS. BUTO: Okay. So are we basing eliminating the  
21 update on -- because given the estimate we have is 3.2  
22 percent to 5.8 percent, because there have been some

1 impacts on what the margin would be going forward -- so are  
2 we basing that recommendation on the Medicare margin for  
3 qualifying cases? Is that sort of the way we're  
4 approaching this?

5 The other thing that you said that really struck  
6 me was their ability to adjust to whatever the payment is  
7 has been incredibly -- so they're very flexible in the  
8 ability to adjust their cost to accommodate any payment  
9 adjustments, it sounds like.

10 MS. CAMERON: Historically, that's what we have  
11 seen. This update does in fact speak to only the cases  
12 that would qualify to receive the full LTCH standard  
13 payment rate.

14 MS. BUTO: Okay. And the margins that we're  
15 estimating are higher, so --

16 MS. CAMERON: Right.

17 MS. BUTO: Thank you.

18 DR. MILLER: Sort of the way I think about it and  
19 the way we've tried to work through this -- and Stephanie  
20 has sweat a lot over this because we have this industry  
21 right in the middle of transition and sort of how to talk  
22 about this. And if this helps you, the way I think about

1 it is if you look at it the hold way, across all cases,  
2 it's about five. Our best current -- and, of course, we  
3 don't make the decision entirely on the margin, but to deal  
4 with your margin point. The best Stephanie can tell with  
5 the cases that would qualify with current data, it's  
6 actually higher. And then projecting forward, we expect a  
7 lot of change in this industry, and so she's giving you her  
8 best range, from 3 to 5 or whatever the actual final  
9 numbers were.

10 But whether you looked at this strictly as a CCI  
11 -- or sorry -- the qualifying cases using current data or  
12 all the cases using current data, it's 5 to 7, and I think  
13 that's the comfort range of saying no update, I think is  
14 the logic. Is that --

15 MS. CAMERON: That's right. I mean, we really  
16 don't know exactly how this, cases and the industry, will  
17 change.

18 AT this point, this quarter, only 12 percent of  
19 facilities will begin the implementation. There was an  
20 earnings call one month into the implementation for one of  
21 the for-profit chains, who reported that three of their  
22 facilities had converted to this new payment system, and

1 that each of those three facilities were in fact able to  
2 replace the patients, the site-neutral, the non-qualifying  
3 patients with patients that qualify.

4 Now, I will say this chain was very, very  
5 cautious in providing this information out of concern that  
6 maybe this won't be reflective of all of the facilities.  
7 That is one indicator, though, that there could be a lot of  
8 movement of beneficiaries.

9 DR. CROSSON: We're still on questions. Alice.

10 DR. COOMBS: Round 2?

11 DR. CROSSON: Well, we can go to Round 2. Are  
12 you on Round 2? So I think actually Warner was first, and  
13 then we'll got Alice and then Rita.

14 MR. THOMAS: So my Round 2 comment isn't  
15 specifically at LTCH. It really is specifically at post-  
16 acute in general, and one of the things that we're doing  
17 actually with one of the rehab providers is constructing a  
18 facility to put all of our -- new facility that's putting  
19 all post-acute in one facility. And I would just encourage  
20 us -- this may be outside of the realm of the payment  
21 update, but to take on or to look at the possibility of a  
22 post-acute payment because, essentially, what you have is

1 it's very difficult to ascertain where patients should go.  
2 Should they go LTCH? Should they go SNF? Should they go  
3 IRF? And it's very difficult.

4           And the regulations are problematic for folks  
5 that are in this each and every day. I know it's not  
6 necessarily for this meeting, but I would encourage us to  
7 put that on our agenda to think about how we could provide  
8 some advice and guidance as to what that might look like  
9 going forward.

10           DR. MILLER: And you'll see it next month, so we  
11 do have this conversation going about trying to look  
12 across, you know, getting a more unified payment system for  
13 post-acute care broadly. We had some conversation starting  
14 in the fall, and the next one comes up in January, unless  
15 I'm forgetting. So we'll be right back to this.

16           MR. THOMAS: So I teed it up right for you, Mark?

17           DR. MILLER: It was perfect.

18           MR. THOMAS: Perfect timing? Good.

19           DR. CROSSON: So, given your predictive accuracy,  
20 I will accept investment advice from you.

21           [Laughter.]

22           DR. CROSSON: Okay.

1 DR. COOMBS: Thank you very much, Stephanie.  
2 Excellent presentation.

3 As we have talked about the CCI cases and site  
4 neutrality, one of the questions I had was, going forward,  
5 how much of this LTCH population is going to be in that  
6 site-neutral versus what we would have anticipated if we  
7 got a recommendation of eight days of intensive care, and I  
8 think that recommendation was a very good recommendation.

9 Part of the missing piece of the puzzle in terms  
10 of being more persuasive would have been if we could have  
11 said that by going to that benchmark of eight days, it  
12 would have decreased the likelihood of overpayment or more  
13 appropriate payment for X number of patients, and I think  
14 that would be a more persuasive argument.

15 As you know, LTCHs serve a definite role. I  
16 being an ICU person understand that the role that they play  
17 is really cardinal for mechanically ventilated patients and  
18 also the ones with wound vacs -- and we talked about them -  
19 - because of the protocols that are in the LTCHs, which are  
20 different than what you would see in a SNF or an IRF. So  
21 they have mastery in terms of protocols for those type of  
22 patients. However, we all agree that they have other

1 patients there, that this overlap is tremendous.

2           So I was looking at two things. One is, what is  
3 this big patient population at the LTCH? How big is it?  
4 And then how better can we persuade that going to an eight-  
5 day ICU length of stay is a better benchmark rather than a  
6 three-day?

7           MS. CAMERON: The eight-day ICU stay requirement  
8 would have encompassed, I believe, about 36 percent of the  
9 LTCH fee-for-service beneficiaries.

10           We base the eight-day ICU stay on several reports  
11 to CMS that were done by Kennell and RTI, and the eight-day  
12 was the number that they showed only -- I believe the LTCH  
13 setting was the only setting in the post-acute care realm  
14 that saw patients with eight or more days in the ICU, and  
15 ultimately, that's how we ended up with the eight-day  
16 recommendation.

17           DR. COOMBS: So one of the things I'm thinking  
18 about is that three-day ICU stay encompasses all kind of  
19 cases. I mean -- and some that are not really appropriate  
20 for an LTCH, and so to steer those patients, I mean, in  
21 some settings, they might be steered to an LTCH when they  
22 didn't need to have that kind of level of intensity.

1 MS. CAMERON: I mean, I think -- yes. I think  
2 the Commission picked eight days for a reason. The  
3 legislation picked three, so there is kind of a  
4 differential there where one could say the eight days as a  
5 more strict requirement does better capture the population  
6 that we feel should be in LTCHs.

7 As we do look even at the three-day differential,  
8 we find that the types of cases are much more concentrated  
9 in the top kind of 25 diagnoses. So, as you remember, if  
10 you look at all of the Medicare cases in LTCHs, the top 25  
11 diagnoses make up about two-thirds of those patients. When  
12 we only look at the cases that qualify -- so I'm only using  
13 the three-day definition -- we're basically looking at  
14 almost 80 percent of those cases.

15 So, even going from kind of a no criteria to  
16 three-day, you do get some increased concentration. I  
17 haven't looked at that, however, for eight-day, so that is  
18 something I can see if I can get to you.

19 DR. COOMBS: Okay. My only comment is that we're  
20 looking at things that we do for the general population,  
21 but I'm thinking that if you can internally change the  
22 behavior of what gets sent to the LTCH, that's probably



1 more powerful than just saying whatever we're recommending  
2 for this year's uptake.

3 DR. CROSSON: Rita.

4 DR. REDBERG: Thank you, Stephanie, for an  
5 excellent chapter on a really complex -- you know, with  
6 changing legislation and moving targets.

7 So my comments really are similar to things we  
8 have discussed before, but I have a lot of concerns that  
9 long-term care hospitals fit into the whole sort of goals  
10 of higher quality, better value, and better outcomes  
11 because these are clearly very expensive places to care for  
12 people. The outcomes seem very poor. The third most  
13 common LTCH DRG was septicemia without ventilator support,  
14 which had 46 percent mortality. I mean, all the mortality  
15 rates are incredibly high. We don't do it, but I suspect  
16 patient satisfaction is low because people don't like to  
17 die in institutions on ventilators. They prefer to be at  
18 home, if possible.

19 And I think some of this is quite predictable  
20 that the mortality rates would be high. Clearly, these  
21 people are sick, but I think -- yesterday we talked about  
22 hospice care, an increasing use of hospice care, and I

1 think there you have -- perhaps the outcomes would be  
2 similar. These are very sick people, but putting them in a  
3 very expensive, unpleasant, uncomfortable place without  
4 really realistic hope of improvement, I'm not sure is good  
5 for the patient or the program. The fact that there's such  
6 variation in use of LTCHs without difference in outcomes  
7 doesn't make one question how are these contributing at all  
8 to improving care. It's a lot of money that going into  
9 these programs.

10 DR. CROSSON: So I think a couple things. As  
11 Mark said and Jim confirmed, in January we are going to be  
12 looking at sort of a site-neutral post-acute care policy,  
13 which could resolve some of that, and we're still left in  
14 this particular case with the fact that, as you know, in  
15 many parts of the country, it's very hard to find a place  
16 to place someone who needs ventilator care, and so that  
17 part of the problem.

18 DR. MILLER: So the other thing I would say --  
19 and we do this at this particular time of the year, and the  
20 Commissioners regularly express some frustration with it.  
21 We're talking about -- by law, we have to talk about what  
22 to pay the IRF. Don't forget -- and this is what Alice was

1 saying -- we've made a separate recommendation that the  
2 right way to target patients for this -- and I'm not being  
3 very articulate, but this particular setting -- is this  
4 eight-day ICU, and then we also made exceptions for  
5 ventilator patients, which I couldn't articulate that rule  
6 right off the top of my head. But I know Stephanie could.

7           So while we're not talking about it aggressively  
8 at the moment, don't forget we've also said in this setting  
9 that there is a much more targeted way to go at this in a  
10 set of patients that might make more sense to be there,  
11 although even in that population, I imagine many of your  
12 comments still stand about where somebody should spend the  
13 last days of their life. I don't mean in any way to reject  
14 that, but the notion of trying to get the best spend for  
15 the dollar is decidedly tied up in this eight-day thing.

16           And I didn't make the comment when Alice was  
17 making it because it was a real cheerleader comment, which  
18 I'm not really particularly good at. The way I see the  
19 situation is the Commission came along and said it should  
20 be eight, and in a relatively short framework, the Congress  
21 went to three, which in some ways, given the way things  
22 work, is pretty huge. But, as Alice says, we're still not

1 there, and that's what I'm also trying to say to you.

2 DR. NERENZ: Well, just to follow on Rita's  
3 comment, I think as we have this discussion of a broader  
4 post-acute care model, and this would also tie to Warner's,  
5 up until your comment, I hadn't thought about life  
6 expectancy or severity of illness as a key part of that,  
7 and I think we'll just need to explore, particularly with  
8 leadership from the clinicians here, about how much of a  
9 branch point or a grouping point that could be. Because I  
10 understand sometimes you don't know or it's not clear.

11 But the last line of discussion was kind of about  
12 LTCH versus hospice, but I'd been thinking about LTCH  
13 versus acute care as something else. I think what  
14 underlies that is the sense of, are we talking about  
15 someone who's very unlikely to survive or are we talking  
16 about somebody who's very likely to survive? So that's  
17 just an observation. I think it enriches the discussion.

18 DR. MILLER: I'm sorry to run this on and I'll  
19 stop, but early on, and it's been many years now, we did  
20 site visits to LTCHs when we first, very first, years ago,  
21 tried to break ground on this area. And I remember  
22 specific conversations going from LTCH to LTCH with medical

1 directors saying precisely what Rita was saying. Many of  
2 the people in here probably should be in hospice, and  
3 either just didn't understand their options, conversations  
4 that we've had here about kind of even how physicians deal  
5 with it, and of course, families who want to deal with  
6 their relatives in a particular way. But decidedly, this  
7 came up repeatedly in those conversations with medical  
8 directors.

9 DR. HOADLEY: Just following on that point, I  
10 remember some of those interviews where people would say,  
11 you know, because we have an LTCH, it gives us the basis to  
12 avoid that conversation. When we don't have an LTCH, if  
13 you're in a particular community LTCH, okay, there aren't  
14 good options, so let's talk about what hospice could mean  
15 and let's have that end-of-life conversation. And so, you  
16 know, the presence of different kinds of sites gives  
17 incentives or disincentives to have those conversations in  
18 kind of subtle and maybe not to subtle ways.

19 DR. CROSSON: Good discussion there. Other  
20 comments?

21 So where we are here is we have a recommendation  
22 to eliminate the update, and I think Stephanie has been

1 very clear that there's a little bit of a level of  
2 uncertainty going on, particularly because of the  
3 application of the regulations passed in the Affordable  
4 Care Act. Nevertheless, in the conversation I didn't hear  
5 a lot of suggestion that we should do something different  
6 with respect to the update at this point in time.

7           So I just want to test that and see if that's, in  
8 fact, the case, if people are comfortable going ahead with  
9 this recommendation and then put it into expedited voting  
10 in January. I'm getting general agreement. Got these  
11 frozen in place, but other --

12           MS. BUTO: I mean, the way you described it is  
13 the way I feel, which is there's a lot of uncertainty about  
14 this. On the other hand, I'm very sensitive to the fact  
15 that I think many of us think there's an over-utilization  
16 of LTCH services for some patients. So I guess I'm glad in  
17 this case the Secretary will have to decide this and will  
18 probably have to go out with notice and comment before she  
19 does anything. I don't think we really know what the  
20 impact is of no update, but I'm comfortable with it. I  
21 think since we're recommending to the Secretary that she  
22 consider it, I think that's an appropriate thing.

1 DR. CROSSON: Okay. So seeing no objection,  
2 we'll go ahead with that in January. So if I have counted  
3 properly, it looks like in January we'll be coming back for  
4 more in-depth discussions on Medicare Advantage, on  
5 hospital and on IRFs. The other seven will be an expedited  
6 voting. We're going to talk about APMs. Jim, remind me.  
7 And then we're going to talk about unified payment for  
8 post-acute care. Anything else in January? Jim doesn't  
9 like to be surprised.

10 DR. MILLER: Well, Jim doesn't like to talk to  
11 people. Those will be two of the big things. I don't have  
12 January's agenda right up in my mind either. We're  
13 basically going to move on to our other issues. I think  
14 we're going to move on to our other issues, but two of them  
15 will be at least those.

16 DR. CROSSON: Okay. Having said all that, thank  
17 you. We are ready for our public comment period for this  
18 morning, so if there are any members of the audience who  
19 wish to make comments, now is the time to come to the  
20 microphone and identify yourself so we can see who you are.

21 [No response.]

22 DR. CROSSON: Seeing none, we are adjourned for

1 our December meeting. See you all next year.

2 [Whereupon, at 10:33 a.m., the meeting was  
3 adjourned.]

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