

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Thursday, November 1, 2018  
9:21 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
AMY BRICKER, RPh  
KATHY BUTO, MPA  
BRIAN DeBUSK, PhD  
MARJORIE GINSBURG, BSN, MPH  
PAUL GINSBURG, PhD  
DAVID GRABOWSKI, PhD  
JONATHAN JAFFERY, MD, MS, MMM  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

B&B Reporters  
29999 W. Barrier Reef Blvd.  
Lewes, DE 19958  
302-947-9541

| AGENDA  | PAGE |
|---|------|
| Mandated report: Long-term care hospitals   |      |
| - Stephanie Cameron, Emma Achola.....   | 3    |
| Evaluating patient functional assessment data used in<br>Medicare payment and quality measurement |      |
| - Carol Carter, Ledia Tabor.....  | 49   |
| Public Comment.....   | 95   |
| Modifying the A-APM incentive payment   |      |
| - Kate Bloniarz, David Glass.....   | 98   |
| Modernizing the Medicare-Dependent Hospital program   |      |
| - Stephanie Cameron, Jeff Stensland.....  | 154  |
| Promoting greater Medicare-Medicaid integration in<br>Dual-eligible special-needs plans           |      |
| - Eric Rollins.....   | 201  |
| Public Comment.....   | 243  |

P R O C E E D I N G S

[9:21 a.m.]

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

DR. CROSSON: All right. I think we can begin. We're going to entertain the second part of our discussion leading to our mandated report on long-term care hospitals. We've got Stephanie and Emma here this morning, and, Stephanie, it looks like you're going to start.

\* MS. ACHOLA: Good morning. Today we are here to discuss long-term care hospitals in response to a congressional mandate due in June of 2019. Before we begin, I would like to thank Cindy Saiontz-Martinez for her contributions to this project.

In September, we discussed the regulatory and legislative history of LTCHs and the context for the mandate. As we provided in your mailing materials, today's presentation will review the mandate and present initial findings using data through 2016. These findings include operational changes LTCHs made in response to the policy as well as trends in LTCH supply, use, and financial performance. We will also review patterns of post-hospital discharge to other post-acute care and hospice providers. Lastly, we will discuss the LTCH quality data since the

1 implementation of the policy.

2           As detailed in your mailing materials, to qualify  
3 as an LTCH under Medicare, a facility must meet Medicare's  
4 conditions of participation for acute-care hospitals and  
5 have an average length of stay for certain Medicare cases  
6 of greater than 25 days. Care provided in LTCHs is  
7 expensive: The average Medicare payment in 2016 was over  
8 \$41,000 across all cases. In 2016, Medicare spending  
9 totaled just over \$5.1 billion for about 126,000 cases.  
10 Medicare fee-for-service beneficiaries accounted for about  
11 two-thirds of discharges.

12           As you'll recall, the Pathway for SGR Reform Act  
13 of 2013 changed the way LTCHs are paid and established a  
14 dual-payment rate structure. Cases that meet criteria are  
15 those that are preceded by an acute-care hospital discharge  
16 and spend either three or more days in the ICU of the  
17 referring acute-care hospital or receive prolonged  
18 mechanical ventilation in the LTCH. These cases receive  
19 the full LTCH payment rate. All other cases, those that do  
20 not meet criteria, are paid a lower site-neutral rate. The  
21 policy began in fiscal year 2016 and is being phased in  
22 over four years. Until 2020, cases that do not meet the

1 criteria are paid a rate equal to 50 percent of the site-  
2 neutral rate and 50 percent of the standard LTCH payment  
3 rate.

4           Given the extent of this payment change, the  
5 Congress mandated that MedPAC examine the effect of the  
6 dual-payment rate structure on different types of long-term  
7 care hospitals, the growth in Medicare spending for  
8 services in LTCHs, the use of hospice care and post-acute  
9 care settings, and the quality of care provided in long-  
10 term care hospitals. The final report is due to the  
11 Congress June of 2019.

12           We face several analytic challenges in carrying  
13 out this work. First, because the dual-payment rate policy  
14 is being phased in over a four-year period, the policy is  
15 still only 50 percent implemented, and our analyses will  
16 reflect this partial policy phase-in. Next, LTCH spending,  
17 use, and margins began to decrease prior to the  
18 implementation of the dual-payment rate structure, so we  
19 compared the rate of change in the years prior to the  
20 policy implementation and the years after. Lastly, LTCHs  
21 have relatively low volume of cases compared with the close  
22 to 5 million PAC admissions and episodes and 1.4 million

1 hospice users; therefore, it will be difficult to detect  
2 changes in use of other PAC providers in aggregate.  
3 Because of this, we isolate our analysis to certain acute-  
4 care hospital diagnoses that are more likely to be  
5 discharged to an LTCH. We also analyze discharge patterns  
6 from acute-care hospitals by different areas based on their  
7 historical use of LTCHs. Even with these attempts to  
8 isolate any changes that occurred, we urge caution in  
9 interpreting the data to attribute such changes to the  
10 implementation of the dual-payment rate structure given the  
11 limited time frame of the available data.

12           Given the limitations with the administrative  
13 data, we augmented our quantitative analyses with site  
14 visits and interviews. Your mailing materials provide  
15 detail of these visits, and I am happy to discuss further  
16 on question. Generally, all of the facilities we spoke  
17 with reported the need to make operational changes in  
18 response to the implementation of the dual-payment rate  
19 structure. The degree to which these changes occurred  
20 varied from facility to facility, and facilities reported  
21 either changing their admission patterns to admit only  
22 patients who met criteria or continuing to take

1 beneficiaries who do not meet the criteria.

2           Some facilities interviewed halted admitting  
3 cases that did not meet criteria. LTCH staff explained the  
4 financial and practical reasons for taking this approach.  
5 Some administrative staff expressed that payments under the  
6 blended rate were not adequate to cover their costs.  
7 Additionally, focusing on cases that met criteria was  
8 helpful to referral sources and provided clear guidance  
9 regarding the kinds of patients appropriate for LTCH  
10 referral. In order to ensure an adequate daily census of  
11 cases that met criteria, interviewees stated their  
12 facilities expanded their referral regions and educated  
13 physicians and case managers in the acute-care hospital on  
14 the LTCHs' capabilities. Additionally, some staff reported  
15 efforts to contract with private payers, including MA  
16 plans, in order to expand the mix of patients and payers.

17           In contrast, some LTCHs interviewed continued to  
18 admit cases that did not meet criteria. Facilities  
19 reported several reasons for taking this approach,  
20 including maintaining relationships with referring acute-  
21 care hospitals, providing a service to the community, and  
22 the belief that cases with a short stay -- typically cases

1 with a length of stay of seven days or less -- could be  
2 financially profitable under the blended rate. Staff at  
3 some facilities, however, expressed concern about the  
4 viability of this approach when the policy becomes fully  
5 phased in during fiscal year 2020.

6           Across facilities we spoke with, there was a  
7 consensus regarding an increase in patient acuity. As a  
8 result, staff at facilities interviewed reported the  
9 increased skills necessary at each staff level. For  
10 example, nurses were expected to be able to provide ICU-  
11 level care and received additional training, including  
12 critical care training. Facilities also increased their  
13 capabilities adding bariatric beds, ICU beds, and telemetry  
14 services. However, even with these admission and  
15 operational changes, staff members at several LTCHs  
16 referenced declining occupancy rates and closures. To  
17 mitigate these declines, some facilities planned to  
18 repurpose beds as inpatient psychiatry, inpatient  
19 rehabilitation, or skilled nursing beds. Another facility  
20 stopped staffing an entire floor, closing those beds to  
21 patients, while another reduced the number of beds it  
22 leased from its host acute-care hospital.

1 MS. CAMERON: So the closures that Emma mentioned  
2 during our site visits and interviews are supported by our  
3 data analysis. Since the start of the dual-payment rate  
4 structure, over 40 facilities have closed, representing  
5 about 10 percent of the industry. Most of these closures  
6 occurred in a areas with other LTCHs, and the remaining  
7 closures occurred where the closest LTCH was within a two-  
8 hour drive. Further, for-profit facilities comprised about  
9 90 percent of the closures. Facilities that closed tended  
10 to have a lower share of discharges that met the criteria,  
11 lower occupancy rates, lower Medicare margins, and higher  
12 standardized costs than facilities that remained open.

13 The share of LTCH discharges that meet the  
14 criteria has increased since 2012. Just over half of cases  
15 met the criteria prior to the implementation of the new  
16 dual-payment rate structure; however, this share increased  
17 to about 64 percent in 2017. Certain types of facilities  
18 have been better able to change their admission patterns  
19 and take a higher share of cases that meet the criteria.  
20 For example, in 2017, only 46 percent of LTCH cases in  
21 rural areas, on average, met the criteria compared with  
22 about 64 percent in urban areas. But the aggregates don't

1 tell us a lot, so next I'm going to review changes in the  
2 volume of cases in areas with high LTCH volume compared to  
3 areas with low LTCH volume.

4           For the remainder of this presentation, we refer  
5 to areas of the country with the highest beneficiary use  
6 based on LTCH days per capita as "high-use areas" and to  
7 areas of the country with the lowest LTCH use as "low-use  
8 areas." As expected, we generally found reductions in  
9 cases that did not meet the criteria nationwide. We also  
10 found a decrease in the volume of cases that meet the  
11 criteria in high-use areas, continuing a trend that began  
12 before the implementation of the dual-payment rate  
13 structure. In contrast, we found increases in the share of  
14 cases that meet the criteria in low-use areas. These  
15 beneficiaries had higher illness severity, risk of  
16 mortality, and longer ICU stays than beneficiary from high-  
17 use areas, possibly suggesting a higher threshold of  
18 illness for LTCH use in low-use areas.

19           Now, even though the share of cases that meet the  
20 criteria has increased, there is still a large share of  
21 cases that do not meet the criteria and thus are paid a  
22 lower rate. These reduced payments resulted in lower LTCH

1 Medicare margins in 2016. Facilities with a relatively  
2 high share of discharges that did not meet the criteria saw  
3 a 13 percent reduction in payment per case and a 7 percent  
4 reduction in cost per case across all discharges. However,  
5 facilities with a lower share of discharges that did not  
6 meet the criteria saw increases in both payment and cost  
7 per case in aggregate. However, this is based off less  
8 than one year of data and only for about one-third of  
9 LTCHs. We will continue to monitor the trends in margins  
10 as cost report data increasingly reflect the policy phase-  
11 in across all LTCHs. Now that we've discussed the changes  
12 in LTCH use, we will move to changes in use of other post-  
13 acute care and hospice providers over time.

14           Spending for PAC grew slightly from 2012 through  
15 2016; however, the supply of PAC providers has remained  
16 stable. On a per beneficiary basis, PAC use has decreased  
17 slightly from 2012 through 2016. In contrast, hospice  
18 spending increased since 2012 in tandem with the number of  
19 hospice providers; however, on a per beneficiary basis,  
20 hospice use remained stable over this time period. Again,  
21 these aggregates do not necessarily reflect changes in  
22 acute-care hospital discharge pattern following the

1 implementation of the dual-payment rate structure given the  
2 relatively small volume of LTCH users. Therefore, we  
3 consider changes in the share of discharges for acute-care  
4 hospital stays by ICU length and by areas of the country  
5 with high and low historical LTCH use.

6           Here we have discharge patterns across PAC and  
7 hospice from 2015 to 2016. Starting with the bars on the  
8 left-hand side, you can see little change in PAC and  
9 hospice use in aggregate. The next four bars as you  
10 continue to the right show PAC and hospice use for 2015 and  
11 2016 in high-LTCH-use areas and then in low-LTCH-use areas.  
12 While we observe here that the use of PAC and hospice are  
13 different in the high-use areas compared with the low-use  
14 areas, we observe minimal changes over time.

15           Because we were unable to see differences in  
16 aggregate by high and low LTCH use areas, we next consider  
17 differences based on beneficiaries' length of stay in an  
18 ICU during their prior acute-care hospital stay. For  
19 beneficiaries with ICU stays less than three days, we find  
20 minimal changes in LTCH, other PAC, and hospice use in low-  
21 use areas. In high-use areas, we find a slight decrease in  
22 LTCH use, but minimal changes across other PAC and hospice

1 use. For acute-care hospital discharges with longer ICU  
2 stays, those lasting three days or more, we find increases  
3 in the share of beneficiaries discharged to LTCHs in both  
4 high- and low- use areas. In high-use areas we  
5 simultaneously find a decrease in the share of  
6 beneficiaries discharged to SNFs. However, because some  
7 changes began occurring prior to the implementation of the  
8 policy and this analysis considers only one year of data  
9 post policy, we emphasize the need for caution in  
10 attributing these findings to the implementation of the  
11 dual-payment rate structure.

12           Lastly, we consider certain conditions that are  
13 more likely to use LTCH care from an acute-care hospital.  
14 We find little change across low-LTCH-use areas, so here  
15 I've provided changes based on areas with high LTCH use.  
16 As you might expect, the share of acute-care hospital cases  
17 discharged to an LTCH increased for certain conditions that  
18 meet the criteria based on ventilator use, including MS-DRG  
19 003 as provided in the table. Here we see a three  
20 percentage point increase in the share of acute-care  
21 hospital discharges that use LTCHs from 2015 to 2016. In  
22 contrast, the next two diagnoses are less likely to use an

1 ICU for three days or longer and, therefore, the decrease  
2 in the share of these conditions discharged to an LTCH is  
3 not surprising. For these conditions, we find slight  
4 increases in SNF use. However, I again want to urge  
5 caution in the interpretation of these results given the  
6 limited data we have analyzed to date.

7 So now that we have examined discharges to other  
8 PAC and hospice providers, we move to our analysis of  
9 quality.

10 The Commission's measures of unadjusted direct  
11 acute-care hospital readmissions, in-LTCH mortality, and  
12 30-day mortality have remained stable since 2015. In our  
13 comparisons of quality measures for cases that meet the  
14 criteria, we find similar rates of direct acute-care  
15 hospital readmissions and 30-day post LTCH mortality, but a  
16 higher rate of in-LTCH mortality. This finding echoes some  
17 of the site visit discussions regarding the admission of  
18 sicker patients in response to the dual-payment rate  
19 structure. We will update this work based on 2017 data as  
20 part of our payment adequacy analysis that we will be  
21 presenting to you in December.

22 Lastly we consider national rates of risk-

1 adjusted measures. Rate of pressure ulcer, catheter-  
2 associated urinary tract infection, central line-associated  
3 bloodstream infection, and 30-day unplanned readmission are  
4 all publicly reported. Here we find minimal differences  
5 since 2015. For example, the rate of pressure ulcers  
6 improved very slightly, while catheter-associated urinary  
7 tract infection increased but still remains lower than  
8 expected. The measure of central line-associated  
9 bloodstream infection remained stable while 30-day  
10 unplanned readmission rates increased marginally. Based on  
11 the lack of consensus in the direction of these changes and  
12 given the minimal changes that did occur, we are unable to  
13 attribute any change in quality to the implementation of  
14 the dual-payment rate structure.

15           We've given you a lot of information today. In  
16 summary, the share of cases that do not meet the criteria  
17 in LTCHs -- excuse me. In summary, the share of cases that  
18 meet the criteria in LTCHs has increased while the volume  
19 of cases not meeting the criteria has decreased. A  
20 relatively large number of facilities have closed; however,  
21 these closures have primarily occurred in areas of the  
22 country with multiple LTCHs and have had lower shares of

1 cases that meet the criteria, lower occupancy, and higher  
2 costs than LTCHs that have remained open. Changes in the  
3 supply or use of other post-acute care and hospice  
4 providers have been minimal. We were unable to detect  
5 consistent or significant changes across the available LTCH  
6 quality measures to date.

7           Keep in mind that LTCHs comprise a relatively  
8 small share of PAC and hospice use, and, therefore, it is  
9 difficult to observe the effect of any policy especially  
10 given the recent implementation of the policy, which  
11 severely limits our capabilities in interpreting any  
12 changes in the use of other providers and in quality  
13 measures. We will continue to monitor trends in use across  
14 PAC and hospice, facility closures, and quality as data  
15 become available.

16           That concludes today's presentation. We look  
17 forward to your questions and feedback on the information  
18 we've presented today, our overall approach to fulfilling  
19 the mandate, and any additional areas of interest you have  
20 in this sector. As a reminder, this spring we will present  
21 a draft of our report to Congress that reflects guidance  
22 you provided in our September meeting and will provide

1 today and relevant analyses in our payment adequacy work  
2 that we will present next month.

3 And, with that, I turn it back to Jay.

4 DR. CROSSON: Thank you, Stephanie and Emma.  
5 Nice work. Nice presentation.

6 We'll take clarifying questions. Kathy.

7 MS. BUTO: Thanks a lot for this presentation.

8 I have a related but not totally on point  
9 question about LTCHs, which is in those areas of the  
10 country where either they're low use of LTCHs or no use of  
11 LTCHs, could you clarify for us whether LTCHs are pretty  
12 evenly spread across the country, or are they concentrated?  
13 I think you've given us this information in the past, but  
14 it would be helpful in thinking about this.

15 I'm also wondering for ventilator-dependent  
16 patients or patients who have had long ICU stays, where  
17 there are not LTCHs, where do they go? Do they go to  
18 hospice, or do they go to SNFs, for example?

19 MS. CAMERON: The LTCHs in general are located  
20 throughout the country but in fairly clustered regions.

21 So, for example, we find a wide variation in a  
22 beds-per-beneficiary calculation when you look at where

1 LTCHs are located relative to the beneficiaries.

2           So they're often in more urban areas. We have  
3 found a large number in certain states, and that's a large  
4 number on a per-beneficiary basis because I think we would  
5 expect that as LTCHs have opened, they do open where there  
6 is a large enough population to support that population.

7           So, for example, there are several in California  
8 in the Los Angeles area, which is a pretty densely  
9 populated area. There are also several and many beds in  
10 Mississippi and Louisiana and in Texas, although that is  
11 all changing as we've seen closures begin to occur since at  
12 least October 1st of 2015. So they are clustered  
13 throughout the country.

14           This is also a result from certificate of need  
15 laws on a state basis. So states that have very strict or  
16 very strong certificate of need programs tend to have fewer  
17 LTCH beds available, and that's kind of a state regulation-  
18 based driver.

19           So does that answer your first question, Kathy?

20           MS. BUTO: Yeah. Thank you.

21           And I just wondered about the second, which is  
22 where do they go if they don't have LTCH.

1 MS. CAMERON: So I think this is a question that  
2 many have been able to answer, and I think we did go to an  
3 area of the country without an LTCH in a state that does  
4 not have LTCHs. And we've heard a few different stories,  
5 and I think some of this depends on the acute care hospital  
6 and whether, for example, they are in an overarching system  
7 that can provide high levels of support, both financial and  
8 clinical, to the local skilled nursing facilities.

9 So a very large system we visited does not have  
10 any LTCHs. There are no LTCHs in that area of the country,  
11 and the acute care hospital does in fact provide some  
12 support to one of the skilled nursing facilities in the  
13 system to provide ventilator care.

14 We've spoken with other facilities in areas of  
15 the country in acute care hospitals that the SNFs in that  
16 area do not have the capabilities to provide vent care.

17 So it is very regional, but I think to answer  
18 your question, there are places where the beneficiary is  
19 discharged to a skilled nursing facility. There are  
20 situations where the beneficiary stays in the acute care  
21 hospital for a longer period of time, and I think depending  
22 on some local practices and based on the beneficiaries'

1 trajectory and decisions they make with their physician,  
2 they may end up in hospice.

3 MS. BUTO: And just a last follow-up, the  
4 outcomes, regardless of where they're discharged to, are  
5 similar, or we just don't have enough data on the other  
6 sites?

7 MS. CAMERON: We really don't have a lot of data  
8 at this point. I think the data analysis that's been done  
9 to date has been mixed at best.

10 There could be a lot of unobserved complexity  
11 that we don't see in the data.

12 On very specific levels, researchers have tried  
13 to answer very specific questions in terms of maybe  
14 mortality or readmissions for a very unique population with  
15 a unique condition, even within that LTCH group, and those  
16 are mixed. I think it really varies. So I don't have  
17 anything definitive in terms of outcome to report.

18 DR. CROSSON: Okay. Pat, Sue, Jaewon, Dana,  
19 David.

20 MS. WANG: This is an important study, so thank  
21 you. It's very informative.

22 One of the assumptions of the work on PAC PPS

1 moving to payment based on beneficiary characteristic and  
2 not provider characteristic is that that shift will result  
3 in changes in capabilities of the delivery system. Is  
4 there anything in what you've seen or is it feasible to see  
5 in the areas where the LTCHs have closed whether remaining  
6 post-acute care providers have developed new capabilities  
7 to test the hypothesis that provider types will morph into  
8 delivering all of the different types of post-acute care  
9 that would be reflected in a PAC PPS?

10 MS. CAMERON: We spoke with one hospital who had  
11 an LTCH that was open for a fairly limited period of time,  
12 and it subsequently has closed that LTCH. And we spoke  
13 with the housing acute care hospital post closure, and I  
14 think we're speaking about a very small number of  
15 beneficiaries, in the low hundreds, if that. And I think  
16 the system has been able to absorb whether it be, again,  
17 staying in the acute care hospital longer, sending  
18 beneficiaries a few hours away if that's what the physician  
19 and beneficiary decide upon for that level of care.

20 But because we're dealing with such a small  
21 number of these facilities that closed in places without  
22 another option, it's very difficult to get at that

1 question.

2 DR. CROSSON: Okay. Sue.

3 MS. THOMPSON: I want to go back to the line of  
4 questions Kathy had. What's your thought process going  
5 forward? Because these patients are going somewhere and  
6 perhaps weren't meeting the criteria or didn't meet the  
7 criteria of LTCH, but they did meet some level of more  
8 intensive sort of service demand. What do we know about  
9 that population, and what do we know about the quality of  
10 the facilities and the places where they go today? And  
11 what's your thinking about that question going forward?

12 MS. CAMERON: So, if I could clarify, you're  
13 thinking about the beneficiaries that previously had less  
14 than a three-day ICU stay who were seeing the larger  
15 changes. Again, I think it's incredibly difficult to  
16 answer because of the limited data at this point.

17 When we look -- and there have been studies  
18 really since LTCHs were created, since the LTCH payment  
19 system began, trying to understand who these patients were  
20 that are going to the LTCHs. And I think one of the  
21 reasons that LTCH policy has been difficult is that there  
22 hasn't been one clear answer, and I think areas of the

1 country use LTCHs very differently.

2 I think it is somewhat in terms of who goes to an  
3 LTCH -- it factors in if there is an LTCH available and how  
4 many beds are in that LTCH.

5 We don't have a good handle on that population at  
6 this time besides to say that we will follow them, but when  
7 we think about the number of individuals in kind of acute  
8 care hospitals that have the less than three ICU stays,  
9 that's most, most beneficiaries. So finding the ones that  
10 have maybe this level of clinical complexity that we can  
11 observe right now in the data or haven't been able to is  
12 really difficult.

13 DR. CROSSON: Jaewon.

14 DR. RYU: Thanks for the presentation.

15 I wanted to ask sort of a mirror-image reverse  
16 question to what Sue and Kathy were getting at.

17 You quoted a couple spots where LTCH use has  
18 actually increased. I think in the low-use markets, MS-  
19 DRG, three. So there are these pockets where there's more  
20 utilization. Any insight into where that's coming from?  
21 Because if those needs were currently met and then -- or  
22 previously met and then you have the dual payment

1 methodology and now that's increasing, I just wonder where  
2 that demand is coming from.

3 MS. CAMERON: So what we have heard -- and,  
4 again, a lot of this is based off of our site visits -- was  
5 that LTCHs have reached out further in terms of their  
6 referral region. So maybe an LTCH really targeted five or  
7 six major teaching facilities, for example, in their kind  
8 of direct city or urban area, maybe a 15-mile radius. And  
9 now they're developing outreach and speaking with hospitals  
10 further away.

11 Part of the relationship, I think, between the  
12 acute care hospital and the LTCH has to do with the  
13 physicians, and the LTCHs being able to -- and have been  
14 reaching out more to potential referring physicians,  
15 explaining the capabilities the LTCH has, especially when  
16 it comes to ventilator care, was the case that it kind of  
17 came up more frequently and being able to explain to a  
18 physician at the acute care hospital, "These are the  
19 services we could provide to your patient. So instead of  
20 your patient staying in your hospital for, for example, two  
21 weeks, we will take them and work with them."

22 So I think it comes from both kind of an

1 expansion of the referral region, but also trying to build  
2 relationships with more referring physicians to work with  
3 them on kind of the patients they should be sending.

4 DR. CROSSON: I've got David first, then Brian.  
5 I'm sorry. Did I miss somebody?

6 DR. SAFRAN: I was in there somewhere.

7 DR. CROSSON: Okay. I'm sorry. Dana, David,  
8 Brian, Marge, Jonathan.

9 Go ahead, Dana.

10 DR. SAFRAN: Thanks. Thanks for this important  
11 work.

12 I just had two questions. One was on a quality  
13 analysis that you did. Understanding now that we have a  
14 different population in theory, anyway, a much sicker or  
15 somewhat sicker population, it could suggest that quality  
16 is better than it was before. Have you considered or did  
17 you attempt to do a kind of analysis backwards to restrict  
18 the population in previous data to the ones that are now  
19 eligible for LTCH and compare quality that way?

20 MS. CAMERON: I have not, but that is certainly  
21 something we could consider. So let me do a little bit of  
22 thinking on that and see what I can pull together.

1           I think one of the words of caution is we have  
2 seen this shift and certainly for going from about 55  
3 percent of patients that would have met criteria up to 65  
4 is not nothing, but it's also in the order of 10- to 20,000  
5 total patients. So the shift is not, I think, as large at  
6 this point as it might be in a few years.

7           But I think your point is well taken to look back  
8 and look at those that would not have met, and I think we  
9 can do something for that, that we can bring forward in our  
10 next presentation.

11           DR. SAFRAN: Great. Thanks. That would be  
12 interesting.

13           My other question, I think it's in this chapter  
14 that at the early part, you talk about the 25 percent rule,  
15 is that correct, about the LTCH can't be getting more than  
16 25 percent of its referrals from the hospital it's  
17 affiliated with? Is that correct?

18           MS. CAMERON: We spoke about that a little bit in  
19 our September mailing materials, and we'll include  
20 something in our final report in the draft of that in  
21 April, but I don't think we spoke too much about it in this  
22 paper.

1           The 25 percent threshold rule is no longer  
2 applicable to LTCHs. It was eliminated in the fiscal year  
3 final rule for this year. So starting October 1st, that  
4 limit has been eliminated.

5           DR. SAFRAN: Yeah. So I think that makes for a  
6 pretty interesting and important analysis, including on the  
7 quality, but also just on some of the questions that were  
8 in Sue and Kathy's questions about what's shifting and  
9 where people are going. So, at a minimum, we could really  
10 understand how has the lifting of that changed the volume  
11 of patients in an LTCH coming from the facility. The fact  
12 that there are now these criteria should mean that the ones  
13 that are getting there are the right patients, but it just  
14 seems that some analysis of that threshold rule and how its  
15 removal coupled with the change in criteria that we're  
16 seeing has influenced where patients are going, the quality  
17 of care that we see them receiving and so forth.

18           MS. CAMERON: And we will definitely be following  
19 through with comparing before and after the 25 percent  
20 threshold rule. Unfortunately, that is not data we will  
21 have at the time that this report is due because it would  
22 be in this fiscal year '19 claim set. So we still have

1 another, just about two years before we'll see that.

2           What I will say, however, is that we heard  
3 through some of our discussions -- and I preface all this  
4 with saying these are examples that we heard and does not  
5 necessarily reflect the entire population of LTCHs -- that  
6 the way that the 25 percent threshold rule being lifted  
7 will actually open the door for some beneficiaries who meet  
8 the criteria from, for example, a tertiary care facility.  
9 They are seeing, of course, a higher share of patients that  
10 are on vents compared to maybe the local hospital 10 miles  
11 further away, and so no longer having that 25 percent  
12 threshold allows more patients who meet the criteria coming  
13 from that kind of primary tertiary care hospital.

14           But, again, it's something that we will be  
15 looking into when we do have the 2019 data.

16           DR. SAFRAN: One additional thing that I just  
17 want to include that's a third element before it turns to  
18 somebody else is I wonder whether there is any way we can  
19 do some analysis and whether the strengthening of the  
20 criteria of who can be an LTCH can allow for a shift in the  
21 rules about the average length of stay that LTCHs need to  
22 be meeting in order to demonstrate the need of the

1 population they serve.

2           The reason I say that is that I've had personal  
3 experience where a patient who is in an LTCH who clearly is  
4 ready to go to the next level of care, the LTCH is  
5 unwilling to discharge the patient until they've been there  
6 a certain amount of time in order to be able to keep up  
7 their average length of stay, which obviously isn't serving  
8 patients nor serving the program.

9           It just occurs to me that by putting these  
10 criteria on the front end and making sure that really the  
11 patients who are getting in there are patients who are  
12 sufficiently sick but they need those services, maybe the  
13 question about how long on average they're staying is  
14 something that can be released or something.

15           So I'd like to see us address that a little bit.

16           DR. CROSSON: Yeah. Very interesting. Thanks.

17           Brian.

18           DR. DeBUSK: Well, first of all, I wanted to sort  
19 of follow up or build on Jaewon's comment -- comment or  
20 question, I'm not sure -- about the LTCH or the volume that  
21 we shifted into these low-use LTCH areas with respect to  
22 this increase. Is it fair to say that the new payment

1 policy -- and I realize it's a complex thing to measure.  
2 Is it fair to say that the new payment policy may be  
3 inducing some utilization in low-use LTCH areas?

4 I would think that's material to the report. I  
5 mean, if you look at what the mandate, the congressional  
6 mandate is, it's to give them insight into I would think  
7 things like this.

8 MS. CAMERON: So the word "induce" just makes me  
9 a little bit nervous.

10 DR. DeBUSK: Okay. Okay. Could it have driven  
11 some of the increase?

12 MS. CAMERON: I think so. I mean, I think  
13 providing clear direction in terms of the number of days in  
14 an ICU required for an LTCH to qualify for, you know, a  
15 full payment allows LTCHs and acute-care hospitals to more,  
16 I think, easily identify what some would deem an LTCH-  
17 appropriate patient. And so I think once, you know, the  
18 kind of criteria was established now there -- you know,  
19 there's less question, I think.

20 DR. DeBUSK: Okay. Now I'm really glad we're  
21 going here. So your thought is that by having a more  
22 clearly defined criteria we may have emboldened low LTCH

1 usage areas to perhaps send some patients that before they  
2 weren't sure if these were qualified patients or not.

3 MS. CAMERON: It is possible, yes. I think we  
4 have very limited data at this point and very low numbers.  
5 You know, but I think based on what we've seen, areas of  
6 the country that had historically low LTCH use seemed to be  
7 sending more patients that meet the criteria outlined to  
8 LTCHs.

9 DR. DeBUSK: So have a well-defined criteria may  
10 have given them the confidence they needed to send these  
11 patients. That's a different -- and I'm really glad we're  
12 exploring this, because Jaewon, I can't read your mind but  
13 we may be going in the same direction here.

14 That's interesting to me because that could drive  
15 better patient care. I would be more concerned if maybe an  
16 LTCH that was sending -- that was accepting too many  
17 patients and now the new criteria's hit, now they look up  
18 one day and say, "Oh, gosh, I need to tap into new markets.  
19 I need to find new places. I need to expand my reach."  
20 That's a little bit different. You know, if they went into  
21 a low LTCH use area that was doing just fine on its own and  
22 all of a sudden they went in and began educating doctors

1 and educating hospitals on these wonderful things they  
2 could do for them, and driving additional volume -- not  
3 inducing utilization, driving volume -- that's a little bit  
4 different. I mean, because as a policymaker I would want  
5 to know if I'm squeezing a balloon here and these people  
6 are just going to move into other areas and find new  
7 fertile ground.

8 MS. CAMERON: But I don't know if, at this point,  
9 we can tease out whether or not the balloon is being  
10 squeezed. I don't know which way of the argument we can  
11 confidently say is happening.

12 DR. DeBUSK: Well, the former is maybe better  
13 care. The latter is a problem.

14 MS. CAMERON: Correct, and I think right now the  
15 caution is on a patient-by-patient basis we certainly can't  
16 determine which way that's going. Both could be happening.  
17 One could be happening. But we don't know that, and  
18 without outcomes data and without good outcomes measures  
19 that is an extremely difficult question to answer.

20 DR. DeBUSK: Okay. And just a follow-up  
21 question, in these low LTCH use areas, obviously they were  
22 getting along. I mean, it was working because we weren't

1 hearing -- we weren't getting feedback otherwise -- is  
2 there an opportunity. Because I read in the congressional  
3 mandate they do talk about that we're supposed to make  
4 recommendations for changes of such section as the  
5 Commission deems appropriate, which seems like a pretty  
6 broad mandate for making recommendations. Have we  
7 considered, in this report, coupling modifications to the  
8 high-cost outlier policy for acute care hospitals and  
9 perhaps even looking at the reimbursement for ventilator  
10 patients and SNFs, maybe revisiting some of that? Is there  
11 a way to sort of blunt the need to drive for a few hours  
12 and find an LTCH?

13 MS. CAMERON: So we have standing recommendations  
14 on some of these issues that I think, you know, we could  
15 certainly reference as part of this. So, for example, in  
16 our 2014 March report to Congress, our recommendation,  
17 which included an eight-day ICU stay for kind of the full  
18 LTCH payment, that this policy was modeled off, also did  
19 include additional spending to the acute care hospitals for  
20 similar cases seen there. So certainly, you know, we could  
21 reference that, I think, in the report.

22 In terms of the increase in payments to other

1 post-acute care providers you'll recall that --

2 DR. DeBUSK: I didn't say increase. I just --

3 MS. CAMERON: Oh, sorry. Excuse me.

4 DR. DeBUSK: -- am thinking budget neutral the  
5 whole time.

6 MS. CAMERON: Okay. I apologize. So changing or  
7 aligning payment for other post-acute care providers, if  
8 you will, is something that we've been working with in our  
9 unified PAC PPS work. And a lot of that work has been  
10 shifting money from kind of the traditional rehab cases to  
11 these medically complex cases, and that undoubtedly  
12 includes the ventilator-dependent patients.

13 So, you know, I think we want to make sure we do  
14 kind of look at this as a whole, and I think those two  
15 recommendations actually do get at some of what you're  
16 asking.

17 DR. DeBUSK: So there could be an opportunity to  
18 advocate for the PAC PPS in this congressionally mandated  
19 report.

20 MS. CAMERON: We can certainly reference it, yes.

21 DR. CROSSON: Okay. A couple of observations.

22 We have used up almost all of our time and we're still on

1 clarifying questions. Having said that I think some of the  
2 ideas that have been buried deeply into the questions are  
3 actually helpful because they've been suggestions for the  
4 report, so we've kind of allowed that. But we need to move  
5 on.

6 So I've got David, Marge, and Jonathan -- is that  
7 correct? -- for questions, and then I think we're going to  
8 need to go into further elaboration of ideas for the final  
9 report.

10 David.

11 DR. GRABOWSKI: Great. I'll be quick. We worry  
12 a lot about cliffs or discontinuities in Medicare policy.  
13 Here, in order to meet the criteria, you have to have  
14 three-plus days in the ICU, and I'm worried if we pay more  
15 for three-plus days in the ICU have we seen any kind of  
16 movement along that continuum. And as a broader comment  
17 maybe I should save that for round two. But I really  
18 thought the role of the acute care hospital was missing in  
19 this chapter. And we've heard a lot about hospice and  
20 other post-acute care settings. I would like to see us  
21 focus more on the acute care hospital, in this domain  
22 especially, about, you know, have we seen any changes

1 around ICU days. Thanks.

2 DR. CROSSON: Marge.

3 MS. MARJORIE GINSBURG: Actually, my comment is  
4 very similar to David's. It occurred to me, and perhaps  
5 this is in the report, that the origin of the three ICU  
6 days and where that came from seems very arbitrary, and  
7 whether any of the hospitals are holding on to their  
8 patients just a little bit longer in order to have them  
9 qualify for the full payment. So I don't know whether  
10 that's even possible to study that. Are those patients  
11 staying in the acute care hospitals longer?

12 MS. CAMERON: And then this is one of the reasons  
13 I did look at the length of stay in the ICU and how that  
14 has evolved over time, and we have looked at this from kind  
15 of the acute care hospital perspective, so I'm happy to  
16 include some information on that.

17 I think, again, we come down to this volume issue  
18 and the critical volume, where close, between 20 and 25  
19 percent of acute care hospital discharges have at least  
20 three days in the ICU. So when you're talking about, you  
21 know, I'm round here, 10 million cases, and 25 percent of  
22 those have three or more days in the ICU, and then you

1 think, well, of all LTCH cases there are, you know, about  
2 115,000 LTCH cases. So as a share of these, you know, 2.5  
3 million it's very, very low.

4 So we can certainly show kind of trends in ICU  
5 use from acute care hospitals over time, but I worry about  
6 showing this aggregate number when even a small share of  
7 those, historically and currently, are going to LTCHs. So  
8 it's really on the margin that these cases may or may not  
9 have an extra, you know, night's stay or not, and that is  
10 very difficult to determine, given just the low, low  
11 volume, relatively, you see in LTCHs.

12 DR. CROSSON: Okay. Jonathan.

13 DR. JAFFERY: Thanks. So you did, I think, a  
14 great job explaining the complexity that makes it difficult  
15 to flesh out why the high-utilization areas and low-  
16 utilization areas may be very different. But do we know  
17 anything about what happens in other countries for similar  
18 types of patients, or similar types of situations, clinical  
19 situations?

20 MS. CAMERON: You know, it's an excellent point  
21 and I haven't done an international comparison. A concept  
22 of an LTCH here is unique to the Medicare program. I mean,

1 LTCHs are kind of a creation of Medicare payment policy in  
2 a lot of ways. So I have not looked at other countries'  
3 use, or lack thereof, of these facilities.

4 I think, you know, the patient that you might be  
5 getting to, which is this highly clinically complex  
6 patient, and thinking about how they're cared for, could be  
7 a result from the whole system. You know, it's not just,  
8 you know, what care is provided in a certain silo and how  
9 they're paid, but I think, you know, we could certainly  
10 look and see if there are any comparators across the globe  
11 and see what they're doing there.

12 DR. CROSSON: Okay. Thank you. So we'll move on  
13 to round two. I have to say I think we've already had,  
14 Stephanie and Emma, I think we've already had a number of  
15 good ideas for you to think about inclusion in the final  
16 summary that you're going to give us in the spring. But  
17 other ideas that you would like to see included in this  
18 summary that we're going to see in the spring and then, of  
19 course, leading to the final mandated report.

20 Paul and Warner.

21 DR. PAUL GINSBURG: Yeah. You know, I think this  
22 seems to be a case where Congress developed a policy and

1 much of the data you've shown so far seems to be in accord  
2 with this policy is doing what it was intended to do, and  
3 we need to make sure we say that, rather than just give  
4 them a lot of data.

5           You know, I think the one possible downside is  
6 that we can't look, as you explained very lucidly why, into  
7 the effect on the acute care hospital because of the  
8 relative volumes. But I know some of the pain that you  
9 pointed out is what you'd expect in a transition, and,  
10 ironically, it seems as though the for-profit hospitals are  
11 more responsive to changes in the environment, changes in  
12 incentives, and rather than kind of hang around and try to  
13 do other things they might decide, "Hey, this is something  
14 that no longer makes sense for us. We're going to leave  
15 and do something else," and it could be anything else.

16           Are you working on things that you'll bring us in  
17 the spring about are there refinements of policy that are  
18 worth bringing forward? I'm just saying that I think it's  
19 important to say that this policy seems to be working, but  
20 we still might have refinements, and, you know, we ought  
21 to, and if you have any in the spring that would be good.

22           DR. CROSSON: Warner.

1 MR. THOMAS: Just a quick question. As far as  
2 value-based payments, quality incentives, or disincentives,  
3 any sort of -- just remind me on payments for LTCHs -- any  
4 sort of construct there?

5 MS. CAMERON: Sure. So there is the quality  
6 reporting program that you see throughout most of the  
7 sectors in Medicare. There is currently no value-based  
8 purchasing program or other changes, and the quality  
9 program is a two-percentage-point reduction, and my  
10 understanding is that all hospitals qualified. So no  
11 hospitals received the two-percentage-point reduction to  
12 their update.

13 MR. THOMAS: So that might be something I would  
14 recommend we think about putting in the report is just  
15 that, you know, having some sort of quality-based, value-  
16 based reimbursement and even tying it back to the acute  
17 care stay could be helpful here. I don't think it needs to  
18 be overly complicated but you went through a couple of key  
19 measures that we really haven't seen any movement, and I  
20 understand the population could be different. But I do  
21 think having value-based payments, potentially up and  
22 downward, would be appropriate and I think create more

1 alignment for the acute care component of the system, and  
2 certainly I think there's a big impact, especially around  
3 readmission. You know, what happens in LTCHs and other  
4 post-acute care providers. I'd like to see us at least  
5 think about what that should look like and think about  
6 having it be part of the report.

7 MS. CAMERON: And I think we are looking at that  
8 from kind of the post-acute care provider perspective. So,  
9 you know, perhaps if it's not directly an LTCH measure I  
10 think we are considering kind of PAC-side measures that  
11 would encompass LTCHs as well.

12 DR. CROSSON: Kathy and you -- Kathy and then  
13 Sue.

14 MS. BUTO: So given the low volumes, I keep  
15 coming back to a question I had even when I was at CMS,  
16 which is why do we have these facilities. And I guess  
17 where I come down on this is that the unified PAC will  
18 probably, over time, mean these facilities will be greatly  
19 reduced in size or become adjunct units, complex patient  
20 units for SNFs or other facilities. Or there might even  
21 be, if the outlier policy changes for hospitals, acute care  
22 hospitals, a way to accommodate them. But they just seem

1 like such an artifact of the Medicare program, and I know  
2 probably, what, 15 years ago there was an effort to  
3 eliminate the category that didn't succeed.

4           So I would just say, from my perspective, I'd  
5 like to go back to Brian's point and find a way of  
6 mentioning the unified PAC and the role that it may play  
7 over time in appropriately paying for the care of these  
8 patients, potentially in other settings.

9           DR. CROSSON: Thank you.

10          MR. THOMAS: Can I make a comment on that?

11          DR. CROSSON: Yes, on that.

12          MR. THOMAS: So just to add on to Kathy's, and I  
13 do think if there was a comment -- you know, going back to  
14 you talked to a lot of facilities, especially some -- you  
15 said there were some skilled nursing that had essentially  
16 ramped up capability. And I think if there were a  
17 modification or expansion of compensation in that  
18 discipline I think you would see the opportunity to take  
19 more patients that would go to an LTCH in that facility,  
20 and that may be something we want to reference in more  
21 detail. But it's going to take a change in the economics  
22 for that to work for skilled facilities.

1 DR. CROSSON: Okay. Sue.

2 MS. THOMPSON: The very fact that we have parts  
3 of the country with low LTCH use, and then high LTCH use,  
4 and I suspect if we would see a map it might be quite  
5 informing and quite impressive that it's a clustering of  
6 where these organizations -- I think CON law certainly has  
7 had some impact.

8 But the very fact that we do have good parts of  
9 the country with low LTCH use should inform this somehow.  
10 And I think the points that Kathy and Warner have just made  
11 are really important in terms of policy, and that is to  
12 incent the health care providers across a community to work  
13 together, whether it's building competencies within SNF  
14 facilities or outlier payments to acute care facilities, so  
15 that there is a more even distribution of these kinds of  
16 services to all Medicare beneficiaries across the country,  
17 not just in parts of the country where these types of  
18 facilities seem to be clustered.

19 I think it's important. There is a good number  
20 of beneficiaries in parts of the country with low LTCH  
21 availability or use that it seems are surviving, or we  
22 would be, I think, hearing more about that, as Brian raised

1 the issue. It may or may not be true. Maybe that's  
2 another whole question to be answered. But I think the  
3 very fact that 40,000 FEHB, if we look at the map, there's  
4 something that's pretty obvious.

5 MS. CAMERON: I'm happy to provide a map.

6 DR. CROSSON: Marge on this point.

7 MS. MARJORIE GINSBURG: Actually, exactly on this  
8 same point. It has occurred to me all along, have we  
9 created an industry here, because we're really good at  
10 creating new industries, and it may tie into seeing what  
11 other countries do with this level of patient. But I don't  
12 think it was part of our assignment with this was to  
13 consider doing away with LTCHs entirely and folding that  
14 need into either acute care or SNF settings. But basically  
15 whether we should even consider that as one of our  
16 recommendations or not, that's a much bigger question that  
17 I can propose. But I think it's something we should at  
18 least consider.

19 DR. CROSSON: Brian. Last comment.

20 DR. DeBUSK: As I sort of hinted in the round one  
21 clarifying question, I do think that this report -- and  
22 again, maybe I'm just reading the mandate wrong, but, you

1 know, it does look like we have some license to make  
2 recommendations beyond just payment formula adjustments,  
3 and when we talk about, you know, the things that we would  
4 deem necessary for policy changes.

5 I think presenting really clearly in this report  
6 the fact that we may not know whether this policy, and  
7 providing this clarifying three-day rule, whether it is  
8 making people -- I mean, emboldening people to maybe use  
9 LTCHs when they're appropriate or is it forcing the LTCHs  
10 that are there to seek out new customers and new markets  
11 and maybe encourage inappropriate use in new areas, I think  
12 we should present that as a front-and-center issue as part  
13 of this report.

14 And I think then what we could do is recommend  
15 some companion policies around maybe adjusting some  
16 payments in skilled nursing, revisiting existing policy on  
17 modifying the high-cost outlier policy for ACHs. It would  
18 be nice to be able to say we don't know, which is, I think,  
19 a good answer in this case because I'm not sure we have the  
20 data to get there. But what would be nice to say is here  
21 are some companion policies that would dampen the effect of  
22 if it is the latter, if it is them seeking out new markets,

1 giving hospitals and skilled nursing facilities that  
2 adjustment that they need, or that these companion policies  
3 could dampen, could be almost a counterweight to the effect  
4 that we may have artificially introduced through this new  
5 three-day -- through the new payment policy.

6           And I think I'm butchering that a little bit but  
7 you understand what I'm saying. This is a problem. We're  
8 not sure if -- well, it could be a problem. We're not sure  
9 if it is or it isn't. Here are some companion policies  
10 that would dampen it if it were a problem. And then I  
11 think the overarching theme is, oh, by the way, the PAC PPS  
12 is, you know, to Kathy's point, the PAC PPS is really going  
13 to address this. But we realize that can't happen  
14 overnight and we're very patient people.

15           So I was thinking, that would be sort of a nice -  
16 - I felt like I wanted to do more than just give Congress  
17 facts and figures. It would be nice to tell a story and  
18 say this is the trajectory and this is what we see. So I  
19 hope that makes it into the report.

20           DR. MATHEWS: So, Brian, just to clarify, to  
21 recap, one, the analysis that we've presented here largely  
22 adheres to what the mandate asked us to do, for two

1 reasons: one, that's what the Congress was interested in  
2 hearing from us; but, two, you know, the amount of time  
3 that we had to do this work didn't really permit a lot of  
4 opportunity for us to develop bold-faced recommendations  
5 above and beyond those that we've already got on the books.

6           So, you know, at the end of the day, in the  
7 spring we will come out with a report that is compliant or  
8 adherent to what we've been asked to do. Obviously, we can  
9 bring in other relevant recommendations that we've made.  
10 For example, you know, recall that we didn't say three days  
11 in the ICU. We said eight days in the ICU. And I think we  
12 can readily incorporate the implications of our work on a  
13 unified PAC PPS in the context of this report. I think we  
14 can do that fairly easily and naturally.

15           But getting beyond bold-faced recommendations and  
16 bringing in international comparisons, things like that, is  
17 probably going to be beyond the scope of this body of work.  
18 And I think to the extent there is a story or a message  
19 here, it is probably going to be along the lines of what  
20 Paul articulated, that based on the incomplete evidence  
21 that we have, given where we are in the transition, we  
22 don't see any cause for alarm. And, in fact, the policy

1 does seem to be working as intended. And while there may  
2 be, you know, potential inducement effects at the margins,  
3 you know, I think the greater expectation is you might see  
4 further adaptation of the market in terms of reduced volume  
5 overall, possible additional closures of LTCHs, and all of  
6 this resulting from the focus on those patients who are  
7 most appropriate for this level of care.

8           So just to kind of set expectations as to what  
9 you could see this cycle and what we might have to leave,  
10 you know, for a future iteration.

11           DR. DeBUSK: Fair enough. And the reason that I  
12 was concerned about this shift or this potential shift was  
13 that if we're seeing it that quickly -- I mean, I know  
14 these people, these operators, can adapt quickly. But if  
15 we're seeing this policy now and we're still just phasing  
16 in this payment change at the 50 percent rate, you would  
17 think that as it approaches the final phase-in, that it  
18 will only drive more momentum for these people to seek out  
19 new markets and new customers. That was my only concern.

20           DR. PAUL GINSBURG: Yeah, if I could just add  
21 something on this, even though it became effective in 2016,  
22 this legislation was passed in 2013. The industry had lots

1 of notice. They probably were waiting for the regs, but  
2 they knew what was happening. So I'm not at all surprised  
3 that they're responding quickly.

4 DR. CROSSON: Okay. Good discussion, valuable.  
5 Stephanie, Emma, we'll see you back in the spring, and  
6 we'll move on to the next piece of work for the morning.

7 Okay. Our second consideration for the morning  
8 session here is really an examination of the pros and cons  
9 of the use of functional assessment in the Medicare  
10 program. This is something that we have, I think, a long  
11 history on the Commission of both advocating periodically  
12 and questioning periodically, and I think we're there  
13 again. And Carol and Ledia are here to kind of take us  
14 through what we're -- maybe what set of considerations we  
15 want to bring to the table now, and Carol is going to  
16 start.

17 \* DR. CARTER: I will. Good morning, everyone.  
18 This presentation is about the work that we plan to do  
19 evaluating the patient assessment data used to pay PAC  
20 providers and measure patient outcomes. I'll go over some  
21 background material and outline our analytic plan, and then  
22 Ledia will discuss ways to improve the accuracy of the data

1 and potential alternative measures of function, and we plan  
2 to include this information in a chapter in the June  
3 report.

4           Functional status is intuitively an important  
5 dimension of post-acute care. The information is used for  
6 many purposes in post-acute care to adjust payments, to  
7 gauge provider performance, and to establish care plans.  
8 However, we know that providers respond to the incentives  
9 of payment policies and public reporting. There are  
10 numerous examples of providers responding to incentives in  
11 unintended ways, and I'll summarize a few of those.

12           If providers respond to incentives by recording  
13 function in ways that do not reflect patients' care needs  
14 just as they have responded to payment policy changes, then  
15 program payments will be unnecessarily high, payments for  
16 individual stays will not be aligned with the resource  
17 needs of the patient, and providers will appear to have  
18 achieved better outcomes than, in fact, they have.  
19 Beneficiaries could select a provider that is, in fact, not  
20 as good as reported at improving patient function, and ACOs  
21 and MA plans could build their networks of PAC providers  
22 around data that may be inaccurate.

1           Let's review how function information is used in  
2 the current PPSs for post-acute care. Three of the systems  
3 use function in defining the case-mix groups that establish  
4 payments. For example, a beneficiary's ability to toilet,  
5 bathe, walk, dress, and transfer adjust payments made to  
6 home health agencies. In contrast, the LTCH PPS uses MS-  
7 DRGs which do not use function to adjust payments.

8           Differences in the assessment of even one  
9 dimension of function can shift the assignment of a stay  
10 from one case-mix group to another, thus creating  
11 incentives for providers to record functional status to  
12 raise payments rather than to accurately record the ability  
13 of the patient.

14           Functional status outcome measures are reported  
15 in each setting's quality reporting program, or QRP, but  
16 the measures vary. The SNF and IRF QRPs include changes in  
17 self-care and mobility, while the home health program  
18 reports on three different measures of activities of daily  
19 living. The Home Health Compare and the Nursing Home  
20 Compare websites also report functional outcomes for  
21 providers, and CMS includes functional status in the risk  
22 adjustments for some outcome measures for some settings.

1           The questions guiding this work are: Do current  
2 provider-reported function data appear to be accurate?  
3 What can CMS do to improve or help ensure the accuracy of  
4 these data? Are there alternative measures of function  
5 that would be more accurate?

6           Answers to these questions will inform  
7 policymakers' decisions about whether and how these data  
8 should be used to adjust payments, measure outcomes, and  
9 tie payments to outcomes.

10           As a reminder, the Commission's work on a PAC PPS  
11 design found that function was not key to setting accurate  
12 payments for most of the patient groups we examined. And  
13 even if the information increases the accuracy of payments,  
14 you might not want to use it to adjust payments, just as we  
15 have avoided designs that include factors that providers  
16 can control.

17           Now let's turn our attention to indications that  
18 the patient assessment data may not reflect the actual care  
19 needs of patients.

20           The first example is the reporting of function at  
21 admission by IRFs. We've found that high-margin IRFs  
22 appear to record lower patient function compared to low-

1 margin IRFs. Their patients had lower acuity during the  
2 hospital stay -- that is, with lower severity scores,  
3 shorter hospital stays, and were less likely to be high-  
4 cost outliers -- but were recorded as more disabled than  
5 patients treated in low-margin IRFs once the patients were  
6 admitted. For example, their stroke patients who were not  
7 paralyzed had the same motor impairment as paralyzed  
8 patients in low-margin IRFs. These findings suggest that  
9 assessment and scoring practices help explain differences  
10 in profitability across IRFs and raise questions about the  
11 patient assessment data.

12           The second example comes from home health  
13 outcomes for provider-reported assessment data compared  
14 with claims-based measures. You can see that over the four  
15 years, the provider-reported activities of daily living on  
16 the left steadily increase, showing steady improvement. In  
17 contrast, the more objective claims-based measures of  
18 adverse hospital events -- and these are on the right --  
19 either increased slightly or remained the same. But for  
20 these measures, an increase means worse outcomes. These  
21 results are surprising because we would expect patients  
22 with fewer limitations in their ADLs to be less likely to

1 require visits to the emergency room or have unplanned  
2 hospitalizations. The contradictory findings raise  
3 questions about the validity of the provider-reported  
4 assessment data.

5           Now I want to shift gears and give some examples  
6 of PAC providers responding to payment incentives. While  
7 these examples are not about functional assessment data,  
8 they raise questions about how providers may respond to  
9 including function in the risk adjustment for payments.

10           Home health agencies changed how they coded  
11 hypertension and the number of therapy visits they  
12 furnished when definitions of case-mix groups were changed.  
13 SNFs have increased the amount of therapy they furnished to  
14 boost payments and changed the therapy modalities they used  
15 when the rules for these changed. And in LTCHs, a length  
16 of stay indicate providers extending stays to avoid being  
17 paid as short-stay outliers.

18           The concern is that if providers are as  
19 responsive as they've been to other financial incentives,  
20 then if payments are tied to functional status, the  
21 recording of disability is likely to increase even though  
22 there will have been no actual changes in patients'

1 abilities. This response to financial incentives would be  
2 consistent with what we have seen in the coding practices  
3 of inpatient hospitals and MA plans. While the coding may  
4 paint a more accurate and complete picture of  
5 beneficiaries' clinical conditions, it raises program  
6 spending even though the beneficiaries and their conditions  
7 did not change.

8           Now to the work we have planned. Because we  
9 cannot directly examine the accuracy of this information --  
10 that would require medical record review and assessing  
11 inter-rater reliability -- our analysis will focus on the  
12 consistency of the assessment information in three ways:

13           First, we will look at assessments of  
14 beneficiaries who transition between PAC settings and  
15 compare assessments at discharge from one setting with the  
16 admission assessment at the next.

17           Second, we will look at the consistency of  
18 reporting of information that is used for payment with  
19 information that is used for quality reporting for the same  
20 beneficiaries. While we appreciate there are differences  
21 in how the items are defined, we would expect broad  
22 agreement in these items.

1           Last, we will compare assessment information with  
2 other beneficiary characteristics such as age, risk scores,  
3 and frailty. We would expect functional status on average  
4 to be correlated with these other beneficiary  
5 characteristics.

6           And now Ledia will talk about strategies to  
7 improve this information and alternatives to provider-  
8 reported assessments.

9           MS. TABOR: Function is an important outcome  
10 measure to beneficiaries and for the Medicare program. So  
11 the Commission may want to consider ways CMS could help  
12 improve the accuracy of these provider-reported data or  
13 collect information about patient function in other ways.  
14 I'll briefly review the following three strategies for your  
15 discussion: improve monitoring of provider-reported  
16 assessment and penalize providers found misreporting;  
17 require hospitals to complete discharge assessments to  
18 patients referred to post-acute care; and gather patient-  
19 reported outcomes, or PROs.

20           Currently, PAC providers attest to the accuracy  
21 of the data they report, but Medicare does not audit the  
22 assessment data through medical record review or other

1 methods. CMS offers providers comprehensive training on  
2 how to properly collect assessment data and operates a help  
3 line to answer providers' questions about the  
4 interpretation and correct coding of assessment items.

5 CMS could implement an audit program and penalize  
6 providers that misreport information. For example, CMS  
7 could monitor changes in function across providers to  
8 detect unusual patterns, such as large improvements that do  
9 not coincide with other beneficiary characteristics. CMS  
10 could conduct follow-up audit activities on these providers  
11 with aberrant patterns and penalize those who are  
12 misreporting. These financial penalties could counter the  
13 other payment and quality reporting incentives. Medicare  
14 could use the RAC program or the QIOs to detect and review  
15 questionable providers practices.

16 One way to confirm the quality of PAC provider-  
17 reported function information would be to require acute-  
18 care hospitals to complete a short assessment of patients  
19 discharged to PAC. This information would allow CMS and  
20 stakeholders to compare functional status of patients at  
21 discharge from the preceding hospital stay with the  
22 admission assessment completed at admission to PAC.

1 Systematic differences between the two could trigger  
2 program integrity efforts. However, because community-  
3 admitted beneficiaries would not have a prior hospital  
4 stay, this approach would not address the quality of  
5 assessment information collected for that population.

6 Patients are a valuable and, arguably, the  
7 authoritative source on information on outcomes, so an  
8 alternative to relying on provider-completed assessments is  
9 to collect function data through patient-reported outcome  
10 tools. We have some examples of how PROs are currently  
11 used to measure functional status in Medicare. Plan-level  
12 measures of improved or maintained physician health are  
13 scored on the MA stars program based on two years of HOS  
14 responses from a sample of the same plan beneficiaries.

15 In the March 2010 report to the Congress, the  
16 Commission observed that, as applied to detect changes over  
17 time and MA plan enrollee's self-reported physical health  
18 status, the HOS often produced results that showed no  
19 significant outcome differences among MA plans.

20 Another survey-level functional measure example  
21 is from the ACO CAHPS survey, which collects a one-time  
22 response on patient-reported functional status from a

1 sample of the beneficiaries. We also have seen some  
2 examples of health systems collecting PRO functional status  
3 on patients with certain symptoms, like knee pain, or  
4 before and after interventions, such as knee replacement  
5 surgery. Health systems use these results for clinical  
6 decisionmaking and for tracking outcomes.

7           There's growing support from clinicians and  
8 researchers to embrace the use of PROs. However, research  
9 and experience with PROs, especially in PAC settings, is  
10 very limited. We spoke with a couple PAC industry  
11 representatives and researchers, and they could not  
12 identify any PAC providers that are implementing PROs into  
13 the work flow. The Commission could consider encouraging  
14 CMS' continued research and testing of PROs in Medicare for  
15 potential provider adoption.

16           This brings us to your discussion. After  
17 answering any clarifying questions, we would like your  
18 feedback on the analysis plan, possible strategies to  
19 improve provider-reported assessment, and eventual use of  
20 alternative measures such as PROs, as well as any other  
21 issues.

22           Thank you, and we look forward to the discussion.

1 DR. CHRISTIANSON: So who has clarifying  
2 questions? Go ahead.

3 MR. PYENSON: Yeah, thank you very much, and let  
4 me say I was glad I put off reading this chapter until  
5 yesterday because yesterday was Halloween and it really put  
6 me in the right mood to look at how things change in ways  
7 you might expect. You know, the movie where you check into  
8 a hotel and there's --

9 DR. CHRISTIANSON: Are we getting to the  
10 clarifying question?

11 [Laughter.]

12 MR. PYENSON: Well, so a story for another day.  
13 I thought one of the really interesting comments made in  
14 the text and also in your discussion was reminding us of  
15 the work that was done earlier, that the information  
16 available upon discharge is really very powerful for  
17 predicting cost. And I'm wondering if that's also true for  
18 predicting outcomes, so if there is a similar approach that  
19 could be used with the data available upon discharge as  
20 predictive of cost, either the discharge from the hospital  
21 or the discharge from PAC.

22 DR. CARTER: So I'm a little confused by your

1 question. The analysis that at least we've done with using  
2 the assessment data from the PAC demonstration, which was a  
3 limited sample, but we found that the function data  
4 actually were not very important in explaining cost  
5 differences.

6 MR. PYENSON: The function data wasn't, but the  
7 diagnostic information of patient status was.

8 DR. CARTER: That's right.

9 MR. PYENSON: And so I'm wondering if that's an  
10 avenue to explore further down on the outcomes from PAC,  
11 that is, are the inputs into PAC really what drive the  
12 outputs? So let me elaborate on that just a little bit.  
13 One way to think about the overlap with cost and quality  
14 might be to look at what are the costs that the system  
15 incurs after someone leaves a skilled nursing facility or  
16 other PAC and with the notion that those costs are --  
17 higher costs are reflective or worse outcomes? And if we  
18 think that's correlated, then understanding the costs post-  
19 discharge might be an avenue to think about the status of  
20 the patients, and the success you've had in developing a  
21 system that looks at the patient information as a predictor  
22 of PAC costs might also work for post-PAC.

1 DR. CARTER: Okay. So we can think about those  
2 ideas for work that we have already ongoing. So function  
3 is used as a risk adjuster for some outcomes, and obviously  
4 clinical characteristics are. And so one of -- in the work  
5 that Ledia and I are doing on hospitalization and  
6 rehospitalization rates, we'll be looking at the risk  
7 adjustment with and without function to see what difference  
8 the function matters in being able to look at the accuracy  
9 of those rates and whether the rates look different.

10 In the MSPB measures, which, you know, include  
11 spending in the 30-day post period, we have not included  
12 function in the risk adjustment, nor has CMS. And so this  
13 is -- but CMS has included function in some other risk  
14 adjusters. Or, actually, I think CMS used the RIC groups  
15 for the IRF MSPB measure, so it's kind of been an  
16 inconsistent inclusion of function. But I understand your  
17 point, and when we look at the readmissions rate in the  
18 post 30-day period, so it's sort of getting at what happens  
19 to functions after the patient's discharged, we'll be  
20 looking at function and clinical characteristics to be able  
21 to explain those differences in rates across providers.

22 MR. PYENSON: A follow-up question on that. So,

1 for example, an indicator of trouble walking might be found  
2 in the DME claims or a claim for a wheelchair or crutches  
3 or something like that. Is that the sort of -- and, of  
4 course, claims base. Is that the sort of thing?

5 DR. CARTER: We wouldn't be probably looking at  
6 that level of detail, but just the overall -- the spending  
7 level as opposed to a specific category of spending like  
8 you're suggesting.

9 DR. CHRISTIANSON: I think there was some  
10 question -- Dana?

11 DR. SAFRAN: Yeah, thanks. Such an important  
12 topic. I'm excited that you're looking at this. I had  
13 three questions, one on each of the kind of approaches that  
14 you talk about on Slide 10.

15 So on the first idea about, you know, some kind  
16 of monitoring or audit, how would that work from a timing  
17 perspective? Because unlike, you know, audit on other  
18 kinds of data that get reported, this is the kind of data  
19 where you need to know sort of within a very short time  
20 parameter whether what the organization is reporting is  
21 validated by what some third party would come in and see.  
22 So can you just explain how would that work?

1 MS. TABOR: So we haven't thought too much about  
2 it, but one possibility would be a medical record review,  
3 so you could have a retrospective review of patient charts  
4 after discharge to see if information that's documented  
5 validates what was in the actual assessment data. It  
6 wouldn't be real time; it would be a retrospective review.

7 DR. SAFRAN: But do you think the chart would  
8 have information on some of the functional impairments that  
9 are captured by the instruments and note we help the  
10 patient with this, that, or the other thing? Like at ten  
11 o'clock, we help the patient get into a chair?

12 MS. TABOR: That's one thing we're thinking  
13 about. If the Commission would like, we can look more into  
14 this to kind of see more how this could work.

15 DR. SAFRAN: Yeah. I think it would be helpful  
16 to understand how could that actually work.

17 Then on the second idea, it ties back a little  
18 bit to the conversation we were having before about the 25  
19 percent rule. But I'm interested to understand kind of  
20 what percentage of PAC stays come from a hospital where the  
21 PAC and the hospital are organizationally related to each  
22 other because the higher that number is, the less I like

1 this option.

2 DR. CARTER: Right. We can get information about  
3 that because you're right. Once they start to have  
4 organizational relationships, this is going to suffer from  
5 sort of the broad questions we might have about the  
6 accuracy of the data.

7 DR. SAFRAN: Yeah.

8 DR. CARTER: Yeah. Okay.

9 DR. SAFRAN: And then my other question was  
10 related to the third option around patient reporting, and  
11 I'll say more about that in the next round. But my  
12 question about it is what do we know about the prevalence  
13 of cognitive impairment in this population? Because that,  
14 of course, gets in the way of the ability to -- and could  
15 censor part of the population that we'd want to be  
16 evaluating functioning in.

17 MS. TABOR: That was an issue that was  
18 consistently raised in the research that we found that it  
19 is an issue to work through, and also, in this population,  
20 you're more likely to have the proxies complete the  
21 surveys, so what effect does that have? So I think it is  
22 an issue that's been identified and that would need some

1 work.

2 DR. CROSSON: Questions. Sue and then Marge.

3 MS. THOMPSON: Just to clarify, this set of  
4 information is based in a foundational assumption of a fee-  
5 for-service model in Medicare, correct?

6 DR. CARTER: The assessment data are collected  
7 for every state paid for by -- but, actually, I think the  
8 assessments are required by every patient that's seen in  
9 the PAC provider. So they are used for payment on the fee-  
10 for-service side, but the information is gathered for all  
11 patients.

12 MS. THOMPSON: Including patients that are in  
13 value-based arrangements?

14 DR. CARTER: Yes. Yes.

15 MS. THOMPSON: Okay. So to the question or the  
16 point that Dana made about the relationship between  
17 hospitals and post-acute facilities? Do you see that  
18 incentive changing in a value-based foundation versus a  
19 fee-for-service base?

20 DR. CARTER: It might actually. If you think  
21 that providers respond to improvement and looking at and  
22 improving their improvement scores, then the incentives

1 might work in the same way; that is, you might not get paid  
2 more, but you might want to look good.

3 MS. THOMPSON: And have the patient receiving  
4 care at the right place at the right time without some of  
5 the complexities of meeting a three-day acute stay before  
6 meeting criteria, the inter-skilled? The point I'm making  
7 is I think there is a different set of incentives if you go  
8 to a value-based platform as opposed to a complete fee-for-  
9 service platform.

10 DR. CARTER: Right. Well, you might use a  
11 different provider and a different level of provider, and  
12 under Unified, maybe those distinctions would start to  
13 blur. But you might still have and respond to an incentive  
14 to look, assess your patients as low at admission and high  
15 at discharge to give the appearance of having gained  
16 improvement.

17 DR. CROSSON: Marge.

18 MS. MARJORIE GINSBURG: At the risk of revealing  
19 too much personal information, over 40 years ago, I was  
20 supervising hospital discharge planners, and I thought it  
21 was a requirement to complete the patient assessment before  
22 the patient was discharged to another level of care.

1           So my question is, Wasn't this ever required as  
2 an expectation that this is what a hospital would do before  
3 they transferred the patient? Was it a requirement and  
4 people just got sloppy and everybody ignored it, or in  
5 fact, was it never an expectation that an official patient  
6 assessment be done?

7           DR. CARTER: There is no question that hospitals  
8 assess patients on function at discharge.

9           DR. CROSSON: Pat.

10          MS. WANG: I thought that Slide 7 was very  
11 compelling, and there's no question in my mind that the  
12 factor of a VBP does seem to show that it influenced the  
13 way that patients were assessed for functional assessment.

14          I guess that question I'd have is whether sort of  
15 validation of the validity of those functional assessments  
16 through use of ED visit and inpatient admission is the  
17 strongest validation there is.

18          The paper sort of says you would think that one  
19 would expect there to be lower ED utilization, lower  
20 inpatient utilization when bathing ambulation and improved  
21 bed transfer occurs. Is that statistically established?  
22 Because inpatient admission and emergency room utilization

1 can occur for so many different reasons. I guess I'm  
2 asking, Is this a statistical correlation that you would  
3 actually expect, especially for home health agency increase  
4 in functional assessment to be directly correlated to a  
5 reduction in ED visit and inpatient utilization, or is this  
6 just sort of it seems like it should be true?

7 DR. CARTER: It seemed like it should be true,  
8 and we can go back and look and see if the literature has  
9 looked at how these outcome measures are correlated. We  
10 have not done that work.

11 This slide actually was taken from -- well, the  
12 data were taken from the first-year evaluation of the home  
13 health value-based purchasing demonstration.

14 MS. WANG: the question that it raises for me,  
15 because I think that ED use and hospitalization is  
16 multifactorial, and you would expect to see more of an  
17 impact on those rates if there were home visits by  
18 physicians after discharge and things like that.

19 What it makes me wonder is whether there is a  
20 better benchmark or comparator to evaluate the validity of  
21 functional assessment other than observing the increase.

22 DR. SAFRAN: Just a quick comment on that exact

1 point. I know there was some work that's been done -- I'm  
2 pretty sure it's been published -- out of Hip and Knee  
3 Functional Status Assessment, the HOOS/KOOS tool. That  
4 does definitely show that baseline patient-reported  
5 functional status at a hospital is a very important  
6 predictor of readmission and lots and lots of data showing  
7 how PROMs predict many things, downstream utilization and  
8 so forth.

9           So I didn't find this a stretch looking at it,  
10 but I think you could find some literature along the lines  
11 of what Pat is suggesting.

12           DR. CROSSON: Okay. Very good.

13           We're going to move on to the discussion period  
14 now. We've sort of got two things on the table, and we've  
15 had a few already. One is suggestions for the analysis  
16 itself, and then secondly, on Slide No. 10, pros and cons,  
17 no pun intended, of these potential approaches.

18           Dana is going to start the discussion.

19           DR. SAFRAN: Yes. Thanks.

20           I think this is such important work and very  
21 complicated. One of the points that you made -- well, two  
22 points in the chapter and I think you covered them also in

1 your slides, one about the lack of evidence with a health  
2 outcome survey that's been in the MA program under Stars,  
3 lack of evidence that plans are differentiated on that.

4 I think it's important as we're emphasizing the  
5 value of functional status information as a measure of true  
6 outcomes of health care to be mindful about how we frame  
7 that because I think the lack of impact of plans or the  
8 lack of differentiation among plans and impacting that  
9 doesn't mean it can't be impacted by good care. So I would  
10 just flag that issue as we look at this.

11 Then the other thing that I was reflecting on is  
12 you make the point about the sort of escalating scores  
13 around positive improvement. That doesn't seem validated  
14 by some other indicators, including some of what we're  
15 looking at here, and it struck me that similarly we see  
16 every year escalation of claims-based measures of case mix.  
17 That ironically in my own work as I started at Blue Cross,  
18 I thought, "Well, how can a population be getting 3 percent  
19 sicker every year by these measures when in the work that I  
20 had left in my academic, which was all about patient  
21 reported functional status, we saw what you point to in the  
22 health of seniors, which is in a general population,

1 functional status just isn't moving? Even in the elderly  
2 general population, functional status just isn't moving  
3 very much very fast.

4           So I think that all that is just by way of saying  
5 that, as you do in this chapter, that payment matters,  
6 incentives matter, and we have to be thoughtful about how  
7 we use these measures.

8           So where that led me and the last thing I'll say  
9 in my opening remarks here is just that understanding the  
10 importance of having good measurement of patient status at  
11 the outset and changes in status and how that is just  
12 central to everything we're trying to do in health care,  
13 it's central to the goal of value-based payment to get to  
14 more outcomes-oriented payment, I would pose a question  
15 about whether it is premature to be using these measures  
16 from any of the sources that we list on page 10 for  
17 payment.

18           That we maybe have so much to learn right now  
19 about how organizations can improve these scores, what's  
20 possible, what interventions work, that we should really be  
21 in the mode of paying for adoption or just condition of  
22 participation, but not paying for the outcomes quite yet

1 because that's so high stakes and can lead to some of the  
2 behaviors that you're expressing concern about and probably  
3 not even using it as a risk adjustment, though I understand  
4 the challenges of removing that lever.

5           So there, I'm a little more unsure, but  
6 certainly, the move to pay for outcomes, I think we're not  
7 ready, and we have some really important science to do and  
8 some really important social science to do. And another  
9 time when we have more time offline, I would love to share  
10 with you the work that we have done since 2013 and using  
11 pay for adoption methodology to get widespread use of  
12 patient-reported outcomes in our network and how we're  
13 using that now to move our way toward patient-reported  
14 performance measures, change scores.

15           But you have to be so careful because these  
16 measures are so easily gamed, including by patients who  
17 want to protect providers, want to give an answer that will  
18 open the door to a procedure. So there's a lot to consider  
19 as we go down this path, but we have to go down it because  
20 it is, as you point out, sort of the ultimate measure of  
21 what we're achieving in health care especially for this  
22 population.

1           Thanks.

2           DR. CROSSON: So, Dana, just one question about  
3 what you said. In terms of the work that you've just  
4 referred to, is that specific to post-acute care?

5           DR. SAFRAN: No. That's across our population.  
6 Yes.

7           DR. CROSSON: Right. So, as you brought up, I  
8 think, in this particular population in terms of patient-  
9 reported outcomes, particularly for institutionalized  
10 individuals, we have a separate set of issues. Okay.

11          DR. SAFRAN: Correct.

12          DR. CROSSON: Or additional set of issues.  
13 Jon.

14          DR. CHRISTIANSON: Yeah. The question I was  
15 going to ask was kind of on that same point. So my  
16 understanding from the data is that the percentage of  
17 people enrolled in skilled nursing facilities with  
18 cognitive impairments has been increasing over time and  
19 probably with severe cognitive impairment.

20                 So one of the things I'd like to have you discuss  
21 in the chapter is the usefulness of thinking about using  
22 PROMs data, and if we don't think it's so useful for that

1 subset of patients, how many patients does that leave that  
2 we think it's useful for, and what do we think about the  
3 ability to generalize to the whole population and those  
4 facilities if we're going to be excluding a large subset of  
5 folks?

6 DR. CROSSON: Okay. So other comments either on  
7 the suggestions for further analysis or comments on these  
8 three potential ways to getting around the problem of  
9 enforced subjectivity or something like that?

10 Kathy.

11 MS. BUTO: This is going to sound pretty  
12 simplistic, but in my mind, who you'd want to be doing the  
13 functional assessment is a physician or caregiver, health  
14 provider, who doesn't have a financial interest in the  
15 outcome of the assessment.

16 I think in our ideal world of the primary care  
17 physician or geriatrician who's actually managing the  
18 overall care of the patient, that's the kind of person you  
19 want to be doing an assessment of is this patient really  
20 improving or what is the functional status of the patient  
21 getting this post-acute care.

22 I don't have an answer of how we loop that kind

1 of an assessment in, but I think either relying on the  
2 patient who, in many circumstances, is not entirely capable  
3 of doing the patient-reported outcome assessment or on  
4 providers who have a financial interest one way or the  
5 other in what the level of functional impairment is, is  
6 very imperfect.

7           And I think that you've probably also -- you're  
8 well aware that auditing is extremely difficult, and I  
9 think somebody else pointed out -- maybe it was Dana --  
10 that where providers have financial interest between the  
11 acute care provider and the post-acute, you've got another  
12 issue of too much consistency in the functional assessment.

13           So there are all sorts of issues, but what we're  
14 really looking for is someone who has the patient's  
15 interest at heart, and how do we bring that person into the  
16 assessment process, rather than relying on these external  
17 abilities to assess?

18           DR. CROSSON: Okay. Bruce.

19           DR. PYENSON: I want to thank you for the chapter  
20 because I think this is really a textbook case in  
21 subchapters of the nightmare that occurs to benefit  
22 Medicare beneficiaries and the responses to financial

1 incentives in the kinds of services that are used or even  
2 how patients are assessed. It's all information that we  
3 all have seen in so many places, but it's really very  
4 concentrated. I found it very compelling, very  
5 interesting.

6 To pick up on Kathy and Dana's comments, I think  
7 what we have is clearly broken from the patient assessment,  
8 and I'm sympathetic with Dana's view that we're not there.

9 What I'd like to propose is that we see if  
10 there's markers in the Medicare claims and encounter data  
11 that we think are good indicators of outcomes. Some of it  
12 is well understood -- the emergency room visits, the  
13 readmissions, mortality rates. Some of it may be more  
14 exploratory, like in the DME that gets used or perhaps the  
15 kinds of drugs that get used by patients post-discharge.

16 So I think developing more objective information  
17 from the standpoint of what a patient's functional status  
18 is based on their resource utilization as opposed to  
19 surveys and subjective types of information, whether it's  
20 patient reporter or reported by providers, I think would be  
21 helpful as direction here.

22 But I really want to thank you. It was

1   nightmarish to read through this, but it was a great  
2   chapter. Thank you.

3           DR. CROSSON: Sorry. I presume you read it on  
4   Halloween. Was that part of it?

5           DR. PYENSON: But before Jon cut me off.

6           [Laughter.]

7           DR. CROSSON: So just one thing about what you  
8   said, looking for correlations in the claims information,  
9   would you see that primarily as a research analytical tool  
10  or as something that could be applied to the payment  
11  process?

12           MR. PYENSON: So, for example, the input to a SNF  
13  is defined by the tools that we've developed for estimating  
14  the cost of patients. So that's an input kind of risk  
15  assessment. It's cost based but I think that's well  
16  developed.

17           So the output is what portion of patients get  
18  discharged needing a wheelchair, for example, and that's  
19  probably variable, or other kinds of assistance that need  
20  continued support in the home, of various types.

21           DR. CROSSON: Right. But you're basically saying  
22  that you could imagine -- you haven't done the work but you

1 could imagine there being enough correlations between  
2 elements of the patient's condition that could be derived  
3 from claims information that it could be used operationally  
4 --

5 MR. PYENSON: Correct.

6 DR. CROSSON: -- beyond just looking at it from a  
7 research perspective.

8 MR. PYENSON: Exactly. That we could grade  
9 organizations based on how well their patients perform  
10 after discharge, and we could -- that's my hope.

11 DR. CROSSON: Yeah. So, okay. I'm seeing hands  
12 in response to this. Let's do that first. Dana and then  
13 Jon on this point.

14 DR. SAFRAN: I would just be concerned, Bruce,  
15 that we could then wind up with access problems. You know,  
16 if I know I'm going to be judged on how many patients are  
17 discharged in a wheelchair, there's a good, easy answer to  
18 that, right. So I like the idea as a way to try to  
19 validate a little bit the data that we're seeing that's  
20 either provider reported or patient reported, but I'd be  
21 very worried about moving to a sort of resource use  
22 substitute for actual assessment of the patient's

1 functional status, no matter whether that's coming from the  
2 patient, the provider, you know, a provider that, as Kathy  
3 says, maybe doesn't have a vested interest. But I'd be  
4 worried about that.

5 MR. PYENSON: That's a real concern, I think,  
6 though if think about is it the SNF that orders the DME  
7 maybe it's the home health agency, and maybe that's a  
8 concern for the home health agency more than the SNF, for  
9 example. But I think your point is valid.

10 DR. CROSSON: Jon, on this point?

11 DR. CHRISTIANSON: Yeah. So I'm not sure. What  
12 do you think about the possibility of introducing  
13 incentives to sort of up-front service utilization in a  
14 facility? I mean, would you be creating an incentive for  
15 over-provision of services early on so that you can look  
16 better later, if you look into the stream of resource use  
17 over time?

18 MR. PYENSON: You mean if the extra resources  
19 produce a better outcome?

20 DR. CHRISTIANSON: They might not, but you  
21 realize that if you're tracking resource use over time you  
22 want to go from high resource use to low resource use

1 within the facility, because then you'll look better.

2 MR. PYENSON: Oh.

3 DR. CHRISTIANSON: So would you have an incentive  
4 to maybe overuse resources early on to make that trajectory  
5 look better?

6 MR. PYENSON: I wasn't thinking of resource use  
7 in the institution per se, right. It's more the upon  
8 discharge from the -- I realize that's not -- all patients  
9 don't go through that.

10 DR. CROSSON: Okay. So now we're going back to  
11 additional items. I've got Warner, and I think I saw John  
12 and then Brian and David.

13 MR. THOMAS: So a question I have is -- and I  
14 concur that the data is not very good and certainly doesn't  
15 correlate to any change in care. I guess the question I  
16 would have is if we make this mandatory and we're going to  
17 put more parameters around it, then where do you see going  
18 with this information? Like what do you see using it for?  
19 How do you see it playing into the process, reimbursement  
20 or value-based? I'm just trying to understand, just kind  
21 of directionally, where your thought is.

22 DR. CARTER: Well, my personal thought is I

1 think, intuitively, change in function that's risk adjusted  
2 has a lot of appeal as an outcome measure for a PAC  
3 provider. So I would like us to have confidence enough in  
4 the data that we can use that as an outcome measure,  
5 because I think that's sort of why people are in post-acute  
6 care. So that just makes kind of sense to me.

7           Even if the data look accurate I would be  
8 reluctant to use it for payment, because of the financial  
9 incentives where we have lots of examples of providers  
10 responding to those. So I guess I would be reluctant, even  
11 if the data looked good, to go there.

12           And in terms of tying payments to outcomes, you  
13 know, in a value-based purchasing, I think, you know, I  
14 guess I'm open to that. I would like to hear your  
15 discussion about that.

16           MR. THOMAS: Because I think, you know, the  
17 reason I'm bringing it up is because if we mandate this --  
18 and I'm not opposed to that at all -- I mean, organizations  
19 will do a much better job in doing this assessment. And  
20 then we're going to say, well, gee, now more people are --  
21 they have a higher acuity and they seem like they're sicker  
22 when they're going into this, and it's because there's

1 going to be a much better assessment done. So I think we  
2 just need to prepare ourselves that that is likely going to  
3 happen. And not that that's good or bad. It is. And I  
4 think getting good information and then deciding where to  
5 use it, and I think using it in a quality program or  
6 holding organizations accountable, once again, on outcomes  
7 around readmissions or, you know, acquired conditions like  
8 central line infections and those type of things, like we  
9 were talking about in LTCHs, I think are good.

10 I was just trying to understand exactly,  
11 directionally, what you're thinking, because I think, once  
12 again, if we mandate this -- and I'm not opposed to that --  
13 I think we will see a much better job, just like we're  
14 seeing in risk scores in MA and just like we see in other  
15 quality areas in coding. I think, you know, organizations  
16 get a lot more sophisticated and they make sure they  
17 capture everything that's going on with that patient. So I  
18 think we should just make sure we understand that's  
19 probably directionally where we'd go if we adopt this type  
20 of approach.

21 DR. MATHEWS: If I could get in here, just to  
22 clarify, Warner. I think the primary question for you is

1 not whether we are mandating, you know, the collection of  
2 patient function information but rather given the problems  
3 with patient function that we've outlined, based on, you  
4 know, the recent history in the post-acute care world, and,  
5 you know, as this discussion has informed some of the  
6 problems with the alternatives that we've proposed, and the  
7 fact that when we modeled the accuracy of payments under a  
8 unified PAC PPS that we were able to predict cost based on  
9 patient condition for most of the patient groups that we  
10 looked at, even absent information on functional status,  
11 the primary question is do we need to be collecting this  
12 information at all for use in Medicare's payment systems or  
13 would we conclude that you can do a good enough job and  
14 avoid the adverse incentives without patient function in  
15 payment, and if you decide that, is there still a utility  
16 of having patient function information for assessing  
17 patient outcomes, quality of care, that kind of thing?

18           So the primary question is do you want to keep  
19 doing this in payment, not, you know, are we mandating  
20 providers to collect this information.

21           MR. THOMAS: Well, I think that's helpful  
22 context. I'm just sitting here trying to understand more

1 globally how you're thinking about it. Because I think,  
2 you know, once again, we shouldn't continue to do something  
3 poorly. So if we're going to do it, I mean, let's do it  
4 well, and then, you know, figure out the right way to use  
5 that data, which, I mean, as you talked about it to me  
6 makes a lot of sense, and then you can tie it to value-  
7 based payments or you can tie it to quality outcomes and  
8 maybe get more predictability in looking at functional  
9 status and outcomes and/or, you know, whether we're really  
10 having the impact we want in post-acute care. So I think  
11 that context is helpful to me. Thank you.

12 DR. CROSSON: Jon.

13 DR. PERLIN: Thanks for that last interchange and  
14 thanks for a very provocative, thoughtful chapter.

15 I think there is information that we would want  
16 from functional status assessment that you would argue as  
17 being confounded at the current point. Jim just made the  
18 comment that you can predict cost based on certain pre-  
19 existing data, and I think that tells us that there is a  
20 path to actually getting reusable functional status  
21 assessment information.

22 I would take some issue with the statement that

1 you made, that claims-based measures are more objective.  
2 That may be true in a certain sense. I mean, obviously  
3 there are certain levels of coding quality that have been  
4 established and certain controls on coding. But they also  
5 suffer from the deficiency of being less sensitive,  
6 specifically to patient-level function, which is a  
7 different purpose. And so it gets to the notion of fitness  
8 for purpose, and I think that fundamentally that underlies  
9 our conversation today about the use of measures.

10 I'm not sure that the types of measures that  
11 we're using, and asking which one is better -- claims-based  
12 measures, patient-reported outcomes, or functional status  
13 assessment -- are even fundamentally comparable. In fact,  
14 it may be that they are really, at best, complementary,  
15 which really leads to the recommendation that in an  
16 intellectual sense we want to be able to find a link  
17 between functional status and payment, and certainly  
18 between improvements in functional status and payment. And  
19 there is simultaneously trajectory in the measurement  
20 community to elevate the value of patient-reported outcomes  
21 and its many circles of Holy Grail to be able to assess  
22 functional status. I mean, so those are goods

1 independently.

2           But it really leads me to agree with this thread  
3 of conversation -- Warner, Jim, and Dana -- that, first,  
4 maybe we don't think of these measures as comparable but  
5 complementary, and that they're not exclusive of each  
6 other, and that, at this moment, our best trajectory is to  
7 really increase our opportunity to learn from these  
8 measures and cross-validate the relationships between the  
9 different types of measures, patient-reported functional  
10 status, and otherwise code it in more of a learning  
11 context. Thanks.

12           DR. CROSSON: Thank you. Brian.

13           DR. DeBUSK: First all, thank you for a really  
14 great chapter. It was somewhat sobering, particularly the  
15 discussion about the gamesmanship, but unlike Bruce I  
16 didn't wait until the last minute and read the chapter on  
17 Halloween.

18           [Laughter.]

19           DR. DeBUSK: I read it promptly on Thursday  
20 afternoon when my mailing materials were received.

21           But anyway, with that said -- I love you, Bruce -  
22 - I really have, over the last two years, come a full 360

1 degrees on this issue. I mean, when I first saw the  
2 functional assessment within the discussion of the PAC PPS  
3 I thought, well, of course we need this data, that we have  
4 to have this data. And just in the materials we've  
5 received over the last few meetings, and I think this was  
6 the crescendo of you sort of breaking the bad news to us,  
7 that the gamesmanship here around, for example, the  
8 functional outcomes, it's there. I mean, you listed, I  
9 think, in the presentation and in the reading materials  
10 some really good precedents that say, look, here's what  
11 happens. When we tie this to payment here's the bad thing  
12 that happens.

13           But -- Carol, I'm going to use your own words  
14 against you -- to your point you said functional assessment  
15 and improving function is fundamental -- I think that was  
16 the word you used was "fundamental" -- as an outcomes  
17 measure, and I think it's an unavoidable thing that we're  
18 going to have to ensure that the integrity is there.

19           So I'm really reluctant, even if we do tie this  
20 to payment, I'm really reluctant to say, well, here's this  
21 history of when we tie something to payment it gets gamed.  
22 You know, you mentioned in the material maybe we engage the

1 recovery audit contractors, maybe the quality improvement  
2 organizations. You know, I like, Bruce, where you were  
3 going with this idea of maybe we look at some claims-based  
4 data as a way of -- you know, I liked your example with the  
5 wheelchair. Don't tell me that someone is highly  
6 ambulatory and then let me see, a month later or three  
7 months later, a DME bill for a wheelchair or a walker or  
8 something like that. So I think there's merit in that idea  
9 of let's look at the trail that the claims leave possibly  
10 as a way to investigate this.

11           But here's what I want to leave you with. As  
12 difficult as it is to say we have to get good functional  
13 assessment data, I think it maybe, you know,  
14 metaphorically, a hill we have to take. I don't know that  
15 we can do it cleanly any other way. And the other thing I  
16 want to leave you with is, you know, if we're willing to  
17 concede that tying things that are subjective or difficult  
18 to measure to payment just can't be done, I worry about the  
19 precedent that we're setting, because that could spill over  
20 into other payment areas, and I'm just not quite ready to  
21 make that concession.

22           So I hope that as we move forward with this work

1 that we really thoroughly investigate how we can enforce  
2 the accuracy of the data. I would love to hear more of  
3 Dana's thoughts on what you guys do on the commercial side.  
4 But I think it's an inescapable thing we're going to have  
5 to measure. And it's not good news, especially in the  
6 context of this chapter. Thanks.

7 DR. CROSSON: Thank you. David.

8 DR. GRABOWSKI: Great. Thanks for this chapter.  
9 I thought it was really well done.

10 I think accurate functional status data are just  
11 the backbone of our both payment and quality measurement in  
12 PAC settings, yet we rely on these self-reported data. I  
13 think there's a lesson in the recent transition in terms of  
14 the reporting of staffing data. Historically, CMS relied  
15 on SNFs self-reporting their staffing data for quality  
16 measurement and payment issues. Over the last two years  
17 they've switched to payroll-based staffing data. Those  
18 data tell a very different story. To Jon's point, all data  
19 have error and can you can make arguments in both  
20 directions. But I do think they're complementary, and this  
21 idea that we shouldn't solely rely on self-reported data I  
22 think played out in the staffing data.

1           So I really like the work you're doing here in  
2 generating, you know, alternative measures of functional  
3 status that aren't maybe as susceptible to some of the  
4 biases that we've seen historically with self-reported  
5 data.

6           I wanted to comment on the analysis plan that you  
7 laid out and just kind of give some feedback there. You  
8 had a number of different ideas. I talked to you  
9 previously about this transitions idea. I like it a lot.  
10 It's a way of checking, you know, if I move from an IRF,  
11 for example, to a SNF, I'm going to have assessments within  
12 days of one another, and so I can see how those assessments  
13 look relative to one another. I think that's a really nice  
14 check, so I really like that work.

15           I like the idea you put forward of comparing the  
16 functional scores against other beneficiary  
17 characteristics, whether that's age, comorbidities, risk  
18 scores. I think that also is a great way of checking this.  
19 And then, finally, you talked about looking within kind of  
20 providers and seeing if these measures are topped out, or  
21 looking at distributions of measures. I think that's  
22 really important here. Is this even a meaningful measure

1 as it's currently constructed if we're going to use it for  
2 risk adjustment, for payment, and quality?

3           So I'll stop there but I look forward to kind of  
4 seeing the results of these different analyses at a future  
5 meeting.

6           DR. CROSSON: Okay. Thank you. So I'm trying to  
7 see if I can summarize where we are. I don't think we have  
8 unanimity on all points here. I think we, as Carol said,  
9 we have this sort of conundrum that, well, you know, what  
10 is post-acute care about in the first place? You know,  
11 largely, not totally, but largely it's about improving  
12 functional status so that the patient can return to, you  
13 know, home or whatever environment that they would prefer  
14 to be in. And yet, for the reasons that I think were well  
15 laid out in the report, we have some concerns about at  
16 least the current ways of assessing functional status,  
17 particularly when it's linked to payment.

18           And so we're looking for a solution to that. One  
19 solution might be to reconsider how functional assessment  
20 is measured, and I think Bruce offered one suggestion there  
21 and I think we should look at that, and David, you just  
22 talked about some others. I have a sense that we're more

1 in line in that direction than we would be on any one of  
2 these three suggestions on page 10, because I think one or  
3 more individuals have pointed out problems with that,  
4 either the complexity inherent in trying to do audits,  
5 which have had variable success and are probably costly.

6           Requiring hospitals to complete the discharge  
7 assessments -- to require assessments at discharge -- has  
8 some attraction, but as Dana has pointed out, to the extent  
9 that hospitals and post-acute care entities are in either a  
10 close business relationship or just simply aligned in a  
11 community then there are some concerns about whether that  
12 would work or not. And then we have, in this particular  
13 case, with respect to patient-reported outcomes, concern  
14 about the reliability of that and whether or not the actual  
15 individuals are doing this, you know, filling these forms  
16 out or somebody is doing it.

17           I haven't heard any robust, full-throated support  
18 for any one of these three, so it leads me sort of back to  
19 saying that I think where we are, Carol and Ledia, is  
20 coming back to you with a request that, you know, to the  
21 extent that you think it's possible, and whether or not you  
22 think it should be linked to payment, which is a separate

1 question, but simply trying to bring back to us some  
2 additional ideas about how functional assessment could be  
3 constructed in a such a way that, at the very least, it  
4 would be useful in measuring the performance of facilities,  
5 and maybe some new thoughts, and you had a few here today  
6 and I suspect you have some of your own, might be what we  
7 would be asking for.

8           Does that seem like where we are? I'm seeing  
9 sort of general assent to that, and I hope that's been  
10 helpful.

11           Thank you again for the work, and we'll see you  
12 again.

13           That concludes the morning session, and we now  
14 have time for public comment on the material that's been  
15 discussed this morning.

16           I see one individual coming to the microphone.

17           MR. BRIERLY: Great. Good morning --

18           DR. CROSSON: I'm sorry. I just want to kind of  
19 give you the rules of the road. Thank you for coming  
20 forward. We are interested in hearing you. Please  
21 identify yourself and any organization or institution that  
22 you are affiliated with, and we would ask you to limit your

1 remarks to approximately two minutes.

2 MR. BRIERLY: Sounds good.

3 DR. CROSSON: When this light comes back on, the  
4 two minutes will have expired.

5 \* MR. BRIERLY: Thank you. Good morning and thank  
6 you. My name is Leif Brierly. I'm with Powers Law, and  
7 I'm the manager of government relations there. We  
8 represent the Coalition to Preserve Rehabilitation. It's a  
9 national provider and consumer coalition with members  
10 including the Brain Injury Association of America and the  
11 American Academy of Physical Medicine and Rehabilitation,  
12 among others.

13 We have a strong interest in the functional  
14 measures work that you're doing and just want to again  
15 drive home the importance of functional measures to not  
16 only the consumers who need that kind of outcome measure to  
17 determine the quality of their care, but also for the  
18 providers who are providing it. You know, functional  
19 measures are fundamental to health care, and as you  
20 consider ways to improve them, we'd look to be your  
21 partner. We would be interested in working with the  
22 Commission and staff on ways that they can be improved, and

1 I think the discussion this morning was encouraging and  
2 enlightening. So thank you for that.

3 DR. CROSSON: Thank you.

4 DR. PHILLIPS: Hello. Cheryl Phillips,  
5 geriatrician, Special Needs Plan Alliance. And as a  
6 geriatrician, I am passionate about the functional  
7 assessment data. I'm really concerned, though,  
8 particularly in reference to the Health Outcomes Survey,  
9 the HOS tool. Right now the HOS, a great tool, but  
10 validated for veterans population that was predominantly  
11 Caucasian, over 65, has not been validated in populations  
12 where low English proficiency or health literacy. It  
13 requires a two-year lookback, which by itself creates a  
14 disparity for those with housing insecurity or progressive  
15 degenerative physical characteristics for whom a two-year  
16 lookback doesn't mean you're going to get better in two  
17 years, so while -- I think we all believe that patient-  
18 reported outcomes are critical. Then I share your concern  
19 that we're a long ways away before we link these to  
20 payment, and that if we're going to use a tool like HOS, we  
21 strongly need to encourage CMS to look back and identify  
22 some ways to revise the HOS tool to better meet disparate

1 populations.

2 Thank you.

3 DR. CROSSON: Thank you. Seeing no one else at  
4 the microphone, we are adjourned for the morning, and we  
5 will reconvene at 1 o'clock.

6 [Whereupon, at 11:31 a.m., the meeting was  
7 recessed, to reconvene at 1:00 p.m. this same day.]

8

9

10

11

12

13

14

15

16

17

18

19

20

21

22

## AFTERNOON SESSION

[1:00 p.m.]

1  
2  
3 DR. CROSSON: Okay. We're ready to begin the  
4 afternoon session. The first topic we're going to take a  
5 look at is the payment incentive system in the advanced  
6 alternative payment methodologies that were created by  
7 MACRA, and Kate and David are here with some suggestions.  
8 Take it away.

9 \* MS. BLONIARZ: So as Jay said, the first session  
10 returns to the topic of advanced alternative payment  
11 models, or A-APMs, and the incentive payment for clinicians  
12 to participate in them. This material follows a series of  
13 discussions we've had on A-APMs and the merit-based  
14 incentive payment system, which together form the path for  
15 Medicare clinician payment.

16 We'll describe today how the current A-APM  
17 incentive payment works and describe a technical policy fix  
18 that would simplify the incentive and greatly simplify  
19 administration of the policy.

20 We first discussed this idea in the Commission's  
21 June 2017 Report to the Congress, and the question for you  
22 is whether to move this to a draft recommendation in

1 December as part of the physician and other health  
2 professionals statutory update.

3           This would require a legislative change, and so  
4 the recommendation would be addressed to the Congress.

5           In 2015, the Congress enacted a series of  
6 policies in MACRA, eliminating the prior formula for  
7 physician fees and replacing them with statutory updates,  
8 and created two paths for clinicians in Medicare. First is  
9 the merit-based incentive payment system, which is a value-  
10 based purchasing program, and the second is the A-APM path.

11           Before I describe the two policies, I just want  
12 to make it clear that the Commission has expressed its  
13 support for the provisions of MACRA that eliminated the SGR  
14 and moved the Medicare program towards comprehensive,  
15 patient-centered care delivery models like those in A-APMs.

16           So A-APMs are a set of CMS payment reform models  
17 that meet certain criteria established in the law.  
18 Entities in A-APMs must assume more than nominal financial  
19 risk, use EHR technology, and have quality measures  
20 comparable to MIPS.

21           CMS has presently deemed nine of their models as  
22 meeting these criteria, including ACOs, bundles, and

1 medical homes.

2           There are two notable benefits for clinicians  
3 participating in A-APMs. First, if they substantially  
4 participate in the model, they may qualify for an incentive  
5 payment from Medicare. The participation thresholds to get  
6 the incentive payment start at 25 percent of revenue in  
7 2019 and rise to 75 percent by 2023.

8           For any year that the clinician meets the  
9 threshold, they qualify for an incentive payment of 5  
10 percent on their total fee-for-service revenue paid in a  
11 lump sum. This includes revenue both inside and outside of  
12 a model.

13           Clinicians that qualify for the incentive payment  
14 are also exempt from MIPS -- both reporting quality  
15 measures and the resulting payment adjustments based on  
16 performance.

17           The prior slide summarized the general concept,  
18 but there are a number of complicated details underlying  
19 the actual determination. The four different factors that  
20 CMS considers in determining eligibility are: whether they  
21 are assessed as an entity or an individual clinician; if  
22 CMS considers revenues or counts of patients; the time

1 period that's used; and whether CMS looks only at the  
2 payment models that Medicare fee-for-service runs, or adds  
3 in participation in models administered by other payers.

4           Let me describe a little bit of the resulting  
5 complexity. The other-payer calculation requires that CMS  
6 collect information from private insurers on the nature of  
7 their contract arrangements with individual clinicians, the  
8 dollars and patients coming through those contract  
9 arrangements, and the total revenue and patients for the  
10 clinician across all of their payers.

11           CMS performs these calculations sequentially,  
12 stopping as soon as a clinician qualifies for the incentive  
13 payment. So in this way, CMS is maximizing the number of  
14 clinicians that qualify.

15           Overall, we have a number of concerns.

16           First is the administrative complexity that I  
17 just alluded to.

18           Second is the form of the incentive. Clinicians  
19 with revenue just under the threshold receive no incentive;  
20 whereas, one just above receives an incentive on all of  
21 their Medicare fee-for-service revenue.

22           There's no incentive, once the threshold is met,

1 to further increase A-APM participation. And the amount of  
2 the incentive is sized to their total professional services  
3 revenue.

4 Then, as the threshold increases over time from  
5 25 to 50 to 75 percent, clinician uncertainty will increase  
6 about whether they will qualify for the incentive payment  
7 and the exclusion from MIPS.

8 So the policy option for discussion today is to  
9 eliminate the thresholds and apply the 5 percent A-APM  
10 incentive payment to any revenue coming through an A-APM.  
11 In other words, clinicians would receive an incentive on  
12 their first dollar of revenue coming through the A-APM, and  
13 the incentive would then be scaled to the total amount of  
14 the clinician participation in the model.

15 This design would be more equitable, less complex  
16 for CMS to administer, and would give clinicians a  
17 continuous incentive to increase their A-APM participation.

18 Here's how the policy option would change the  
19 clinician's incentives, and this example is 25 percent of  
20 revenue, which is in effect for 2019 and 2020. Under  
21 current law, the clinician receives no incentive, which is  
22 the tiny red line to the left, until they hit 25 percent of

1 revenue coming through the A-APM, when the incentive  
2 increases to equal 5 percent of all of their Medicare fee-  
3 for-service revenue.

4           Then this is what the proportional incentive  
5 would look like. Clinicians would see a steady increase in  
6 their incentive at any level of A-APM participation.

7           So, altogether, clinicians with revenue below the  
8 threshold would now receive an incentive -- that's the plus  
9 sign -- and clinicians above the threshold would receive a  
10 smaller incentive than current law -- shown by the minus  
11 sign.

12           This dynamic continues to play out over time as  
13 the threshold rises from 25 percent to 50 to 75?

14           Clinicians with revenue below the current law  
15 thresholds would now receive an incentive payment -- those  
16 in the purple area on the chart. Clinicians with A-APM  
17 revenue above the current law thresholds would still  
18 receive an incentive payment, but it would be smaller than  
19 current law. That's the yellow. And this table just gives  
20 a little more detail of the potential impact of the policy  
21 option by year.

22           In 2019 and 2020, there will be a small increase

1 in the number of clinicians qualifying, offset by a  
2 moderate reduction in the average payment rate. Then, over  
3 time, that will change as relatively more clinicians  
4 qualify under the policy option.

5 We are still working through the total net effect  
6 of all of these puts and takes and whether it increases or  
7 decreases Medicare spending relative to the current law  
8 incentive.

9 For the discussion, we would like your feedback  
10 on the policy option and reactions on moving to a draft  
11 recommendation as part of the physician and other health  
12 professional services update in the December-January time  
13 frame.

14 I'm also happy to answer any questions you have  
15 and look forward to your discussion.

16 DR. CROSSON: Thank you, Kate, David. Very  
17 clear. We'll take clarifying questions. Pat.

18 MS. WANG: Thanks, Kate. It is, it's very clear.  
19 Thank you. In the paper you had discussed this approach in  
20 connection with what's coming, I guess, by law later to  
21 include Medicare Advantage and other payer arrangements as  
22 helping a clinician kind of get to the threshold. Can you

1 talk about the implications of what you've outlined here on  
2 that?

3 MS. BLONJARZ: Sure. So this would take the  
4 current law incentive from kind of contemplating other  
5 payer revenue starting in 2021, and the incentive under  
6 this policy option would only be based on fee-for-service,  
7 Medicare fee-for-service. You know, separately, we've  
8 talked at the staff level about, you know, if there was an  
9 interest in having a separate discussion about how to  
10 create incentives for participation in other payers, that  
11 would then be separate, you know, kind of a separate issue.  
12 But this takes all of the other payer pieces out of it.

13 And the other point I just want to make is that,  
14 starting in 2021, you know, MA and other payers will be  
15 counted in the threshold determination, but starting in  
16 '19, the MA benchmarks include whatever the kind of ambient  
17 A-APM incentive payment spending will be. So those are  
18 going to be in the benchmarks starting in '19, you know, as  
19 kind of those -- they show up in the fee-for-service  
20 spending trends which then convert to the MA spending  
21 trends.

22 MS. WANG: If you could just clarify for me, the

1 way that the introduction as it stands now of other payer  
2 arrangements would work is that if a clinician failed to,  
3 in the current construct, meet the thresholds, you would  
4 then look at MA and commercial, and if they met thresholds  
5 there, then the bonus would apply to fee-for-service  
6 Medicare revenue?

7 MS. BLONIARZ: Yeah, that's exactly right. So,  
8 first, in the all-payer threshold, a clinician still has to  
9 participate in some Medicare fee-for-service A-APM. So  
10 let's say they participate in MSSP Track 2, but they're  
11 only at 10 percent of revenue. Then if they have other  
12 payer revenue that is, you know, in a contract arrangement  
13 that's like an A-APM, CMS will redo the determination to  
14 see if on an all-payer basis, you know, they meet that 25  
15 or 50 percent or 75 percent. If they do, the incentive is  
16 5 percent applied to Medicare fee-for-service spending.

17 MS. WANG: Okay.

18 MS. BLONIARZ: So it's kind of crossing concepts.  
19 The incentive is -- the eligibility is based on this all-  
20 payer concept, but it's only applied to Medicare fee-for-  
21 service.

22 MS. WANG: Thank you.

1 DR. CROSSON: Jonathan and Sue and Amy.

2 DR. JAFFERY: Yeah, so thank you again. This is  
3 clear, but I have, I think, three questions.

4 One is, when you talk about the bonus payment  
5 years and meeting the revenue thresholds in 2019 to 20 --  
6 2024 -- because my understanding was that the thresholds --  
7 isn't there a two-year delay in the payments, so the  
8 thresholds need to be met in 2017 through 2022 and the  
9 payments are actually 2019 to --

10 MS. BLONJARZ: That's right. Yeah, so the way  
11 that it works is there's a two-year delay between whatever  
12 activity is being measured and when Medicare will make a  
13 payment. So in 2017, CMS said, okay, you know, here's the  
14 list of participants in all of these models. They then  
15 will determine whether they meet the dollar -- the revenue  
16 and patient count thresholds based on 2018, a snapshot of  
17 time. And then if they qualify, the 5 percent incentive  
18 payment is applied to their 2018 revenue, which then gets  
19 sent to them in the middle of 2019. So there is a two-year  
20 lag kind of all together.

21 DR. JAFFERY: So we're actually already butting  
22 up against the 50 percent.

1 MS. BLONIARZ: Right. So the first performance  
2 year has already passed.

3 DR. JAFFERY: Yeah, okay. The second question --  
4 and I think you mentioned this in the report, but we also  
5 get into the fee updates starting in, I think, 2026, the  
6 differential fee updates, and it has never been clear to me  
7 what the threshold of participation in advanced APMs is to  
8 get you that higher fee update.

9 MS. BLONIARZ: Right. So in 2025 and later, the  
10 higher update is based on the 75 percent threshold.

11 DR. JAFFERY: Great. And the last thing, maybe  
12 just another clarifying point. You had just given an  
13 example of if providers only had 10 percent of Medicare  
14 revenue, then they could get -- they might qualify through  
15 all payer, but as I recall, there's an actual minimum  
16 Medicare revenue requirement of 25 percent, even if you're  
17 going the all-payer model.

18 MS. BLONIARZ: You're right. That's right.  
19 That's right.

20 DR. JAFFERY: Okay.

21 MR. GLASS: I think that's in our mailing  
22 material.

1 DR. JAFFERY: Okay. Thanks.

2 DR. CROSSON: Sue.

3 MS. THOMPSON: Thanks, Kate and David. You know  
4 I enjoy this chapter. And, David, you know I'm going to  
5 ask about attribution because it seems this discussion is  
6 based on a thought that the current attribution model  
7 works. And we know from experience the current attribution  
8 model still has some flaws, and we have some of our  
9 patients who are not attributed necessarily to the right  
10 provider, which, you know, has extraordinary impact on what  
11 happens as you take this to its end.

12 Thoughts about attribution, and likely in the  
13 Midwest we see a lot of beneficiaries traveling to the  
14 South in the wintertime, where some or more of their care  
15 is provided, and we lose that attribution. So talk to me  
16 again, David, about your thinking in terms of the existing  
17 attribution model and what we need to think about in this  
18 policy.

19 MR. GLASS: Well, so the attribution for ACOs is  
20 the plurality of a subset of E&M codes, who provides those.  
21 And if the plurality is provided by a physician or  
22 clinicians who participate in the A-APM, then that ACO gets

1 the attribution of that beneficiary.

2           Now, there is also the possibility of a  
3 beneficiary voluntarily saying this is my primary care  
4 provider on Physician Compare and the website, and then  
5 that beneficiary would automatically be attributed to that  
6 ACO. So it could be that eventually people will start  
7 voluntarily attributing themselves to a PCP, and that would  
8 solve your snowbird issue. Otherwise, that's just going to  
9 be difficult to do. I think. I'm not sure that there is  
10 any magic solution to that -- unless you -- I guess you  
11 could associate an ACO in the Midwest with one in Naples,  
12 Florida, and then it could be considered one ACO because  
13 the ACOs don't have to be physically proximate to each  
14 other.

15           MS. THOMPSON: I have two more questions. The  
16 second question is: Do you have any thoughts about how  
17 this proposal might affect the thinking of a commercial  
18 payer? We're trying to bring more commercial payers into  
19 the mix of going at risk with us as providers. So your  
20 thought there?

21           MS. BLONJARZ: Yeah, we talked a little bit about  
22 this in terms of the MA context of, you know, this is a

1 little bit -- the all-payer determination is a little bit  
2 of a nudge for other payers to have kind of contract terms  
3 that meet the A-APM criteria, right? So I think we thought  
4 there'd still be an incentive for kind of aligned, you  
5 know, models and aligned incentives and things like this.  
6 I don't know how big of a nudge this is for the commercial  
7 payers. I mean, I know that, you know, CMS hasn't really  
8 sent any information yet, but MA plans are starting to  
9 submit information, and there is also like a clinician-  
10 initiated process to kind of report this information. But,  
11 you know, I think -- I don't know that we have a good sense  
12 yet of what that is.

13 MR. GLASS: And, you know, I would have thought  
14 that commercial payers wouldn't be particularly eager to  
15 expose the terms of their contracts and the number of lives  
16 and the amount of money going to particular providers, you  
17 know, and why Medicare would want to get involved in  
18 finding out all about that would seem unusual. The  
19 business case has to be there for the providers to enter in  
20 with a commercial entity into a contract like this. If  
21 it's there, they'll do it. And if it's not, they won't.  
22 And I don't think this tiny nudge would have much effect on

1 that.

2 MS. THOMPSON: Okay. And then a final question.  
3 In the context of the full amount of Part B dollars, both  
4 attributed lives and other Part B fee-for-service revenue  
5 under the current arrangement the 5 percent bonus is based  
6 on, do we know -- are we close to knowing or when will we  
7 know what percentages on attributed lives under an advanced  
8 APM and what's Part B billing under fee-for-service? So  
9 what's the amount that will go away?

10 MS. BLONJARZ: So this is something we've also  
11 talked a fair bit about in trying to figure out in our own  
12 minds, you know, is this a saver or cost-er, just kind of  
13 what's the net effect of the policy. Part of the challenge  
14 is -- so this year there's nine models that qualify, and we  
15 have a bit of a sense on things like MSSP of, you know, how  
16 much revenue is in the ACO versus not for clinicians. I  
17 think some of the other models we have way less  
18 information, either because they are new or because, you  
19 know, it's just more opaque in terms of how the models are  
20 running and thinking there and some of the bundling models.

21 I think we would -- you know, we plan to kind of  
22 think about that and get a little more information, but,

1 yeah, we would love to know that as well.

2 MS. THOMPSON: Thank you.

3 DR. CROSSON: Amy.

4 MS. BRICKER: So not having the experience that  
5 Sue and others have, I found the material in the chapter to  
6 be very clear, and it made sense. This just seemed like a  
7 no-brainer.

8 Usually, we see the downside, right? So here are  
9 all the pluses, but we must consider the downside, and I  
10 didn't see any. Is there a downside?

11 MR. GLASS: Put up the picture, the one with the  
12 plus and minuses.

13 If you're a clinician that's above the threshold,  
14 that's above the 25 percent threshold, you're going to get  
15 a smaller amount. For those clinicians, that's the  
16 downside.

17 As you go from 25 to 50 percent, there are going  
18 to be fewer clinicians up there, but they will still be the  
19 ones who, instead of getting 5 percent on all their fee-  
20 for-service revenue, they will only get 5 percent on the  
21 revenue coming through the A-APM. So they would consider  
22 that a downside.

1 MS. BRICKER: Sure. But from the plans -- I get  
2 it. So some providers will feel the effect of this policy  
3 change, but I think that's the thing that we're attempting  
4 to correct. Yes?

5 MR. GLASS: Yeah. We're trying to make it  
6 proportionate to their involvement in A-APMs.

7 If you're one of those providers, that would be  
8 your downside, I think.

9 DR. CROSSON: Correct me if I'm wrong here. For  
10 physicians who have one foot in the MA canoe and one foot  
11 in the fee-for-service canoe, without putting numbers to  
12 it, there would be an adverse effect on some of those  
13 physicians by eliminating the MA portion of their practice  
14 from qualification. Is that right?

15 MR. GLASS: No. I wouldn't go --

16 DR. CROSSON: No? All right, then.

17 MR. GLASS: This is just about their revenue  
18 through the A-APM as opposed to the rest of their fee-for-  
19 service revenue. That's another consideration, but it's  
20 really hard to know how that goes.

21 DR. CROSSON: Okay. Help me here.

22 MS. BLONIARZ: So, Jay, you could see some

1 clinicians. There may be some clinicians when the all-  
2 payer policy goes into effect that would have met the  
3 threshold only when their all-payer revenue was added in,  
4 their MA revenue or their Medicaid revenue. They still  
5 would get an incentive payment, but like everyone else, it  
6 would be smaller --

7 DR. CROSSON: Yes.

8 MS. BLONIARZ: -- because it would be  
9 proportionate based on their A-APM participation.

10 DR. CROSSON: Okay. But in the base case, it  
11 would have been a full payment?

12 MS. BLONIARZ: Would have been on 100 percent of  
13 their fee-for-service revenue.

14 DR. CROSSON: It's not MA?

15 MR. GLASS: No, it's never on their MA.

16 MS. BLONIARZ: It's never on their MA.

17 DR. CROSSON: Okay. The MA is just for  
18 qualification.

19 MR. GLASS: Yes.

20 DR. CROSSON: All right. Thank you.

21 Is that what you were going to tell me or  
22 something like that?

1 DR. JAFFERY: Not exactly, but --

2 [Laughter.]

3 DR. CROSSON: I got that.

4 So I've got Warner and then Paul and -- I got  
5 lost. Okay. All right. Got you, Dana. Warner, Paul,  
6 Marge -- Dana, Marge, right?

7 MR. THOMAS: So I guess a couple of questions.  
8 Do you know what the rationale was for including commercial  
9 in the calculation, or do you have any thoughts on that?  
10 Do we know kind of what the thinking was behind that?

11 MS. BLONIARZ: Well, I don't know that we would  
12 speculate on what was in the Congress' mind as they were  
13 drafting it.

14 But I do think there is a general interest that I  
15 think Sue alluded to for aligned incentives across payers,  
16 and so you see this in CMMI. They often have multipayer  
17 models, and I think it was likely the same kind of  
18 motivation.

19 And I think there's also been a fair bit of  
20 interest in once an incentive was on the table to see if  
21 there was a way to get clinicians that substantially  
22 participated in MA to also qualify for that incentive.

1           MR. THOMAS: And maybe this is a little bit of a  
2 take-off of Sue's question, but do you have a sense of -- I  
3 mean, we know how many people are in the ACO models and  
4 whatnot. Do you have a sense of how many people are kind  
5 of in this, I guess this section of they're taking some  
6 risk, but they're not hitting the 25? I mean, do we think  
7 it's -- is this significant, or you just have no idea?

8           MR. GLASS: They're taking some risk.

9           DR. SAFRAN: They're in the A-APM.

10          MR. THOMAS: They're in the A-APM --

11          MR. GLASS: Right.

12          MR. THOMAS: -- but they're not at the 25.

13          MR. GLASS: Oh, yeah.

14          MS. BLONJARZ: So right now, when the threshold  
15 is 25 percent, I think almost all entities in A-APMs  
16 qualify because CMS is doing a 12-step determination to see  
17 if they qualify, and initially CMS said that they thought  
18 that every participant, every qualifying participant in  
19 every model, except for CJR, would qualify in the first  
20 year.

21          MR. THOMAS: So, I guess, what is the population  
22 we're trying to target with this policy change from the

1 zero to 25?

2 MS. BLONJARZ: I think it's of more importance as  
3 it goes from 25 to 50 to 75 because that is where  
4 clinicians won't know if they will make it in or not, and  
5 you will have clinicians substantially participating, but  
6 not getting an incentive payment.

7 MR. THOMAS: Okay. Thanks.

8 DR. CROSSON: Paul.

9 DR. PAUL GINSBURG: You may have had this in the  
10 materials, but I don't remember. If you go to the gradual  
11 continuous thing, what happens with excusing physicians  
12 from MIPS?

13 MS. BLONJARZ: I think that's kind of a question  
14 of design.

15 What we had thought of is that it might still be  
16 desirable to say that a clinician with any participation in  
17 an A-APM would be excluded from MIPS, and the idea there is  
18 kind of in the work we did last year, we had this idea that  
19 there should only be one set of incentives and one kind of  
20 set of -- enrolling in one group only and one set of  
21 incentives on cost and quality. So saying that clinicians  
22 that participate in any A-APM are exempt from MIPS would do

1 that.

2 MR. GLASS: As you remember, when the Commission  
3 recommended getting rid of MIPS, there was this voluntary  
4 value program in back of it that clinicians joined another  
5 group of some sort, and the idea was that you were either  
6 one of those or in an A-APM. And it was a binary choice.

7 DR. CROSSON: Dana.

8 DR. SAFRAN: Thanks.

9 So building off of your answer to Warner's  
10 question, which is kind of how I hear it is, it is not  
11 during the time period where things are at the 25 percent,  
12 but when it gets beyond that, that this is actually most  
13 helpful. I mean, all the complexity arguments and the  
14 cliff arguments apply there, but it really gets more  
15 helpful there.

16 Can you speak to kind of -- given that, what do  
17 you think, what do you imagine that this shift in the  
18 policy would do to A-APM adoption? What's the sort of  
19 thought process that clinicians and groups will go through?  
20 That I'm assuming you think it will drive up A-APM  
21 adoption. So what does that look like?

22 MR. GLASS: I think the idea is it just will help

1 with the certainty. They know they will get summary work  
2 for the work they do through the A-APM as opposed to maybe  
3 not at all, and I think that's really important because  
4 when we've talked to ACOs and others in the past, it's the  
5 uncertainty over many issues such as attribution, et  
6 cetera. But the uncertainty is what really bothers people,  
7 and this would give them certainty that whatever they do  
8 through an A-APM will be rewarded.

9 DR. CROSSON: Brian, on this?

10 DR. DeBUSK: Specifically on this. I like your  
11 choice of the word "certainty," and I'm saving most of this  
12 for Round 2. But here's a prelude.

13 When it comes to adoption of A-APMs and  
14 participation, do we want to make anyone more comfortable  
15 or give them more certainty or anything else?

16 Again, I'll get into this in Round 2, but don't  
17 cliffs have a purpose?

18 MR. GLASS: Off of them?

19 DR. DeBUSK: Back to your point, I mean, I  
20 appreciate what you're saying, and this is a question. But  
21 you opened the door when you were talking about certainty.  
22 I'm just curious about that. Is the goal here to try to

1 make this more comfortable, and if so, isn't this a  
2 process? Isn't not participating in an APM something we  
3 should make more uncomfortable, not -- it's almost like  
4 we're rewarding lukewarm participation now.

5 MS. BLONIARZ: I guess I don't know that I would  
6 say that -- I think that the incentive to join an A-APM are  
7 not -- this is probably not even on the top five reasons  
8 that entities would join an A-APM. There's a fair bit of  
9 infrastructure and other reasons, I think, kind of the  
10 business case for the models.

11 I don't know that keeping this structure in place  
12 makes fee-for-service more uncomfortable, for example.

13 DR. CROSSON: More to come.

14 Marge.

15 MS. MARJORIE GINSBURG: I don't necessarily want  
16 to dredge up old history, but I am curious. The new  
17 recommendation looks so much better, and it seems to just  
18 make more sense.

19 I'm a little curious whether MedPAC was involved  
20 with the original structure, and if so, did Congress ignore  
21 you? Or did you actually think the original design of this  
22 really made sense at the time and now it just doesn't?

1 MS. BLONIARZ: I think I'm going to kick it to  
2 Jim.

3 [Laughter.]

4 DR. MATHEWS: So we were, as Kate said, at the  
5 outset very supportive of value construct for clinicians as  
6 part of the SGR elimination in MACRA.

7 Obviously, with respect to MIPS, we disagreed  
8 with how that program had been set up and made a  
9 recommendation this past June to eliminate MIPS. But we  
10 did not have any involvement in terms of the mechanics of  
11 how an A-APM structure would be set up.

12 We did -- in which year? -- 2016 outline  
13 principles for A-APM?

14 MS. BLONIARZ: Yes, 2016.

15 DR. MATHEWS: Yeah. but we didn't get down into  
16 the weeds and say "And here is what an A-APM should ideally  
17 look like, and here are the mechanics of how it should be  
18 rewarded."

19 Our fingerprints are on this, but not all over  
20 it.

21 DR. CROSSON: Marge, just as a general principle,  
22 if something works very well, MedPAC had a role in it.

1 [Laughter.]

2 DR. CROSSON: If not, it's open to discussion.

3 Okay. Kathy?

4 MS. BUTO: I just had a late question as I looked  
5 at this slide. We could also create a more gradual  
6 proportionate incentive system, but not include any reward  
7 for zero to 25 percent, correct?

8 The concept of gradual, back to Brian's point,  
9 and the concept of trying to push entities into becoming A-  
10 APMs are a little bit in conflict here because this makes  
11 the glide path pretty -- you don't lose much by gliding  
12 into it, where I think originally when we talked about it,  
13 we really wanted something that would create an aha moment  
14 for physicians and others to say, "You know what? I want  
15 to really jump in here. I want to aggressively look for an  
16 arrangement that will get me into this other thing."

17 Anyway, I just wanted to ask the question. You  
18 constructed it this way, but it obviously has some room to  
19 --

20 MR. GLASS: Right. You can use continuous  
21 function, if you like. You can make a cool S-shaped curve,  
22 if you wanted to.

1 [Laughter.]

2 MS. BUTO: Okay. I'll think about that one.

3 MR. GLASS: You could increase 5 percent to 10  
4 percent. You can do lots of things, but we were just  
5 trying to simplify life, not complicate it.

6 MS. BUTO: Got it. I appreciate that thought.

7 DR. MATHEWS: But this is something that is worth  
8 consideration and worth your discussion, especially if  
9 having one dollar go through the A-APM doesn't only get you  
10 5 cents, but it also frees you up from obligations under  
11 MIPS.

12 So you may want to discuss whether or not zero is  
13 the place for the continuous function to begin or whether  
14 it is some other percentage.

15 DR. CROSSON: Okay. Seeing no further questions,  
16 we're going to go into the discussion.

17 This set up, just to remind you, to the extent  
18 that we have a sense of direction here, you would then see  
19 this proposal or somewhat altered proposal brought back in  
20 December for an initial discussion with a draft  
21 recommendation and then again January. That's the plan.

22 The thesis here is that at the end of this

1 discussion, we have a sense that we're kind of on the same  
2 path or not.

3 Paul is going to start the discussion.

4 DR. PAUL GINSBURG: Sure.

5 I think you've done a very good job taking us to  
6 the point. Clearly, what you're proposing for this  
7 proposal is better than what we have, and I'd be very  
8 supportive of this coming up and supporting it.

9 But while we're here, I don't want to lose the  
10 chance to see if we can strengthen the incentives for A-APM  
11 participation.

12 Kathy really started with a thing about maybe we  
13 don't want to start with a 1 percent as far as letting  
14 people out of MIPS. Maybe it has to be more.

15 I know we're working in a budget-neutral world.  
16 Maybe we even want to -- this will be the most  
17 controversial -- bump up the incentives but actually have a  
18 negative for people who in a sense make MIPS less than  
19 budget neutral. So for people who don't qualify, they're  
20 going to get less than they would be doing under current  
21 law.

22 I don't want to throw this opportunity away to

1 come up with ideas to make the incentive more powerful.  
2 This clearly is the direction the Commission wants to go,  
3 fostering alternative payment models, and so let's work on  
4 some more but still for December.

5 DR. CROSSON: Okay. Jon asked for an initial  
6 comment as well.

7 DR. CHRISTIANSON: It is more just a question for  
8 you, Sue. I'll put you on the spot here, but I'm going all  
9 the way back to your first comment about alignment. I  
10 didn't know whether you were sort of implying that you  
11 wanted us to improve in some way the alignment process  
12 before we would move forward with something like this. I  
13 mean, would that be conditional on your support for the  
14 kinds of things that are being proposed?

15 MS. THOMPSON: Well, in part.

16 My concern, as you will hear when I make my  
17 comments, is that we're reducing the overall pool of  
18 dollars that we're going to be distributing through, that  
19 the 5 percent will be applied to. The attribution model  
20 only further reduces the amount of dollars for physicians  
21 and providers who choose to participate in advanced APM.  
22 So that's one structural component of what contributes to

1 the payments upon which the 5 percent is applied.

2 As you'll hear in my comments, I'm concerned that  
3 we don't know what this overall pool reduction will be and  
4 what the impact that will have on a provider's enthusiasm  
5 towards participating in risk.

6 DR. CHRISTIANSON: Why don't you go on with your  
7 comments at this point.

8 DR. CROSSON: Yeah, that's fine.

9 MS. THOMPSON: Is that okay?

10 DR. CROSSON: GO for it.

11 MS. THOMPSON: Well, I am quite concerned that we  
12 don't understand the total impact here because we don't  
13 understand what's going to happen to that total pool, which  
14 I've just stated. I think it's going to seriously reduce  
15 the total amount of dollars that are available to us to  
16 incentivize providers to participate in risk, and I think  
17 overall that's MedPAC's vision is to create opportunities  
18 that will enthusiastically encourage providers to want to  
19 get into this with us as opposed to diluting, especially  
20 for those physicians and providers who are taking greater  
21 risk. We're actually on that -- was it page 10 or slide  
22 10? Their amount goes down. Its' the one with the glide

1 path, the one before that. Their amount actually comes  
2 down.

3 I think anything we do that further reduces the  
4 incentive to physicians, particularly our specialists and  
5 independent and the relationship to ACOs doesn't get us  
6 where we're wanting to go. So I'm just quite concerned  
7 about that piece.

8 DR. CROSSON: So you think this policy might have  
9 the opposite effect from what's intended.

10 We'll go down this way. Jonathan.

11 DR. JAFFERY: Yeah. So I think, interestingly, I  
12 have a very different perspective with some of the same --  
13 maybe starting with some of the same points.

14 I actually have been dealing with this issue  
15 internally and thinking about how do we manage as the  
16 thresholds go higher and recognize that we've got no  
17 problem with 25 percent, but it is going to be harder and  
18 harder.

19 The specialist idea actually is -- or the  
20 specialist issue is one that I think about a lot with this,  
21 and it actually makes me supportive of this more gradual  
22 approach, although I do like this idea of having maybe a de

1 minimis of 25 percent or whatever it would be.

2           So as time goes on, as a quaternary-tertiary  
3 center that gets a lot of Medicare business from the region  
4 and beyond, with a lot of specialists and subspecialists,  
5 it becomes harder and harder for us to hit those  
6 thresholds, even if we try to be all in with our local  
7 population.

8           So my concern is that in organizations like us,  
9 if we are going to continue to try and meet those  
10 thresholds, we're actually going to end up excluding our  
11 specialists over time from participation in an ACO. That's  
12 actually a strategy we've discussed, that 25 is no problem.  
13 I think we're going to hit 50 percent okay, but there's no  
14 way we'll hit 75 percent. So, at some point, in that time  
15 period, do we actually remove some or all of our  
16 specialists?

17           DR. CROSSON: You just want to change the  
18 denominator. Change the denominator is what you're saying.

19           DR. JAFFERY: Yeah, yeah. Which goes in the  
20 opposite direction, I think, of what we're trying to do.  
21 We're just starting to get some traction with engaging our  
22 specialists.

1           A second point that I wanted to make relates to  
2 things that you talked about more in the report, but how do  
3 we bring in and encourage participation in A-APMs with  
4 other commercial payers?

5           And I do agree that it's not at all clear how CMS  
6 is going to administer this and figure this out, but maybe  
7 there's something we can think of in a policy that would  
8 continue to encourage that, even if it's not based on a  
9 percentage or doesn't -- we don't make a calculation.

10           But, for example, you could keep the calculations  
11 still based on percent of Medicare revenue, Medicare fee-  
12 for-service revenue or perhaps MA as well, but  
13 organizations over time might be required to have some  
14 meaningful contract, A-APM-type contract. It doesn't have  
15 to be on a percentage basis, but actually would have a  
16 contract or over time two contracts or three contracts.

17           You wouldn't necessarily have to make that all or  
18 nothing. The bonus depended on that all or nothing, you  
19 could say, if you have that contract. If you don't have  
20 any contracts, maybe instead of 5 percent, you get 4  
21 percent or 3 percent, and maybe you could actually even  
22 sweeten it by saying if you have a contract, you get 6

1 percent or two contracts, you get 7 percent, something that  
2 you would try to figure out in a budget-neutral fashion.

3 Those are my thoughts.

4 DR. CROSSON: Okay. Further comments?

5 Bruce.

6 MR. PYENSON: Thank you very much. I'd like to  
7 support Paul's view that we have an opportunity here to  
8 tilt the curve even more, and I like the idea of having an  
9 initial cliff in that, or an initial negative period for  
10 the incentive. But I also don't want to miss the  
11 opportunity to suggest that this uncertainty problem points  
12 out the advantages of moving Medicare to a two-year basis,  
13 that rather than calculating these kinds of participations  
14 annually that having a certainty that a provider or system  
15 is in or not lasts for more than a year is a good thing for  
16 them and for the program. And that's, in my opinion, true  
17 of many things that the Medicare program does on an annual  
18 basis. We'd be better off if we moved to a two-year basis.

19 DR. CROSSON: Jaewon.

20 DR. RYU: Yeah. I think net-net, I like the idea  
21 of the graduated approach, and I also like the idea of an  
22 initial cliff as a hybrid to that. And the reason why is I

1 share Sue's concern of unintended consequences. I think  
2 the advantage of having that cliff of the initial bump up  
3 to 5 percent was -- I suspect there are a lot of systems  
4 out there where that was part of the calculus of entering  
5 into an APM, because in some ways it de-risked the decision  
6 to actually take downside risk because they automatically  
7 had a 5 percent bump and they could say, you know, even if  
8 we don't do well and come out 5 percent less we're back to  
9 where we started from and so all is well.

10 I think you'll lose a lot of those folks and  
11 they'll pull out of the downside risk aspects of APMs if  
12 you just go graduated. So that would be my only concern.  
13 I don't know if there's a way to model that or to  
14 anticipate what that is. I suspect there isn't. But I  
15 think that's the migration that I'd be concerned about.

16 DR. CROSSON: Okay. We'll move over here to Jon.

17 DR. PERLIN: Yeah. I want to join in thanking  
18 you for your attention to this area. I agree,  
19 fundamentally, with your concerns that the current program  
20 is complex, to support this in the context of seeing it as  
21 an opportunity hopefully to streamline.

22 And just a number of things that are not

1 inconsistent with a number of my colleagues. You know, the  
2 previous program was complex but even figuring this out on  
3 a linear rate is going to be very complex for the groups,  
4 let alone individual practitioners to understand how  
5 they're doing. And that does get to the issue of  
6 incentives and the adequacy of the incentives as well,  
7 along those lines.

8           There are issues, I would agree with Sue, in  
9 terms of attribution but in a number of dimensions as well,  
10 even within a group, the issues of how, say, a radiologist  
11 might be, you know, sort of collectively attributed to the  
12 work of someone who has more substantive contact with a  
13 particular patient, et cetera, is confusing.

14           We have a very expansive country with different  
15 geographies and different opportunities, obviously, to  
16 participate in APMs, and, you know, I do wonder for those  
17 entities that are not necessarily directed in that  
18 direction are there implications, then, for a successor to  
19 MIPS? I know our feelings on MIPS, but what are the  
20 alternative opportunities?

21           I think in terms of all the complexities that  
22 exist, it just strikes me -- and I just ran this up against

1 thoughts of some practitioners in my community and their  
2 response was almost uniform. It's that this is the sort of  
3 thing that drives them to affiliate with larger groups.

4           So I know we've had conversations about impacts  
5 on consolidation, et cetera, but we get to a point where  
6 these sorts of approaches are no longer within the realm of  
7 small groups, let alone independent practitioners who would  
8 be able to contemplate without affiliation with larger  
9 entities. Now you might say, well, that occurs de facto in  
10 the context of A-APM, but it does really change -- it  
11 exerts yet another pressure on the dynamic of the  
12 organization of practitioners in the community.

13           I note all of those issues and do hope that we  
14 take this as an opportunity to perhaps provide streamlining  
15 for what, as you've outlined quite eloquently in the  
16 chapter, is already very complex. Thanks.

17           DR. CROSSON: Paul.

18           DR. PAUL GINSBURG: I just wanted to mention that  
19 I really liked Jonathan's suggestion about how to bring the  
20 non-Medicare payers in. And, you know, the current way is  
21 extremely administratively complex and it actually has some  
22 risks of kind of -- it's like telling the commercial payers

1 "you need to have APMs like Medicare's," and they may have  
2 a better idea. But just the notion that having a looser  
3 definition and have it be a form of perhaps even higher  
4 payments to motivate the providers to get into APM  
5 arrangements with commercial payers as well as Medicare.  
6 That's really something we should explore.

7 DR. CROSSON: Brian.

8 DR. DeBUSK: First of all, thank you both for a  
9 really good chapter. I thought the analytics work was  
10 great. I thought the proposal, the technical fixes were  
11 great. So knowing that, what I'm about to say, I don't  
12 disagree with some of the issues around implementation that  
13 you have identified and the idea of trying to simplify.  
14 You know, for example, the commercial. You know, some of  
15 my fellow Commissioners have mentioned, trying to address  
16 things like the commercial calculation.

17 But with that I want to take a moment and focus  
18 on the cliff, and I think three or four other Commissioners  
19 have talked about this and this notion of comfort and  
20 certainty versus discomfort and uncertainty. You know, a  
21 cliff implements -- sort of big picture, a cliff implements  
22 a disproportionate reward or sanction for failing to

1 demonstrate a targeted behavior. And I love the fact that  
2 we're using cliff almost in a pejorative way now across the  
3 board, because that's largely how I see them.

4           And, you know, by means of example, you know,  
5 when a cliff is used, say, to block a biologic, you know,  
6 using a rebate trap -- a biosimilar, I mean, from a  
7 reference biologic using a rebate trap, it's clearly a bad  
8 thing. This is a situation, though, where we may be using  
9 a cliff for a good thing, which is we need to be  
10 encouraging the participation in A-APMs, and I don't know  
11 that we want to provide certainty and continuity and  
12 comfort.

13           I mean, again, technical fixes notwithstanding --  
14 I do appreciate some of the implementation issues that you  
15 guys have pointed out, but I think whatever we publish this  
16 summer I'm hoping that it incorporates some type of cliff  
17 or disproportionate sanction. And I think Paul mentioned,  
18 and Bruce agreed, this idea of, you know, maybe even a  
19 penalty incorporated into that. Whatever can create some  
20 separation there, I think that would be very useful.  
21 Cliffs do work. I mean, we've seen them work effectively  
22 in a lot of different segments.

1           And then the final thing I want to touch on is I  
2 do think there's going to be an enduring benefit to having  
3 sort of an all-in group and an all-out group, and I think  
4 you mentioned this in the reading materials. You know,  
5 Kate, you mentioned earlier that the 5 percent bonus isn't  
6 the number one issue of why they would be participating in  
7 A-APMs in the first place, and I agree with you. But I  
8 think if you create this group of, yes, these are the  
9 people who qualify, these are the people who aren't, it is  
10 bigger than the 5 percent, because as others have mentioned  
11 here, I think you have MIPS, exemption from MIPS. And I  
12 think bigger picture. Stark exemption or relaxation, anti-  
13 kickback, civil monetary penalties.

14           I think there are a lot of things -- it's going  
15 to be really useful for us to have this concept where we  
16 can put providers in there, or physicians in there, where  
17 they are going to enjoy some benefits beyond the 5 percent  
18 bonus, and I think as we try to encourage A-APM adoption  
19 and encourage physicians to participate, having that  
20 container that we can continue to build on is going to be a  
21 real benefit for us. Thanks.

22           DR. CROSSON: Okay. Dana.

1 DR. SAFRAN: Thanks. So I really like what  
2 you've done to try to simplify this and I think that the  
3 conversation so far is really offering some ideas that will  
4 strengthen it further, and so I'll just underscore a couple  
5 of additional things or things that I liked in what was  
6 said.

7 So somewhere that I thought Jay was about to go,  
8 that I would go, is if there's a way to include and credit  
9 the membership that they have in MA, I think that would be  
10 a really valuable thing to do. We've had conversations  
11 before about, you know, shouldn't we be agnostic between  
12 where beneficiaries, and we don't want providers to feel  
13 torn about how much of their population is in MA versus in  
14 A-APM. So I'd like to explore that.

15 The idea of the cliff, I think, is worth  
16 considering, and in particular I would tie it to this issue  
17 that came up about how do we continue to make fee-for-  
18 service just an unappealing option to promote greater  
19 participation in the A-APMs? And to that end I like how  
20 you've focused it on Medicare and not added the challenge  
21 of other payers, which, to some extent, might be out of  
22 providers' control. You know, I hear all the time when I

1 go out and talk about our global budget model providers  
2 say, "Well, how do I get my commercial payers to do  
3 something like this?"

4           So I don't know to what extent but they may feel  
5 that's not in their control. So I like that you've severed  
6 that but at the same time, as the conversation here  
7 suggested, I think it would be good if we can find some way  
8 that encourages that anyway.

9           Back to the cliff issue for one second, Kate, you  
10 had said something about right now, basically, anyone who  
11 is participating is going to make the 25 percent, so that  
12 just does make me wonder whether, like, is that the right  
13 number for a cliff.

14           And -- oh, I hope I don't lose it. There was one  
15 last piece I wanted to offer and I didn't write it down and  
16 now it just dropped out of my brain. So I'll put my hand  
17 back up if it comes back to me.

18           MR. GLASS: Can I ask you a clarifying question?

19           DR. SAFRAN: Oh, yeah.

20           MR. GLASS: On the MA, would you be saying all  
21 MA, anyone in any MA contract, or just MA contracts that  
22 are putting them at risk and are somehow equivalent to an

1 A-APM? In other words, if the MA contract is just paying  
2 fee-for-service, would you --

3 DR. SAFRAN: I would.

4 MR. GLASS: -- want to --

5 DR. SAFRAN: I would.

6 MR. GLASS: -- reward that anyway?

7 DR. SAFRAN: I would, yeah.

8 MR. GLASS: Really?

9 DR. SAFRAN: Yeah, I would, because leave it to  
10 whatever MA plan is working with them to make those  
11 incentives work right. I know that's how we do it. So I  
12 would, and thank you for that moment to recover what the  
13 other thing was that I was going to ask you about, which is  
14 -- and I should know this but I don't, so this should have  
15 been around one question.

16 The 5 percent, does that come through as a bonus  
17 or as a rate increase, fee-for-service rate increase?

18 MS. BLONIARZ: It's a bonus.

19 DR. SAFRAN: It's a bonus.

20 MS. BLONIARZ: And we have argued back at the  
21 office about whether it counts in terms of whether it would  
22 make like an ACO not meet its benchmark.

1 DR. SAFRAN: Right.

2 MS. BLONJARZ: I think that varies by model.

3 DR. SAFRAN: Yeah. Okay. Thank you.

4 DR. CROSSON: Warner.

5 MR. THOMAS: So a couple of comments. I would  
6 agree with Sue that I think that it could be the reverse  
7 incentive here, so I would keep the cliff in place. I  
8 think if you want to have proportionate payment to  
9 percentage of risk then I would think about having your  
10 slope go from 25 to 50 and really incent people to get over  
11 50, because I think once you're over 50 you're kind of at  
12 the tipping point. So almost put 25, 25 to 50 have a slope  
13 that you showed as proportionate, and then over 50, you  
14 know, have it apply to all.

15 I would exclude commercial, and the reason behind  
16 that, I would recommend we think about this, is that I find  
17 commercial insurers are not adopting risk models as much  
18 and I think it penalizes a payer if they want to go in that  
19 direction but they can't get the insurer to go in that  
20 direction with them. I do think having MA in is really  
21 important. I differ a little bit with Dana in that I think  
22 the payment mechanism with the provider ought to be a risk

1 deal between the MA plan and the provider, because I think  
2 the more you can get the risk, the better. And I think if  
3 they're incented to get over that 50 percent by their MA  
4 population -- in some markets MA is larger than traditional  
5 Medicare, so I think it's a really important component from  
6 that perspective. So I think those are important.

7 I would also agree with Brian that I think having  
8 other benefits there and trying to add on to those, whether  
9 it's anti-kickback or other types of components that you  
10 give relief to advanced APMs I think is a really good idea  
11 and I think it's another reason to have providers moving  
12 down that road. So Just a couple of thoughts.

13 DR. CROSSON: I just want to -- I don't know if  
14 you can see this -- I just want to clarify what I think you  
15 said, which is --

16 MR. THOMAS: Yeah.

17 DR. CROSSON: -- you know, David had said S-  
18 shaped curve. You'd basically be 0 to 25, slope up to 50,  
19 and then 5 percent at -- okay. Got it.

20 Pat.

21 MS. WANG: I agree with a lot of the comments  
22 that have been made, the concerns that Sue and Jon raised,

1 and the notion of maintaining a cliff or a step or whatever  
2 you want to call it, and ensuring that revenue goes.

3 I think it's really important to include MA,  
4 really important. MA is part of the Medicare program. I  
5 agree with Warner's comments about commercial. It's a  
6 different product. I mean, this is a very different  
7 coverage model where I think there is a greater diversity  
8 of payment arrangements at the provider level. But in the  
9 MA world, you know, Medicare is Medicare, so I don't think  
10 that we should distinguish, and I think that it could  
11 create artificial distinctions between how people plot out  
12 their strategies to move forward in some sort of value-  
13 based environment -- how much is in ACO, how much is in MA,  
14 and if they could be combined in some fashion it would be  
15 good.

16 I agree with Warner that the MA arrangement  
17 should qualify as some sort of risk-based, value-based  
18 model, and it's more because I think it will create more of  
19 kind of a market demand from the clinician community to MA  
20 plans that these are the kinds of arrangements that they  
21 want. You know, I appreciate that there are payers out  
22 there who are very progressive about moving that way

1 themselves, but not everybody is. So I think kind of  
2 creating more signals out there that this is the desired  
3 way and having clinicians saying that they want to move in  
4 that direction because it helps them with the bonus, would  
5 be a positive thing.

6           As far as the administrative complexity of  
7 gathering the data, because you mentioned that, I just  
8 wonder, because in the paper you mentioned that CMMI is  
9 doing this demo now for clinicians involved in a  
10 significant degree of risk arrangements with MA plans being  
11 exempt from MIPS reporting, whether there might be  
12 something in there that CMS identifies as an easier way to  
13 identify and evaluate the existence of, you know, value-  
14 based arrangements with MA plans and, you know, what they  
15 look like. I would think that they have to collect that in  
16 the demo.

17           MS. BLONJARZ: Yes. It's the same as what  
18 they're collecting from the MA plans to execute the all-  
19 payer calculation, so the same information.

20           MS. WANG: Okay.

21           DR. JAFFERY: So this has been a great discussion  
22 and I think having listened to everybody's thought I think

1 Sue's concerns about certain kinds of unattended  
2 incentives, and mine, I think actually sort of go -- they  
3 conflict a little bit but I think that Warner's suggestion,  
4 as captured by Jay's artwork, may thread that needle. I  
5 don't know about the exact percentages where those things  
6 happen but I think that might thread that needle nicely.

7           And then the only other thing I wanted to comment  
8 on was I totally agree that MA should be included, but I  
9 also do think that we should, not just for this policy but  
10 for several that we'll talk about today and over the  
11 months, we should be encouraging MA plans from moving away  
12 from just taking money from CMS and distributing it on fee-  
13 for-service. So I would support that.

14           MS. BUTO: So I like the idea of maintaining some  
15 cliff. I like the idea of graduated, as Warner laid out,  
16 up to, say, some percentage. I don't know, 50 is where I  
17 would set it. But 50 feels like it's halfway there but,  
18 you know, not totally committed.

19           And I like the idea of including MA but not  
20 commercial. I think that makes sense. I don't know how I  
21 feel about risk versus fee-for-service arrangements within  
22 MA. I mean, the idea behind A-APMs is really to get people

1 into more of a managed arrangement, a coordinated care  
2 arrangement. So I'm less troubled by the actual payment  
3 arrangement between the MA plan and physicians. It seems  
4 to me there are other issues there.

5           So I have to say I think the work here has been  
6 terrific and has been very thought provoking. I think the  
7 initial appeal was yes, this makes a lot of sense, but the  
8 conversation has really, I think, clarified that many of us  
9 feel there needs to be some greater push to get into that  
10 A-APM world.

11           DR. CROSSON: So this has been a good discussion.  
12 This is why we have a commission to take a good idea and  
13 make it better, and that's what I think we're going to try  
14 to do here.

15           So we do have some, I think, areas of agreement,  
16 more or less, here. One is that the current system is  
17 really kind of complicated and confusing, and you can read  
18 all the time articles about, you know, physicians  
19 scratching their heads about A-APMs and the like. I'm not  
20 sure all of that is captured in this but some of it is.

21           I think, you know, as a number of Commissioners  
22 have said, you know, one of our basic thrusts here,

1 principles, is to try to improve the involvement in value-  
2 based health care delivery and A-APMs is part of that. And  
3 so encouraging more physicians, certainly not discouraging  
4 them, to take part in A-APMs would be our intention.

5           And, therefore, I think there's a question on the  
6 table about whether the proposal that we have, you know,  
7 here, presented, does that or doesn't do that. And, you  
8 know, in the discussion people have, I think quite  
9 effectively, thought about ways to kind of improve that,  
10 and maybe -- I'm not sure -- maybe tilt it in the proper  
11 direction. I think we'd have to understand that.

12           I think the issue about including participation  
13 in MA towards, you know, passing whatever threshold we have  
14 or whatever graduated thing we have is -- I've heard most  
15 people support that idea as well.

16           So what do we do? The initial notion was to come  
17 back in December, assuming we had a slam-dunk here, which  
18 seems to have escaped, somehow gotten out the door -- I'm  
19 not sure how that happened -- and then if we get support  
20 for that bring it back in January. I think we might still  
21 be able to do that. I'm not sure.

22           I'm getting some -- so keep going. Okay. Then

1 you'll hit me.

2 I think we need to do some work offline here, to  
3 try to decide on, you know, with Jim and the staff, to try  
4 to decide, and we could potentially come out in one of two  
5 places. Either based on that work and discussion with the  
6 staff we come to the conclusion that we're pretty close to  
7 -- this would be new for December -- but we would be pretty  
8 close to a recommendation that we think people would  
9 support, in which case we would come forward with that, on  
10 that schedule, and then assuming support we'd go to  
11 January. Or the alternative would be that we could decide  
12 that we're not quite ready to do that yet, and we need to  
13 come back to the Commission for more elaboration of these  
14 issues, in which case Jim would schedule that at whatever  
15 point that would need to be done.

16 But that's sort of where I think we are. Paul,  
17 would you like to add to that?

18 DR. PAUL GINSBURG: Yeah. I'm just asking a  
19 clarifying question, is that if the staff came to us in  
20 December with something that, you know, the Commission, for  
21 the most part, is positive about, but has some tweaks to  
22 improve it, can that still go on that schedule so that the

1 improved version is put before us January, we say yes?

2 DR. CROSSON: So Jim may want to correct me, but  
3 what we've basically said in the past is something like  
4 this, that if, in the initial discussion -- because our  
5 general rule is, you know, we want people to see something  
6 that they're going to vote on one, time, have a discussion,  
7 think about it, and then come back. And if the changes  
8 that we make in December, to whatever is constructed as a  
9 new recommendation or draft recommendation, are minor to  
10 moderate, and everybody agrees -- like I say at the end of  
11 the discussion, you know, is everybody okay if we come back  
12 with this as amended in January -- then that's okay. If we  
13 make a left or right turn and we've basically got an  
14 entirely new concept then it doesn't work.

15 DR. PAUL GINSBURG: I would argue in favor of  
16 trying to do this in December and January, because we've  
17 had a very good discussion and it's nice knowing that the  
18 proposal brought to us in December doesn't have to be  
19 perfect --

20 DR. CROSSON: Yep.

21 DR. PAUL GINSBURG: -- that we can still make  
22 minor and moderate changes and move forward in January.

1 DR. CROSSON: And one other point I wanted to  
2 make, which I didn't make, is that I would think if we can  
3 do it, and there may be some ways we can do this, we could  
4 build into that new recommendation even more incentive for  
5 A-APMs, which was, I think, your original point.

6 Now, okay, Kate, let me have it.

7 MS. BLONIARZ: No. I'm just -- I want to put a  
8 couple of things in your head, just as we kind of work  
9 towards this. So I have the general sense of how there  
10 would be a cliff and kind of a, you know, cap, and then a  
11 continuous function there. And I guess some of the  
12 questions would be does that start -- you know, is this  
13 assessment done at the individual clinician level versus  
14 the entity, and how does MA get brought into it? Does the  
15 A-APM incentive payment get backed out of the MA benchmark  
16 so that it's not paid twice, or, you know, how that.

17 And I think the only other kind of policy lever I  
18 would think about is if 25 percent -- is it sufficient? Is  
19 it too low? Is it too high? Kind of what are the  
20 inflection points. So that would be what I would be  
21 looking for.

22 DR. CROSSON: All right. So now, going back to

1 my initial confusion here with respect to MA, I need to  
2 understand what people are saying here because we've been  
3 making some assumptions. So people who are saying we ought  
4 to include MA, are you saying we ought to include  
5 participation in MA as a way of getting to whatever  
6 threshold, or climbing up whatever ladder we have, or are  
7 you saying that the bonus, the 5 percent or 3 percent or 2  
8 percent, ought to be applied to MA patient care as well?  
9 Which is on the table?

10 MS. WANG: I was saying the former.

11 DR. CROSSON: The former. Is everybody saying  
12 the former? That's what I assumed. So, then, we're not  
13 talking about backing it out of the MA benchmark, right?

14 DR. RYU: I think that's what you're getting at,  
15 right, Kate, is the fee-for-service experience would factor  
16 into the benchmark, so that's what you're saying you'd have  
17 to pull out so it doesn't, then, pervade the MA benchmark  
18 for future use.

19 DR. CROSSON: Okay. All right.

20 MS. BLONIARZ: Right. And I think, then, just  
21 this kind of other piece of it is right what you went to,  
22 Jay, which is the incentive would help clinicians reach the

1 threshold, then the incentive would be applied to fee-for-  
2 service revenue, MA revenue, which we have to determine  
3 what it is?

4 DR. CROSSON: I think that's a question I just  
5 asked, and what I --

6 MR. GLASS: Just fee-for-service.

7 DR. CROSSON: -- thought I heard back was just  
8 fee-for-service.

9 MS. BLONJARZ: Okay.

10 DR. CROSSON: And so, Kate, you're designing your  
11 own work plan here. This is very good. I like this. It  
12 will save Jim some work.

13 DR. MATHEWS: No, no. I think these are  
14 technical things that we can easily go back and sort out,  
15 and we'll make our best shot at capturing as much consensus  
16 as we can among the Commission. And as Jay said, we'll  
17 come back in December and we'll either be at a place where  
18 we can put a draft recommendation up on the screen or we  
19 can come back to and say we've talked about this  
20 internally, we need some more input from the Commission,  
21 and it'll be a later point in time when we re-engage. I  
22 think those are the two paths.

1           MR. THOMAS: Just real briefly, I think that --  
2 the reason I think that the 25 and the 50 that you have  
3 their makes sense is that I think 25 is significant enough  
4 that, you know, you're weighing in and you're kind of  
5 leaning in to make some differences, versus 5 or 10. And I  
6 think 50, it is kind of the tipping point of, you know,  
7 once you're getting at that much risk, I mean, you kind of  
8 all in and you've got to keep going. So I just would kind  
9 of make that comment that I think those are good  
10 percentages, what you have there. If you were going to go  
11 to kind of three components where you're have essentially a  
12 trend upward and then you're into the total, you know,  
13 upside piece. So just one viewpoint.

14           DR. CROSSON: Okay. Kate and David, thank you  
15 very much, and, really, thank you to the Commission because  
16 this is the creative stuff that we do here and it's fun.  
17 Although it doesn't always feel that way, but sometimes it  
18 is.

19           [Pause.]

20           DR. CROSSON: Okay. Time for the next  
21 discussion. Jeff and Stephanie, I'm sure you're happy the  
22 Commission is warmed up here. We're all ready for you.

1           We're going to take on -- and this is to some  
2 extent an issue that we've dealt with repeatedly, which has  
3 to do with payments to hospitals, but specifically I think  
4 here taking a look at something we haven't looked at, at  
5 least in a long time, and that's the issue of Medicare-  
6 dependent hospitals. And Jeff and Stephanie are here to  
7 take us through it. Jeff's got his light on, so I guess  
8 he's going to start.

9 \*           DR. STENSLAND: All right. Good afternoon. As  
10 Jay said, we're going to talk about the Medicare-Dependent  
11 Hospital program, also known as the MDH program, and I'll  
12 just touch on some of the key issues to get you teed up for  
13 your discussion.

14           The Medicare-Dependent Hospital program was  
15 enacted in 1989 due to concerns that the introduction of  
16 the Inpatient Prospective Payment System had caused the  
17 closures of some small rural hospitals. The program's  
18 objective was to temporarily increase payments to high-cost  
19 small rural hospitals that were dependent on Medicare  
20 revenues, and thereby prevent closure. Hospitals had to  
21 have fewer than 100 beds and usually were located in rural  
22 areas. Now, the MDH program has been extended several

1 times and most recently was extended through September 30,  
2 2022.

3           The magnitude of the MDH add-on payments depend  
4 on the level of each hospital's historic costs.  
5 Specifically, MDHs are paid the higher of either the PPS  
6 rate for inpatient care or that PPS rate plus 75 percent of  
7 the difference between the hospital's historic costs  
8 trended forward and the PPS rate. The historic costs that  
9 are used are the highest costs in either 1982, 1987, or  
10 2002 trended forward by each year's hospital updates.

11           The net result is that 60 percent of the  
12 hospitals that qualify for the MDH program get higher  
13 payments and 40 percent get the standard PPS rates. Those  
14 hospitals getting the higher rates are those that  
15 historically had high costs in one of those three reference  
16 years.

17           In 2016, among the hospitals that got an add-on  
18 payment due to having high historical costs, the add-on  
19 averaged \$1.2 million per hospital or about \$125 million in  
20 total.

21           So why should Medicare modernize the MDH program?

22           First, it fails to accurately measure what

1 hospitals are dependent on Medicare. It was designed in  
2 the 1980s when inpatient services dominated, and it only  
3 looked at inpatient days and discharges to measure Medicare  
4 dependence. Clearly, any measure of Medicare dependence  
5 should also consider outpatient revenue.

6 In addition, some hospitals receive much higher  
7 prices for commercial patients than other hospitals. For  
8 example, consider two hospitals. Hospital A has 60 percent  
9 of their days are Medicare and the remaining 40 percent are  
10 commercial patients paying relatively high rates. Now,  
11 Hospital B also has 60 percent of its inpatient days that  
12 are Medicare, but its remaining 40 percent of patients are  
13 primarily Medicaid and the uninsured. The current MDH  
14 program would compute equal levels of Medicare dependence  
15 for the two hospitals. Clearly, the one that receives very  
16 little in the way of commercial patients is much more  
17 dependent on their Medicare revenue.

18 Second, the MDH program makes adjustments to  
19 payments based on historic costs, and this is problematic  
20 for two reasons. First, the costs used are use from cost  
21 report years that are up to 37 years ago, as we describe in  
22 your mailings. But, more importantly, costs are not a good

1 indicator of need. Just because a hospital can afford to  
2 have higher costs per discharge does not mean that it has  
3 greater needs than the hospital that is under financial  
4 pressure and, therefore, forced to keep its costs low.

5 Third, geographic equity is lacking. The program  
6 is open to rural hospitals, small ones, and urban hospitals  
7 in three states. Therefore, most urban hospitals do not  
8 qualify. It may be more equitable to make the program  
9 available to all hospitals that are necessary for access.

10 So why are we talking about the MDH program now?  
11 And should it be available to rural and urban areas?

12 One reason to focus on the MDH program now is  
13 that Medicare margins have declined. As we said last year,  
14 even relatively efficient hospitals have slightly negative  
15 Medicare margins. Therefore, it is hard to remain  
16 profitable when you have high Medicare shares.

17 We could use the MDH program to preserve full-  
18 service hospitals that are important sources of access and  
19 are dependent on Medicare, and this could be true whether  
20 the hospital is located in a rural or an urban area.

21 Now Stephanie will walk you through some of the  
22 data.

1 MS. CAMERON: As Jeff mentioned, the current MDH  
2 program may not target the hospitals most dependent on  
3 Medicare. The program requires 60 percent or more of  
4 inpatient days or discharges attributed to the program, and  
5 when we consider Medicare's share of revenues, we can see  
6 that inpatient days or discharges do not capture a  
7 provider's financial reliance on the Medicare program or  
8 the amount of financial pressure a provider is under to  
9 maintain low costs.

10 So let's consider hospitals with the highest  
11 share of Medicare revenue and focus on those in the tenth  
12 decile in the top row of the table. As you can see, the  
13 median Medicare share of revenue here is 51 percent;  
14 however, the share of days varies from about 51 percent to  
15 77 percent. Considering the lower bound, that 51 percent  
16 share of Medicare days, some facilities with the highest  
17 Medicare share of revenue would not qualify for the current  
18 MDH program. In contrast, if we move further down the  
19 table, we see that hospitals in the fourth decile have a  
20 median Medicare share of less than 30 percent, but some  
21 could qualify for the current program based on the share of  
22 inpatient days equal to 60 percent at the upper bound.

1           Across all current MDHs, the Medicare share of  
2 revenue also varies widely. MDHs with a high proportion of  
3 Medicare discharges yet a low share of Medicare revenue are  
4 more likely to be under less financial pressure to reduce  
5 costs.

6           Medicare's financial pressure to reduce costs or  
7 slow cost growth can be seen when we look at the median  
8 cost per discharge by decile of Medicare share of patient  
9 care revenue. Here we see that as the share of revenue  
10 from Medicare decreases, the standard Medicare fee-for-  
11 service cost per discharge increases. In other words, the  
12 more a hospital is dependent on Medicare revenues, the  
13 lower their standardized cost. Their high Medicare share  
14 of revenue implies that they have a lower share of  
15 commercial payers and are thus under pressure to keep their  
16 costs down. In contrast, low Medicare share providers are  
17 likely under less cost pressure and thus have a higher  
18 median cost per discharge.

19           In 2016, most hospitals had negative Medicare  
20 margins, while the hospitals with a high share of Medicare  
21 already have relatively low costs; therefore, it might be  
22 appropriate to target any additional payment to support

1 operations at the hospitals with higher Medicare shares,  
2 especially for isolated or high-occupancy providers.

3 In your paper we provide some detail on  
4 modernizing the Medicare-Dependent Hospital program, but to  
5 summarize:

6 First, we would base eligibility on the ratio of  
7 Medicare patient revenue to all patient care revenue. This  
8 would explicitly include outpatient revenue. Also, because  
9 it focuses on revenue and not simply discharges, it also  
10 implicitly factors in prices hospitals receive on their  
11 non-Medicare business.

12 Second, the adjustment would be based on Medicare  
13 share, not costs. As we discuss in your paper, high-cost  
14 hospitals are often hospitals with higher levels of  
15 resources. Therefore, we do not want to pay them more than  
16 low-cost hospitals that may be under pressure to constrain  
17 their costs.

18 Third, the program could be expanded to include  
19 both rural and urban hospitals that are needed for access  
20 to care.

21 Fourth, the program would no longer apply to  
22 hospitals of a certain bed size, eliminating that current

1 requirement.

2           And, fifth, the program could be limited to  
3 hospitals deemed essential to Medicare beneficiaries based  
4 on a measure of geographic isolation or occupancy.

5           To facilitate today's discussion, we have  
6 developed an example of a modernized MDH program using the  
7 following policy parameters.

8           First, we based program eligibility on each  
9 hospital's share of Medicare revenues. Here we used a 35  
10 percent threshold, reflecting about 40 percent of  
11 hospitals, or those in the seventh through tenth decile  
12 that I previously discussed.

13           Next, we would consider the add-on amount based  
14 on the share of revenue on a sliding scale. For modeling  
15 purposes we chose a maximum of 5 percent, and I will come  
16 back to this in more detail momentarily.

17           Lastly, we wanted to operationalize Medicare  
18 dependency based on geographic isolation and occupancy.  
19 Here we required hospitals either to be located 15 miles or  
20 more away from the next closest PPS provider or to have an  
21 occupancy rate in the hospital or hospital's market that  
22 exceeds the average hospital occupancy, which is about 62

1 percent.

2           This figure represents the sliding scale add-on  
3 payment that we modeled. Hospitals with less than 35  
4 percent of their revenues from Medicare would receive a 0  
5 percent add-on while those with 45 percent or more would  
6 receive a 5 percent add-on. This 5 percent add-on reflects  
7 the current average add-on payment across all qualifying  
8 MDHs.

9           Using these parameters, and based on 2016 data,  
10 the number of MDHs would expand to over 600, and about 45  
11 percent of current MDHs would qualify for this modernized  
12 program. The facilities that would qualify for the program  
13 span each category of hospital including urban/rural, for-  
14 profit/nonprofit, teaching and non-teaching. A larger  
15 share of major teaching hospitals and hospitals deemed  
16 relatively efficient would qualify for this modernized  
17 program. We estimate that the average add-on payment would  
18 equal about 2.7 percent of hospital inpatient and  
19 outpatient revenues from Medicare. About one-quarter of  
20 hospitals would receive the maximum 5 percent add-on.  
21 These changes to the MDH program would transition payment  
22 away from costs and data from almost 40 years ago.

1           So what does this mean for a hospital's bottom  
2 line? Using the aforementioned policy parameters and  
3 assuming no change in cost after the implementation of the  
4 program, we expect Medicare and total margins to increase  
5 slightly in aggregate using our 2016 data. Hospitals that  
6 are relatively efficient and dependent on Medicare would be  
7 expected to have positive Medicare margins. Under the  
8 proposed parameters, we expect fee-for-service payments to  
9 hospitals to increase by about \$900 million, based on 2016  
10 data. The extent to which the Commission would like to  
11 change the parameters will ultimately change the expected  
12 increase in fee-for-service payments.

13           Now, that brings us to our discussion. First, we  
14 are seeking feedback on whether eligibility for the MDH  
15 program should change to a measure of Medicare revenue and,  
16 if so, if a 35 percent threshold is reasonable? We are  
17 also interested in feedback regarding other eligibility  
18 requirements such as measures of geographic isolation and  
19 occupancy that we discussed. The size of the adjustment  
20 was based on an average MDH payment across all currently  
21 eligible facilities, but the Commission could consider a  
22 smaller or larger adjustment, and should consider whether

1 using a sliding scale is preferable over a flat increase.

2 Lastly, we are looking for feedback on whether  
3 the program is funded with new money or a reduction to the  
4 payment update that we will discuss next month.

5 And with that, I turn it back to Jay.

6 DR. CROSSON: Okay. Thank you, Jeff and  
7 Stephanie. We'll take clarifying questions. Let's start  
8 with Pat.

9 MS. WANG: Thank you very much for this. It's  
10 fascinating.

11 On page 11 of the paper, you have a table that  
12 shows characteristics of hospitals with varying shares of  
13 Medicare revenue. The third column describes the share  
14 with non-Medicare margins less than 1 percent, and so just  
15 taking the first row, high Medicare-dependent hospitals, 37  
16 percent have non-Medicare margins below 1 percent. Do you  
17 have information on the other 63 percent and so on, the  
18 characteristics of total margin, for example, and non-  
19 Medicare margin or the ranges of the financial profile of  
20 hospitals that qualify for this program?

21 DR. STENSLAND: There's going to be a big range.  
22 We don't have the exact range with us, but there's going to

1 be a wide range of performance in any of these categories.  
2 But, generally, those that have high Medicare shares  
3 generally have lower total margins overall, and that's just  
4 a function of that Medicare's a relatively unprofitable  
5 payer compared to the average payer.

6 MS. WANG: Okay. Is there any information that  
7 describes a correlation or relationship of high Medicare  
8 share among these hospitals with the non-Medicare payer  
9 mix? For example, high Medicare goes with high Medicaid;  
10 high Medicare goes with high commercial; high Medicare goes  
11 with some mix? Are there other characteristics of these  
12 hospitals that are generalizable?

13 MS. CAMERON: We didn't find any. I think, you  
14 know, we did look at the next column, which is the SSI  
15 percent, and that was generally the same kind of across  
16 each category of hospitals. So we didn't find anything  
17 kind of glaring as such. I mean, I think the largest  
18 factor we found, which is what we tried to describe here  
19 and what Jeff mentioned is typically as the share of  
20 Medicare increases, we have found kind of a lower average  
21 cost, but also a lower total margin.

22 Now, that's not to say it's for every provider.

1 Within that there is a large range, and we can maybe  
2 describe in the future a little more of who falls into what  
3 we might describe as a higher non-Medicare margin or a mid-  
4 level and give you details that way that I just don't have  
5 with me today.

6 MS. WANG: That's fine.

7 MS. CAMERON: But, yeah, I mean, I think that's  
8 the largest kind of factor.

9 MS. WANG: Thank you.

10 DR. CROSSON: Jon.

11 DR. PERLIN: First, let me thank you for a really  
12 thoughtful analysis here. It's pretty sweeping in terms of  
13 how it would change the program. This may have been in  
14 there, and I may have missed it in the readings, but is  
15 this envisioned to be new money or redistribution amongst  
16 the pool there?

17 MS. CAMERON: So that's a question we'd like to  
18 ask the Commissioners to discuss. I think that's  
19 ultimately up to all of you and your preference, so we  
20 would be looking forward to your input on that.

21 DR. PERLIN: Obviously, the implications of  
22 either, if redistribution, then a change at the magnitude

1 of the benefit size and its potential impact on  
2 stabilization even of efficient providers, new money always  
3 has its own challenges.

4           Let me ask a second question, which is, on page  
5 11 of the reading materials, you had noted that a hospital  
6 has to be a full-service hospital. And on page 12, and  
7 also in the presentation today, you had noted that a  
8 hospital cannot be in the market with low average occupancy  
9 rates. I think about the challenge of rural hospitals  
10 where their mission is changing, where in this era  
11 particularly of -- you know, take a condition like stroke,  
12 for example, there may be certain patients who are retained  
13 because they're stable, others need mechanical thrombectomy  
14 or an intervention and have to transfer. In some of those  
15 hospitals, their best position for serving Medicare  
16 beneficiaries in the community is actually by remissioning,  
17 and it may be a reduction of their inpatient footprint. So  
18 I'm curious about your thinking of basing eligibility in  
19 part on the inpatient census, yet at the same time  
20 calculating the magnitude of the benefit on the dollars  
21 that are the aggregate of both in- and outpatient.

22           DR. STENSLAND: Well, I think that's why when we

1 talk about the criteria for qualifying, it can be  
2 either/or. Either you're in a high-occupancy market, which  
3 that may apply more to an urban hospital, or for a rural  
4 hospital, if you're more than 15 miles away from anybody  
5 else, then we don't require that high occupancy because you  
6 may have that situation exactly what you're talking about.  
7 This is an important, you know, stabilizing transfer  
8 facility.

9 DR. CROSSON: Dana.

10 DR. SAFRAN: Yeah, I was going to go there, too,  
11 on the occupancy question because I was confused, but now  
12 you're saying it's the occupancy in the market or the  
13 occupancy of that facility?

14 MS. CAMERON: So here what we did was we provided  
15 two different criteria, so I'm going just going to take a  
16 step back, and the first was: Are you geographically  
17 isolated? And if the answer was yes and you met the  
18 threshold, then that was kind of what allowed you to be  
19 eligible for the program. If you didn't meet that  
20 geographic threshold, for urban areas we looked at the  
21 market-level occupancy. So were you in an urban area that  
22 had higher occupancy indicating that, you know, those beds

1 -- an indication of need, those beds were potentially more  
2 needed than if the urban area had many facilities with very  
3 low occupancy rate.

4           However, for the rural areas, looking at kind of  
5 the occupancy, I was concerned about you getting the state  
6 average there, and so for the rural areas, we did look at  
7 the occupancy levels for the facilities themselves, not  
8 necessarily kind of the entire kind of rest of state rural  
9 share.

10           DR. SAFRAN: Okay. So here's a comment couched  
11 as a question. Aren't you worried about the incentives  
12 you're creating with the occupancy?

13           MS. CAMERON: So for rural, most of them do not  
14 meet the occupancy.

15           DR. SAFRAN: Not the rural. I'm thinking in the  
16 urban. Are you not concerned about creating incentives  
17 that row in the direction opposite where we're trying to  
18 go, to some of Jonathan's points about remissioning, et  
19 cetera, by having it based on occupancy and a reward that  
20 follows?

21           MS. CAMERON: I think our hope was that using the  
22 market level occupancy, it would take pressure away from an

1 individual hospital to admit unnecessarily to achieve a  
2 certain level of occupancy.

3           We have heard feedback in the past about thinking  
4 about how do we target Medicare dollars to certain  
5 providers that we believe are kind of essential providers  
6 of care, and trying to operationalize that, we looked at  
7 these two factors.

8           These might not be the other factors. So if  
9 there are other suggestions on how we can appropriately  
10 target, we would definitely be open to hear that.

11           It is difficult because looking at occupancy does  
12 become an inpatient measure, which I absolutely agree is  
13 something we are trying to, I think, walk away from a  
14 little bit. But there is no equivalent on the outpatient  
15 side.

16           So we are open to any suggestions you have to  
17 help us get there.

18           DR. SAFRAN: Thanks.

19           Then my other question was, in your diagram on  
20 Slide 10 and that 35 percent point, I just wondered how you  
21 thought that through because, again, we had a lot of  
22 conversation about a different kind of cliff, and this is a

1 cliff. One, I'm not sure about whether it creates the  
2 incentives that we would wish.

3           So I just wonder whether you thought about other  
4 versions of what this curve might look like, and if you  
5 did, tell us a little bit about your thinking of how you  
6 landed here.

7           DR. STENSLAND: It could be anything -- the main  
8 point here is it starts at 35, so you need some point that  
9 it starts at. And it's not a vertical line. You gradually  
10 move from 35 to 45, so you start at some point. You  
11 gradually move so that every little extra bit of Medicare  
12 share, you only get a little extra bit of payment, and then  
13 you top off at some point. There's no magic to 35 and 45,  
14 but the general idea of it being continuous and not a  
15 vertical line were the key points.

16           DR. SAFRAN: I wasn't talking so much about the  
17 diagonal part of the S curve, but the flat part at the  
18 bottom.

19           MS. CAMERON: So referring back to Table 2 in  
20 your mailing materials and the simplified chart of that,  
21 that we provided in the slides, I think we're looking to  
22 target, again, a group of hospitals, and kind of looking at

1 what the median share is, you're right around the 7th  
2 decile. So right there, we thought that seemed to be a  
3 good starting point.

4           Then we picked the 45 because that's just over  
5 kind of the 9th decile. So then you figure somewhere  
6 between the 7th and 9th, you have this curve, and then  
7 after that, there are going to be providers kind of --  
8 again, this goes to the 90th percentile, but there are  
9 providers above that. So about 10 percent of providers  
10 would be on that flat part.

11           Now, could we make it continuous? Absolutely,  
12 but then that hinges on kind of the providers that may have  
13 kind of a high outlier share of revenue versus kind of the  
14 90th-ish percentile.

15           DR. SAFRAN: Thank you.

16           DR. STENSLAND: Then there's also the effect that  
17 if we started it down at zero or somewhere lower than 35,  
18 then it ends up costing a lot more money.

19           DR. CROSSON: Just for the record, this shape  
20 curve from now is going to be called the "Thomas curve."  
21 Got it? Thank you.

22           MR. THOMAS: I did one thing in five years.

1 [Laughter.]

2 DR. MATHEWS: And it doesn't have any true  
3 curves.

4 [Laughter.]

5 DR. CROSSON: All right. Further questions?  
6 David.

7 DR. GRABOWSKI: Yeah. Thanks. I was hoping you  
8 could connect a couple of numbers for me. On Slide 3, you  
9 said today the average add-on payment is \$1.2 million, and  
10 then on Slide 11, you said under the illustrative policy,  
11 the average add-on would equal 2.7 percent of inpatient and  
12 outpatient Medicare revenue. What is the dollar value of  
13 2.7 percent there?

14 MS. CAMERON: It's somewhere between about  
15 \$500,000 and a million on average, but there's quite a bit  
16 of variation. Again, there's a bit of variation to that  
17 because we are basing this on -- it would be a multiplier  
18 off the share of revenues, so it's going to vary by  
19 hospital.

20 DR. GRABOWSKI: So the number of hospitals would  
21 greatly expand, but the payment per hospital would go down  
22 slightly?

1 MS. CAMERON: That's right.

2 DR. GRABOWSKI: Thanks.

3 DR. CROSSON: Sue.

4 MS. THOMPSON: Thank you both for this chapter.

5 There's like a middle story here that I'm missing  
6 because in the beginning the whole Medicare dependent  
7 hospital program was developed as a safety net to rural  
8 hospitals and the beneficiaries that live in rural parts of  
9 America, and in the narrative of the chapter, inpatient  
10 services are no longer the dominant service lines upon  
11 which much of that criteria had been built. So we jumped  
12 to the program inconsistently excludes urban hospitals.

13 So take me back. What conclusions did you draw  
14 about the need for safety net in rural hospitals that was  
15 the intent of the original program?

16 DR. STENSLAND: So I think that originally, after  
17 the IPPS was started, you saw some rural hospitals closing.  
18 There were possible closures all over, but there was a  
19 disproportionate share of the ones that were rural were  
20 closing.

21 The truly isolated ones were in the sole  
22 community hospital program, and that was always a part of

1 the program.

2           So then there's these other ones that are not  
3 necessarily isolated, but they're rural and they're still  
4 concerned. They have a high Medicare share, so we're going  
5 to give them some extra money. And that was going to help  
6 them.

7           Then for a long time, the Medicare margins were  
8 generally pretty good for a lot of years. So there was  
9 even a question of is this really necessary. If you're  
10 making money on Medicare, why is having a lot of Medicare a  
11 problem?

12           But then over time, now we're getting to now  
13 where Medicare margins are relatively low. So this is a  
14 problem whether you're in a rural area or an urban area,  
15 and the idea, I think, generally is if you're in a rural  
16 area and you're the only hospital around and you have a  
17 high Medicare share, we might be concerned. But if you're  
18 in an urban hospital and you're the only hospital in an  
19 urban area and you have a high Medicare share, we might  
20 also be concerned, or if you have a couple of hospitals in  
21 the urban area and you're running at 80 percent occupancy  
22 and you just don't have much extra capacity, then we might

1 be concerned there too.

2           It's creating more of a -- it's focusing more on  
3 is the hospital necessary for access, and do the patients  
4 need them as opposed to a rural urban criteria.

5           MS. THOMPSON: So how many urban hospitals have  
6 closed?

7           DR. STENSLAND: Over the years, I don't know.  
8 It's usually probably about as many as rural hospitals that  
9 have closed if you're looking at the overall closure rate,  
10 and I think generally whether -- probably on average less  
11 concerned about some of the urban ones, if there's another  
12 source of access nearby.

13           But I think that's probably not always going to  
14 be the case. I think we're kind of entering a new era  
15 right now from where we were before.

16           DR. CROSSON: Okay. Kathy.

17           MS. BUTO: So, Jeff, picking up on your point --  
18 or on Sue's point, I looked at this and wondered without  
19 the Medicare dependent hospital payments, how many of these  
20 hospitals are financially distressed? In other words, I  
21 think you've partly answered the question by saying as  
22 margins, total margins go down. These hospitals are sort

1 of the most at risk, but I'm wondering without these  
2 changes, because we go from 155 or so to 600 hospitals that  
3 would be eligible for payment, how would those hospitals --  
4 are they really in need of additional funding? is what I'm  
5 wondering, especially the increment above the 155. Do we  
6 feel like they are at risk to a greater extent,  
7 financially?

8 DR. STENSLAND: I think there's probably a  
9 philosophical question for the people around the table here  
10 to consider.

11 There's the question of is the one reason you  
12 might do this is to say, "Oh, they're going to go under if  
13 we don't increase their payment rates," and we could do  
14 some analysis of saying how many of them are at risk. And  
15 there's going to be some proportion of the rural and urban  
16 ones that would be at risk, but probably not a huge  
17 proportion.

18 The other question, you could go around the table  
19 and say, "Well, if somebody is really dependent on Medicare  
20 and they're operating efficiently, should Medicare be  
21 paying their cost of care?" And that's kind of a  
22 philosophical question, and this would probably bring their

1 payments up to the cost of care, at least for their  
2 Medicare patients. So we would be saying if you're  
3 dependent on Medicare, you can probably break even on  
4 Medicare.

5           So there's two different objectives that people  
6 might have, and I don't think it's a quantitative answer as  
7 to whether those are good objectives or not, but those  
8 would be two potential objectives you might accomplish by  
9 expanding the program.

10           MS. BUTO: And I guess I'm wondering whether you  
11 -- the second question is whether you looked at Medicare  
12 dependent hospitals in relation to sole community hospitals  
13 and critical access hospitals to see whether it makes any  
14 sense to increase payments for these hospitals or for some  
15 of the 600 or 400-something-odd that would get additional  
16 payments.

17           It makes sense emotionally in some ways, but I'm  
18 just wondering whether in terms of access, there's really  
19 an issue that we're trying to address here.

20           DR. STENSLAND: Yeah. That's that same question  
21 again. If your only concern is access, then it would be a  
22 different computation, I think. Then you really wouldn't

1 be looking at Medicare profitability at all.

2 MS. BUTO: Okay. So last point, and this is a  
3 little bit of Round 2. But it struck me very much in  
4 looking at the chapter that this is almost part and parcel  
5 of what we're going to be doing next month, looking at IPPS  
6 hospital margins, total margins, and that this is sort of  
7 the answer to the question of, as Medicare margins go down,  
8 what is the Commission recommending be done about this?

9 It sort of answers part of a question that we've  
10 been asking about the last couple of years. I'm wondering  
11 whether this really belongs as part of that discussion.  
12 That's just a rhetorical question we can get to in Round 2.

13 DR. CROSSON: Right. I mean, I think you're  
14 right.

15 Where we put it on the agenda or where we put it  
16 in what we write up, I guess is a separate question.

17 But you are correct in the sense that as we've,  
18 in the last couple of years, talked about payments to  
19 hospitals, we've become increasingly concerned that there  
20 are certain hospitals -- and you can identify them in  
21 different ways. There are certain hospitals, particularly  
22 those serving a disproportionate share of Medicare

1 beneficiaries, that are under greater pressure and more at  
2 risk than others.

3           While I don't know how to solve that completely,  
4 this is one part of a potential solution.

5           Is that fair enough, Jim?

6           DR. MATHEWS: Mm-hmm.

7           DR. CROSSON: Okay. So we're going to have a  
8 discussion now, and, Sue, you're going to lead off.

9           MS. THOMPSON: Well, you might anticipate my  
10 comments are going to be led by how important I think it is  
11 for us to think about all Medicare dependent hospitals,  
12 whether in that classification today are not, but the  
13 intent of this particular program was to provide safety net  
14 to the beneficiaries in the rural parts of our country.  
15 And I just don't want us to lose sight of that.

16           While roughly 20 percent of our population lives  
17 in rural America, a slightly larger percent of that  
18 population is made up of Medicare beneficiaries, and access  
19 is important. And this program does play a key role in  
20 assuring that not only these facilities have revenue to  
21 have capital and operate, but to be able to recruit  
22 providers. We have a lot of discussion here about the

1 difficulty in recruiting providers to rural parts of  
2 America. This is a piece of that.

3 I think the growing number of hospitals that are  
4 closing, while made up of both rural and urban, the  
5 predominant numbers of hospitals that are closing are in  
6 rural parts of our country.

7 I just don't want us to lose sight, and I think  
8 we have a responsibility to those beneficiaries to maintain  
9 access and to do what we can to support those facilities  
10 that are in rural parts of our country.

11 I was confused by the chapter. It felt like we  
12 did a bit of a jump shift, and it feels as though we're --  
13 while I think we are indeed challenged to think about  
14 finding more money to add to the program, this is going to  
15 be a shifting of money from one part of our country to  
16 another. Let's just be very thoughtful and remember that  
17 this is a safety net program, and in that, I just really  
18 want us to remember in this rural part of America,  
19 providing health care is increasingly challenging. And  
20 those are beneficiaries that are seeing hospitals close at  
21 a higher rate than our urban counterparts, who likely have  
22 access from facilities within miles as opposed to hours.

1 DR. CROSSON: So, Sue, given that concern, is  
2 there a suggestion that you have for how we could move  
3 ahead to solve the problem, as I just described, and not  
4 create a problem as you see it?

5 MS. THOMPSON: Well, if indeed there's an  
6 opportunity to find more money, certainly. I am opposed to  
7 moving money from one part of the country to another part  
8 of the country when we're putting safety net at risk.

9 DR. CROSSON: Okay. Further discussion?  
10 We'll start over here with Pat again, I guess.

11 MS. WANG: I just want to thank you, Sue, for  
12 reminding us of the importance of the program and the  
13 original purpose of the program.

14 That said, I was going to make the same comment  
15 that Kathy did as her comment question, which is that it  
16 feels very important to understand how the program works  
17 and some of the possible ways to change it, but given  
18 pressure on funding, this is a very special program that  
19 could be modernized in a way to fulfill its original  
20 mission but also target funds where it's actually needed.

21 And that's why I was asking the questions about  
22 overall margins because frankly there are high Medicare

1 hospitals that can be 40 percent Medicare and 50 percent  
2 commercial, Blue Cross commercial, and similarly, 40  
3 percent Medicare hospitals that are 60 percent Medicaid and  
4 uninsured. And I Just think that there is a difference  
5 there, and we need to understand a little bit more of that  
6 before kind of just working inside of this box with many of  
7 the excellent suggestions that were made.

8           It feels like we should be considering this as  
9 sort of a tool in the toolbox when we talk about update  
10 factor, and it might help us be more nuanced here while  
11 appreciating the original purpose of the program.

12           DR. CROSSON: Dana.

13           DR. SAFRAN: Thanks.

14           This is really interesting work. I didn't really  
15 know anything about this before reading, so appreciate it,  
16 and I appreciate the discussion so far.

17           I had just three things to say and contribute  
18 about it. One is I'm kind of troubled by or at least not  
19 convinced by why we're attaching share and not just reward  
20 those who have a low cost per discharge. It seems we're  
21 trying to reward those who are efficient providers, and  
22 you're making a tie between the share and the evidence that

1 they're efficient and therefore wanting to reward them.  
2 But I just wonder why if what we want to reward is  
3 efficiency in the providers, why not pick that?

4           Similarly, as my comment earlier might have  
5 suggested, the occupancy piece, I'm worried about that as a  
6 criterion for incentivizing behaviors that run counter to  
7 what we're trying to incentivize, and yes, even among  
8 hospitals within a market. I don't think that's a hard  
9 thing to fathom.

10           Then the final thing that this most recent  
11 exchange between Sue and Pat made me wonder was -- in your  
12 question about new dollar versus redistribution, I do get  
13 worried, to Sue's point, about expanding this because it  
14 sort of dilutes the dollars available for the rural  
15 hospitals who would be meeting these criteria, but what if  
16 the way it was structured, those hospitals were rewarded  
17 with new dollars while the urban hospitals that qualified,  
18 it was a redistribution that afforded us the dollars to  
19 reward them, so just a thought.

20           DR. CROSSON: Further comments?

21           Bruce, then Marge.

22           MR. PYENSON: Thank you very much. Considering

1 the methodology you've used, I appreciate the focus on  
2 Medicare revenue as opposed to Medicare cost, and I think  
3 that gets at some of the issue of who the other payers are  
4 to some extent.

5           However, I am still uncomfortable with the use of  
6 Medicare cost reports as a basis for in aggregate, across  
7 the whole country, of understanding the margin of Medicare,  
8 Medicare payments and the margins hospitals make. But  
9 extending that to individual hospitals seems very  
10 problematic to me, and the theoretical underpinning of that  
11 I question.

12           We often have this conversation about predictive  
13 models or risk scores, and they may be in aggregate  
14 adequate. But applying them to an individual patient is  
15 not what it was intended to do and is probably faced with  
16 lots and lots of variability. So the concern -- the focus  
17 of this work seems to me to be the concern that some  
18 Commissioners expressed last year that Medicare margins  
19 were turning negative, and I'm not sure that we have really  
20 good evidence for that. So I am questioning the underlying  
21 -- an underlying premise here.

22           Now, all that said, I'm not too concerned as long

1 as the program is not funded with new money. I'd be very  
2 concerned if this were an expansion. I'd also express some  
3 of the concern about creating a new game for some hospitals  
4 where perhaps an LTCH might be considered inpatient or  
5 considered Medicare inpatient or outpatient revenue or a  
6 dialysis center or a SNF, and so there's a potential boost  
7 in percentages dependent on some ownership or not. So I'm  
8 concerned about that potential here. I suppose there's  
9 technical fixes for those.

10 But the overall big question I have -- and it's  
11 been -- as Kathy raised, it's going to come up again next  
12 month -- is use of the Medicare cost report to surmise  
13 negative margins.

14 DR. CROSSON: So, Bruce, as you said, I think the  
15 last thing you talked about in terms of other entities  
16 qualifying, I think that could be dealt with. But, I mean,  
17 you're absolutely right. To a certain degree, you know,  
18 this proposal or others that we've considered is predicated  
19 on the fact that there's a declining Medicare margin among  
20 hospitals, and --

21 [Comment off microphone.]

22 DR. CROSSON: No, I'm -- let me -- and that's

1 been presented by the staff on an annual basis, but you  
2 have a different perspective, and maybe this isn't the  
3 right time to have you elaborate that. Maybe it's next  
4 month. But it would be helpful because what you're saying  
5 -- and I understand that you have a basis for that -- is  
6 kind of diametrically opposed to the staff analyses that we  
7 see. Right?

8 MR. PYENSON: Perhaps. I think there wasn't  
9 unanimity among Commissioners last year on the declining --  
10 the issue of declining Medicare margins. There had been  
11 some --

12 DR. CROSSON: I'm sorry to interrupt --

13 MR. PYENSON: That they had turned negative.

14 DR. CROSSON: Yeah, I think where we weren't --  
15 where we were not unanimous as a Commission was doing  
16 something about declining margins, but maybe I've  
17 forgotten. That's possible. But I do think that we've  
18 fundamentally for the most part accepted the staff's  
19 analysis of Medicare hospital margins. But, clearly, you  
20 have a different way of looking at it, and maybe we can't  
21 adjudicate that right now. But I do think if you have that  
22 fundamental difference, which is, as you say, a predicate

1 for policy considerations, then you should bring that  
2 forward probably next month.

3 DR. MATHEWS: Actually, if I could, if I could  
4 ask you to take two, three minutes --

5 DR. CROSSON: Okay. Go ahead.

6 DR. MATHEWS: -- to collectively remind us what  
7 your concern was about the use of Medicare cost reports and  
8 why that might not be the best indicator, because this is  
9 going to be relevant to everything we do next month.

10 MR. PYENSON: Medicare cost reports are derived  
11 through a process of using charge masters assigned to cost  
12 centers, and there's unfortunately not a universal charge  
13 master in use throughout the U.S. And in other work that  
14 the Commission has done, we've identified problems, for  
15 example, outlier payments for some specialty hospitals and  
16 things like that. And the way that costs get allocated  
17 could be affected by how a charge master is established.  
18 And that creates or could create uncertainty when it comes  
19 to the allocation, the costs versus revenues.

20 Now, I think there was a similar study that staff  
21 did on dialysis centers, I think, that questioned some of  
22 that as well. So I think that on a -- as the reports come

1 out, there's no question that the margin from one year to  
2 the next to the next is going down. It's just not as clear  
3 to me what that means. And is that a cost allocation  
4 change or something else going on there?

5 DR. MATHEWS: Okay. So I understand that there's  
6 variability in how hospitals are accounting for their costs  
7 and how they're allocating different types of overhead  
8 costs and the possibility that hospitals have some degree  
9 of creativity that they can apply to this process and that  
10 for any given hospital you might have questions about, you  
11 know, the relationship between the numbers that are  
12 reported on the cost report versus the true cost of care  
13 for providing for Medicare beneficiaries, commercial  
14 Medicaid, that kind of thing.

15 All of that is a given, but in the aggregate,  
16 that is the information that we have, and it is the  
17 information we have and use across all of our sectors. And  
18 we do have to put some faith that in the aggregate those  
19 numbers do reflect, you know, a close-to-reasonable  
20 perspective on their financial performance under Medicare.  
21 And in some sectors, we say the providers are doing quite  
22 well under Medicare, zero update, reduce their rates. In

1 the hospital sector, we're in a little bit of a different  
2 place. But we have to give some significance to these  
3 numbers as indicators of the adequacy of Medicare payments.

4 I'll say two more things, and then I'll stop  
5 talking and let you react.

6 With respect to alternative methods of assessing  
7 the adequacy of Medicare's payments, this Commission in  
8 prior iterations has considered a budgetary model where we  
9 say, you know, the U.S. Government can only afford to  
10 expend X amount of dollars on Medicare, and for any number  
11 of reasons, we have felt that was not the right approach  
12 for the Medicare program. And we have also considered an  
13 access model -- you'll recall Mike Chernew was a big fan of  
14 this model -- where we pay no attention to the reported  
15 costs on the cost reports, and we only increase payments  
16 when hospitals, other providers start closing their doors  
17 to Medicare beneficiaries, which I would argue when that  
18 starts happening, it is very late in the process to move  
19 the ship.

20 So I say all of this by saying with the  
21 recognition that there are flaws in the cost report data in  
22 the aggregate that is our coin of the realm, and while you

1 have, you know, every prerogative of pointing out the  
2 flaws, in the absence of anything better this is, you know,  
3 where we are.

4 MR. PYENSON: I agree with that. I think my  
5 concern is the use of that for subsets of hospitals. So,  
6 for example, in our report last year, the concern was that  
7 efficient hospitals were negative, and here we're likewise  
8 getting into a subset of hospitals. And I guess given the  
9 uncertainty, I'm much more comfortable if this is not  
10 funded with new money.

11 DR. CROSSON: And I want to come back to that  
12 question before we finish this discussion. Marge.

13 MS. MARJORIE GINSBURG: Very briefly and perhaps  
14 this has been addressed before. The hospitals that take  
15 Medicare but are doing fine are not a problem, urban  
16 hospitals. Do they, surreptitiously or not, set a limit on  
17 how many Medicare patients come in in order to hold their  
18 losses to something that they can define? Or is this done  
19 at all? Is it done subtly? Any indication that that goes  
20 on?

21 DR. STENSLAND: I've never seen any indication of  
22 a hospital doing that. I think a physician's office, how

1 many slots you have open for Medicare, would be a different  
2 story.

3 DR. PAUL GINSBURG: And to follow up on what Jeff  
4 said, I think hospitals' incentives to, you know, be the  
5 place that their medical staff can send their patients is  
6 very strong. And at the margin -- I mean, Medicare  
7 beneficiaries may have a negative margin on average, but  
8 certainly not at the margin. So that additional patients,  
9 Medicare patient, is a very positive thing for hospitals.  
10 So I would very much doubt that they would try to modulate  
11 the number of Medicare patients at this point.

12 DR. CROSSON: Okay. So let's go with Jon and  
13 then Amy, Warner.

14 DR. PERLIN: First, very quickly, I wanted to  
15 identify with Sue's comments about support for rural. But  
16 second is also identify with the question of what problem  
17 we're trying to solve, and in that regard, I wonder about  
18 the interaction between this program and the other programs  
19 like the low-volume hospital program, which would seem to  
20 have some sort of co-variation with us, and, you know,  
21 frankly, and even more broadly, toward the issue we're just  
22 discussing, the annual update cycle.

1           Thanks.

2           DR. CROSSON: Amy.

3           MS. BRICKER: I just want to make sure I'm kind  
4 of piecing together some of the comments that have been  
5 made around the table. I agree with Sue's initial comments  
6 and the need for us to continue to keep an eye on rural  
7 hospitals. If we don't use new money -- so the current  
8 spend is \$125 million in this program?

9           MS. CAMERON: That's right.

10          MS. BRICKER: And we're suggesting that with this  
11 new definition, over 600 hospitals would qualify, so if my  
12 math is right, on average each is getting \$1.2 million, it  
13 would be more like \$200,000 if we don't use new money?

14          DR. STENSLAND: I think the idea if we didn't use  
15 new money, it would have to come out of the update. So  
16 right now, under current law the update is something like  
17 2.5 percent. And you guys will all have a recommendation  
18 on what the update will be, and you can think of, well, if  
19 we want to spend -- however much money you want to spend,  
20 you can decide how much you want to spend in giving  
21 everybody an increase of 2 percent, 2.5 percent. The  
22 effect of giving everybody an increase of 2.5 percent is

1 about the same of saying let's add an extra \$900 million  
2 into the Medicare-dependent hospital program and give  
3 everybody a 2 percent update. Those are kind of  
4 equivalent. But, of course, it's going to be a judgment  
5 call next month, and this is a lot of like precursor to get  
6 your creative juices flowing between now and December on  
7 how you want to deal with that.

8 MS. BRICKER: I got you. Then the other point  
9 that you made in the paper is that even hospitals that are  
10 MDH-qualified hospitals are still closing, 25 percent or  
11 something --

12 MS. CAMERON: Right.

13 MS. BRICKER: -- of closures were MDH. So if,  
14 again, the goal is to attempt to keep these open because  
15 they're critical or for access, I don't know that we're  
16 accomplishing that. So, again, rhetorical, but I guess if  
17 we can all get a consensus on allocating dollars to the  
18 hospitals in need through the mechanism that you just laid  
19 out, maybe that's --

20 DR. STENSLAND: And I just want to make it clear  
21 that this is just the Medicare-Dependent Hospital program,  
22 so nothing would happen to the sole community hospital

1 program, which is more generous for more isolated -- you'd  
2 still have the low-volume adjustment. You would still have  
3 the critical access hospital program for all the small  
4 hospitals. This is one measure of many here, and there's  
5 also the idea in there that we -- you guys could make the  
6 call of whether you think they should all stay open or  
7 maybe there's some cases maybe where you don't need even a  
8 Medicare-dependent hospital to be open. If it's 10 miles  
9 from another hospital and its occupancy is 20 percent,  
10 maybe that's not the top priority.

11 MS. BRICKER: So maybe that's a future topic,  
12 just rolling all of these programs together so that we can  
13 have in one place a conversation around rural hospital  
14 access or how these programs are helping to achieve that  
15 goal. Maybe it's something to consider.

16 DR. CROSSON: Did I miss somebody here? Paul.

17 DR. PAUL GINSBURG: I think your paper really  
18 contributed a lot. It's kind of shocking how out-of-date  
19 this program is, you know, the use of data from 1982 and  
20 your point about using revenues rather than patient days,  
21 bringing the outpatient in. I think that all makes sense.

22 What I'm somewhat concerned about is that, you

1 know, since most of the money went to rural except for some  
2 urban hospitals that snuck in because their member of  
3 Congress dictated that they're in a rural area, except for  
4 that, in a sense, I think we're thinking a program for  
5 rural and we're, you know, greatly expanding it to do more  
6 for urban hospitals. And I wonder if we'd be better off  
7 just fixing this program for the rural hospitals and very  
8 separately, perhaps in conjunction with doing the update,  
9 or maybe later, you know, think about what we should be  
10 doing for urban hospitals where Medicare -- they have a mix  
11 of Medicare and Medicaid, very little commercial,  
12 Medicare's declining rates or declining margins becoming  
13 increasingly a problem for them. But it seems like this  
14 may be a tail wagging the dog thing, and this prompted, I  
15 think appropriately, Sue's comments about their taking the  
16 rural money and putting it in urban hospitals.

17 DR. CROSSON: Yeah, Warner.

18 MR. THOMAS: So I would agree with Sue and I  
19 would agree with Paul as well. I think that, you know,  
20 it's a program that's morphed and really had a specific  
21 purpose. We ought to go back to that. But I'd also agree  
22 with Amy that I think we ought to just aggregate these

1 different programs if there's others like it so we look at  
2 them together along with the update, and to me we shouldn't  
3 be allocating more dollars to special programs. We ought  
4 to look at the update factor and figure out what we want to  
5 do from that perspective across the whole spectrum of  
6 hospitals. And if there's targeted areas like rural and  
7 we've got to make sure we take care of that, then let's  
8 make sure we do that, but not broaden a program that had a  
9 specific focus.

10 But I do think it would be nice if there's other  
11 special programs like this. You know, a lot of people  
12 don't know about Medicare-dependent hospitals. I'm sure  
13 there's other programs -- I don't know. It would be nice  
14 to look at them all and just kind of understand what they  
15 are and what their target has been.

16 DR. CROSSON: Kathy.

17 MS. BUTO: This reminds me of something I've  
18 thought of for a long time, which is I don't think we're  
19 smart enough to do this for every region of the country,  
20 with all the different rural options that are out there.  
21 And at some point -- not now -- I think we ought to  
22 consider something more like a payment that gets decided by

1 a region to make decisions about what rural entities --  
2 they could be EDs; they could be, you know, urgent care  
3 centers; they could be primary care practices, not just  
4 hospitals. But it just feels like we think maybe if we  
5 keep tinkering around all these individual entities, that  
6 maybe we'll get it right. But I just don't believe that,  
7 having watched the program struggle to do this for quite a  
8 long time.

9 DR. CROSSON: Okay. So here we come to the time  
10 when we try to say where we are.

11 [Comment off microphone.]

12 DR. CROSSON: Yeah, go for it. I think my sense  
13 of this is that we probably need to divide the issue here,  
14 and I think there's a -- I heard a number of people in  
15 different ways saying let's take the rural issue and look  
16 at that from a policy perspective as a whole. And I think  
17 we can do that. We can't do that next month, but I think  
18 we can do that.

19 What remains for me then is still the issue --  
20 and it goes back to last year, and we'll see when we get to  
21 the update discussion on hospitals next month what the  
22 margins look like. And I understand your concern, Bruce.

1 We'll see, you know, whether the trend that we've  
2 identified is continuing. If it is, it still raises for me  
3 the question that we tried to address last year, and I  
4 think we need to address again this year, which is: Do we  
5 have a concern about the viability or just the stress that  
6 this is placing on hospitals who are dedicated to serving  
7 more than the average percentage of Medicare beneficiaries?  
8 Because I think there's reason to be concerned. And so I  
9 think if -- and melding this -- we had some suggestions.  
10 Isn't this part of the update? It certainly could be. And  
11 I think it needs to be, and so I think when we come back in  
12 December we'll segment out the issue of rural hospitals.  
13 We'll take that on when we can. But I do recommend that,  
14 as we get into the update in December and then in January,  
15 that we look at this issue of Medicare-dependent hospitals.

16           And with that, Stephanie and Jeff -- do you want  
17 to make a comment?

18           DR. MATHEWS: Let me just say one last thing. So  
19 in response to Sue, I do understand that, you know, the  
20 original intent of the MDH program was indeed to support  
21 rural providers and ensure access. However -- and so what  
22 we are explicitly considering here is a redefinition of the

1 program, that if we are talking about Medicare dependency,  
2 it is a broader definition. It is not necessarily  
3 restricted to rural but would include any hospital that met  
4 the criteria that -- you know, assuming we can collectively  
5 come to some agreement.

6           So you are correct, this would be a reorientation  
7 of the program, and I am, you know, sensitive to the point  
8 you raise about this, whether -- depending on how this  
9 would be funded, does it shift dollars from rural to urban?  
10 That's a fair point to raise, and we can think about that  
11 when we get back to the office. But one of the motivations  
12 that led us down this path was comments that have been made  
13 by the Commissioners in the context of our payment adequacy  
14 work over the last several years to the effect that, as the  
15 Medicare population becomes a greater and greater share of  
16 providers' patient census, it becomes more and more  
17 difficult for any provider to walk away from that patient  
18 because Medicare is not paying adequately. And, therefore,  
19 if a provider does have some, you know, determined share of  
20 Medicare patients in its census, that the program does have  
21 an obligation to pay adequately for those kind of  
22 providers.

1           So I just want to say that as, you know, why we  
2 are putting this information in front of you in general,  
3 and in particular, why we are putting it in front of you in  
4 advance of our payment adequacy discussion next month.

5           DR. CROSSON: Good. Jeff, Stephanie, thank you  
6 very much.

7           Okay. We are now going to take on the issue  
8 which we've discussed a number of times over the years and  
9 particularly recently, which is the particular problem of  
10 integrating care services and other aspects of the  
11 management of Medicare and Medicaid for the dual-eligible  
12 patients, and particularly the duals who are in D-SNPs.

13           And Eric, I just want to compliment you for the  
14 chapter which you wrote, which was so thorough and so  
15 articulate that it was quite enjoyable, actually. So let's  
16 take us through the discussion.

17 \*           MR. ROLLINS: Thank you. Today I'm going to talk  
18 about promoting greater Medicare-Medicaid integration in  
19 dual-eligible special needs plans, or D-SNPs. This session  
20 is a continuation of the work on managed care plans for  
21 dual eligibles that we started during the last meeting  
22 cycle. We plan to follow today's presentation with another

1 session in the spring that looks at other aspects of  
2 integration, and the material from these two presentations  
3 will appear as a chapter in the Commission's June 2019  
4 report.

5           Before I begin, I'd like to note that CMS  
6 released a proposed rule last Friday that has several  
7 provisions related to D-SNPs. We are still reviewing the  
8 proposed rule and have not accounted for it in the material  
9 that I am going to walk you through today.

10           I'd like to start by giving you an overview of  
11 the presentation. I will start by briefly recapping the  
12 work we did last year on managed care plans for dual  
13 eligibles and by providing some background on D-SNPs.  
14 After that, I will talk a bit about the extra benefits that  
15 D-SNPs provide and how they differ from the extra benefits  
16 provided by regular MA plans. Then I will describe some  
17 factors that limit the level of Medicaid integration in D-  
18 SNPs and outline some potential policies that would promote  
19 greater integration.

20           Last year, the Commission began looking at  
21 managed care plans that serve individuals who qualify for  
22 both Medicare and Medicaid, known as dual eligibles. These

1 beneficiaries often have complex health needs but may  
2 receive fragmented care because of the challenges in  
3 dealing with two distinct programs.

4           Many observers have argued that creating plans  
5 that provide both Medicare and Medicaid services would  
6 improve quality and reduce spending for this population  
7 because these plans would have stronger incentives to  
8 coordinate care than either program does on its own.  
9 Integrated plans have shown some ability to reduce the use  
10 of inpatient and nursing home care, but they have been  
11 difficult to develop and enrollment in highly integrated  
12 plans is low.

13           In our work last year, we reviewed the progress  
14 of the financial alignment demonstration, which is testing  
15 the use of highly integrated plans known as Medicare-  
16 Medicaid Plans, and described how Medicare has four types  
17 of integrated plans that serve dual eligibles but differ in  
18 many respects. We noted that policy changes to better  
19 define the respective roles of each type of plan or  
20 consolidate them in some fashion may be needed.

21           Today's presentation focuses on the most widely  
22 used type of integrated plan, the Medicare Advantage D-SNP.

1 During our work last year, Commissioners expressed interest  
2 in learning more about why dual eligibles enroll in these  
3 plans and why the level of Medicaid integration for D-SNPs  
4 is generally low. We are here today to provide you with  
5 more information on both issues.

6 D-SNPs are identical to regular MA plans in most  
7 respects but they have three additional features. First,  
8 D-SNPs only enroll dual eligibles while regular plans are  
9 open to all beneficiaries in their service area. This  
10 restriction is meant to make it easier for sponsors to  
11 tailor plans to meet the care needs of dual eligibles.  
12 Second, D-SNPs must follow an evidence-based model of care  
13 that has been approved by the National Committee for  
14 Quality Assurance. Third, D-SNPs must take steps to  
15 integrate Medicaid coverage by having contracts with states  
16 that meet certain minimum standards. However, the level of  
17 integration required by these contracts is fairly minimal.  
18 For example, states are not required to make capitated  
19 payments for any Medicaid services.

20 At the same time, D-SNPs that meet higher  
21 standards for integration can become what are known as  
22 fully integrated D-SNPs, or FIDE SNPs, which may enable

1 them to receive higher Medicare payments. For example,  
2 FIDE SNPs must have a capitated Medicaid contract that  
3 includes acute and primary care services as well as  
4 services like nursing home care.

5           This slide gives you a high-level overview of the  
6 current D-SNP market. D-SNPs are available in 43 states  
7 and have about 2 million enrollees. However, the level of  
8 integration for D-SNPs is generally low because most plans  
9 either do not provide any Medicaid services or provide only  
10 a limited subset, such as Medicare cost sharing. As you  
11 can see, relatively few plans -- 46 out of 381 -- are FIDE  
12 SNPs. These plans are available in 10 states and have  
13 about 172,000 enrollees, but most of their enrollment is in  
14 just three states: Massachusetts, Minnesota, and New  
15 Jersey.

16           Since D-SNPs typically provide few or no Medicaid  
17 services, they have little advantage over other MA plans in  
18 terms of greater integration, and must have other features  
19 that are attractive to dual eligibles. One feature is  
20 likely the ability of plans to offer extra benefits that  
21 are not covered by traditional Medicare. In MA, plans  
22 submit bids that represent the cost of providing the Part A

1 and B benefit package. These bids are compared to  
2 benchmarks that are based on local fee-for-service  
3 spending, and plans that bid below the benchmark receive  
4 part of the difference as a rebate that must be used for  
5 extra benefits.

6           These benefits can take many forms, such as  
7 coverage of Part A and B cost sharing, supplemental medical  
8 or drug benefits that Medicare does not cover, or a  
9 reduction in the Part B or Part D premiums. However, dual  
10 eligibles already receive many of these benefits from other  
11 programs. For example, Medicaid covers Part A and B cost  
12 sharing for most dual eligibles and the Part D low-income  
13 subsidy covers most or all of the premiums and cost sharing  
14 for drug coverage.

15           Since D-SNPs only serve dual eligibles, plan  
16 sponsors can account for this existing coverage in their  
17 extra benefits. Compared to regular MA plans, we found  
18 that D-SNPs use more of their rebates to cover supplemental  
19 benefits like dental, hearing, and vision services. States  
20 may not cover these services under Medicaid, or cover them  
21 in a very limited fashion, so the extra benefits offered by  
22 D-SNPs can be appealing for many dual eligibles.

1           The next slide compares how regular MA plans and  
2 D-SNPs use their rebates based on information submitted  
3 during the bid process. As you can see, the rebate amounts  
4 for the two types of plans in 2018 are comparable, at \$94  
5 and \$89, respectively. However, regular MA plans used most  
6 of their rebates to reduce Part A and B cost sharing, while  
7 D-SNPs used most of their rebates on supplemental medical  
8 benefits. Regular MA plans also used more of their rebates  
9 to provide supplemental drug benefits or lower their Part D  
10 premiums.

11           We will now shift gears to look at why the level  
12 of integration for many D-SNPs is relatively low. The lack  
13 of integration is a concern because D-SNPs will not have  
14 the proper incentives to coordinate care unless they are  
15 responsible for both Medicare and Medicaid services.  
16 States' use of Medicaid managed care is thus a key  
17 ingredient for greater integration. This is particularly  
18 true for long-term services and supports, or LTSS, which  
19 account for about 80 percent of Medicaid's spending on dual  
20 eligibles. The ability to make capitated payments for  
21 these services makes greater integration more feasible.

22           States have been slower to use managed care to

1 provide LTSS than acute care services, but the number of  
2 states with managed LTSS or MLTSS programs has grown from 8  
3 in 2004 to 24 today, and further growth is likely. It is  
4 also worth noting that most large states have these  
5 programs and that these 24 states account for about 75  
6 percent of all dual eligibles. Many programs do not cover  
7 the entire state or exclude certain types of beneficiaries,  
8 but the number of dual eligibles enrolled in Medicaid  
9 managed care could grow substantially over time as states  
10 develop their programs.

11 To better understand the overlap between D-SNPs  
12 and Medicaid managed care, we compared the plans operating  
13 in each market in mid-2018. The areas where the markets  
14 overlap, meaning that a company offers both products in a  
15 state, are in the best position to achieve greater  
16 integration.

17 We found that only 17 percent of D-SNP enrollees,  
18 about 350,000 people out of 2 million, were in plans with a  
19 meaningful level of integration, which we defined as  
20 instances where the parent company of the D-SNP also  
21 provides all or most of the beneficiary's Medicaid  
22 benefits. About half of these beneficiaries were in FIDE

1 SNPs and about half were in regular D-SNPs that had a  
2 companion or "aligned" MLTSS plan.

3           We found that the low level of integration for  
4 the remaining D-SNP enrollees had three underlying causes,  
5 and I am going to take a little time here to walk you  
6 through each one.

7           The first factor limiting integration is that a  
8 significant number of D-SNP enrollees, about 27 percent,  
9 are partial-benefit dual eligibles. For these  
10 beneficiaries, Medicaid only covers the Part B premium and,  
11 in some cases, Part A and B cost sharing. There is no  
12 coverage of LTSS or other important services such as  
13 behavioral health. This coverage is so limited that there  
14 simply isn't much to integrate and D-SNPs provide little  
15 obvious benefit in this regard over other MA plans. It is  
16 worth noting that FIDE SNPs, the D-SNPs with the highest  
17 levels of integration, are all limited to full duals.

18           The second factor is that about 40 percent of  
19 enrollees -- and these are all full duals -- are in D-SNPs  
20 that don't have MLTSS contracts. This can happen for  
21 several reasons, but the most obvious is when D-SNPs  
22 operate in a state without an MLTSS program. However,

1 these plans accounted for only about 14 percent of  
2 enrollment. The other 26 percent were in states that have  
3 MLTSS programs but the plan sponsor either doesn't have a  
4 Medicaid plan or has a Medicaid plan but doesn't offer it  
5 in every county served by the D-SNP. In all of these  
6 situations, some plan sponsors might be willing to develop  
7 more highly integrated plans, but are simply not in a  
8 position to do so.

9           The third factor is misaligned enrollment, which  
10 accounts for about 16 percent of enrollees, and again,  
11 these are all full duals. These are cases where the D-SNP  
12 has a companion Medicaid plan but the beneficiary is only  
13 enrolled in the D-SNP. Some mismatches may occur because  
14 the Medicaid plan has more restrictive eligibility  
15 requirements, but we don't have enough data to determine  
16 how many beneficiaries are in this situation. However,  
17 many beneficiaries have to enroll in MLTSS plans, and  
18 enrolling in another company's D-SNP is not a recipe for  
19 integrated care.

20           Now that we have examined why the level of  
21 integration for many D-SNPs is relatively low, I am going  
22 to outline some potential policies that would promote

1 greater integration. States can already implement many of  
2 these policies using their contracts with D-SNPs, but only  
3 a small number have done so. Given the lack of  
4 integration, the question is whether federal policymakers  
5 turn some of these policies into standard requirements,  
6 especially in states with MLTSS programs.

7           The first policy would limit the ability of  
8 partial duals to enroll in D-SNPs. Medicaid's coverage for  
9 partial duals is so limited that there isn't much to do in  
10 terms of integration, and, as we discussed in the mailing  
11 materials, our analysis of HEDIS quality data for partial  
12 duals suggests that D-SNPs perform about the same as  
13 regular MA plans. Policymakers could do one of two things.  
14 They could limit D-SNP enrollment to full duals, which  
15 would require the partial duals in D-SNPs to switch plans,  
16 or they could require plan sponsors to cover partial duals  
17 and full duals in separate plans. Both options would make  
18 it easier to pursue greater integration for full duals, but  
19 the second option would give partial duals access to the  
20 specialized extra benefits that D-SNPs typically offer.

21           Turning now to Slide 12, the level of integration  
22 for D-SNPs will remain low if they do not have Medicaid

1 contracts where states make capitated payments for key  
2 services such as LTSS. One potential policy to increase  
3 integration would thus be to require D-SNPs to have  
4 Medicaid MLTSS contracts.

5 States vary greatly in their ability, and  
6 willingness, to contract more extensively with D-SNPs, so  
7 policymakers would need to decide if this requirement would  
8 apply to all D-SNPs, or just those in states with MLTSS  
9 programs. If the requirement applied to all D-SNPs, some  
10 states that do not have MLTSS programs might be prompted to  
11 develop them, particularly those that have previously  
12 explored the idea. However, states usually need several  
13 years to develop a program and would need time before the  
14 requirement took effect.

15 Having said that, most of these states would  
16 probably not be persuaded to develop MLTSS programs and  
17 would respond by closing their D-SNPs, but the impact on  
18 areas such as care coordination would be limited because  
19 the level of integration for these plans is low.

20 The next potential policy would require D-SNPs to  
21 follow a practice known as aligned enrollment. Under this  
22 approach, beneficiaries could not enroll in a D-SNP unless

1 they were enrolled in an MLTSS plan offered by the same  
2 parent company. This policy would address each of the  
3 barriers to greater integration that I discussed earlier in  
4 the presentation, and effectively incorporates the other  
5 policies that I described as well, because partial duals  
6 cannot enroll in MLTSS plans and a company would not be  
7 able to offer a D-SNP unless it had an MLTSS contract.  
8 Four states -- Idaho, Massachusetts, Minnesota, and New  
9 Jersey -- currently use aligned enrollment, and almost all  
10 of the D-SNPs in these states are FIDE SNPs. Here again,  
11 policymakers would need to decide if this policy would  
12 apply to all D-SNPs or just those in states with MLTSS  
13 programs.

14           This policy would ensure that all D-SNP enrollees  
15 receive their Medicare and Medicaid benefits from the same  
16 company and would lay the groundwork for integration in  
17 other areas, such as developing a single care coordination  
18 process that oversees all Medicare and Medicaid service  
19 needs, a single set of member materials instead of separate  
20 versions for each program, and a unified process for  
21 handling grievances and appeals.

22           Requiring D-SNPs to use aligned enrollment would

1 likely reduce the number of D-SNPs because the ability to  
2 offer them would be linked to participation in the MLTSS  
3 market, which often has fewer plans. Judging from the  
4 robust D-SNP market, plan sponsors find dual eligibles  
5 profitable, and some sponsors might respond by looking for  
6 ways to circumvent the limit on D-SNPs.

7           One way that plan sponsors might do this is by  
8 offering what are known as look-alike plans. These are  
9 regular MA plans that "look like" D-SNPs because they offer  
10 the same kinds of extra benefits as D-SNPs, such as richer  
11 coverage of dental, hearing, and vision services as I  
12 described earlier. However, because look-alike plans  
13 operate as regular MA plans, they are not subject to the  
14 requirements that apply to D-SNPs, such as the need to have  
15 a Medicaid contract. Efforts to promote greater  
16 integration in D-SNPs thus may need to account for  
17 potentially offsetting effects in the market for regular MA  
18 plans.

19           Policymakers could do this by taking steps to  
20 restrict or prohibit look-alike plans. For example, CMS  
21 could be given authority to reject applications to offer  
22 look-alike plans, freeze enrollment in plans where dual

1 eligibles account for a sizable majority of enrollees, or  
2 designate look-alike plans as de facto D-SNPs and require  
3 them to meet the same requirements as actual D-SNPs.

4           That brings us to the discussion portion of our  
5 session. We would like to get your feedback on whether D-  
6 SNPs should be required to meet higher standards for  
7 integration, focusing on the three policies that we  
8 outlined. First, should Medicare prohibit partial duals  
9 from enrolling in D-SNPs or, as an alternative, require  
10 plan sponsors to cover partial duals and full duals in  
11 separate plans? Second, should D-SNPs be required to have  
12 Medicaid MLTSS contracts? Third, should D-SNPs be required  
13 to use aligned enrollment? We would also like to know if  
14 you think these policies should apply to all D-SNPs, or  
15 just those in states that have Medicaid managed care  
16 programs.

17           Finally, we would also like to know if you think  
18 CMS should have authority to prevent the use of look-alike  
19 plans. That concludes my presentation. I will now be  
20 happy to take your questions.

21           DR. CROSSON: Thank you, Eric. So we'll go to  
22 clarifying questions. We'll start over here with David.

1 DR. GRABOWSKI: Great. Let me echo Jay in saying  
2 what an impressive chapter this was to read, so great work.

3 The first question, one approach is obviously to  
4 put these higher standards on D-SNPs. You also discussed  
5 the FIDE SNPs. Why not just require D-SNPs be FIDE SNPs?  
6 Take us through the distinction there of why this approach  
7 rather than that approach.

8 MR. ROLLINS: So I think at this point, again,  
9 circling back to the material that we discussed in the  
10 spring, it was sort of starting from the ground up on  
11 understanding why is the level of integration in D-SNPs  
12 low, and I think we're trying to sort of flesh that out  
13 here. And I think sort of based on that you would say,  
14 well, to have greater integration you need to figure out  
15 what you want to do with partial duals, and you may want to  
16 consider something like aligned enrollment. Once you had  
17 those policies in place I would say you are already a lot  
18 of the way towards being a FIDE SNP.

19 The reason why we didn't get into it in detail  
20 here was more sort of just interest of time. I didn't want  
21 to talk for longer than Jim was going to make me talk. And  
22 also to leave open, I think, the potential for discussion

1 later about sort of, okay, in some states maybe we think a  
2 more integrated plan is conceivable, but to sort of leave  
3 open the discussion of what exactly should that look like.  
4 Does it necessarily have to be the FIDE SNP model we have  
5 now or would we maybe want to start incorporating elements  
6 that we're seeing from the financial alignment  
7 demonstrations.

8 DR. GRABOWSKI: And just to follow on that, you  
9 mentioned aligned enrollment. In the chapter, it almost  
10 sounds like aligned enrollment solves everything, but like  
11 you have all these other steps. If I'm thinking about  
12 aligned enrollment correctly, that's going to already push  
13 out the partial duals that's going to deal with -- it's  
14 going to require an MLTSS plan. So you're ultimately going  
15 to get there with an aligned enrollment.

16 Am I thinking about that correct?

17 MR. ROLLINS: It gets you a lot of the way there.  
18 I think you can still have a discussion about other issues.

19 So I think having the same company responsible  
20 for both your Medicare benefits and your Medicaid benefits  
21 is sort of a necessary first step. I think one question  
22 that you can discuss is how much integration do we sort of

1 want to require. Is it simply enough for us to know that  
2 the same company is handling both sides?

3           The concern that we have heard in some of our  
4 site visits for the financial alignment demonstrations has  
5 been that these are, in some cases, very large insurance  
6 companies, and they can be somewhat siloed internally. And  
7 so the fact that Betty Jones is in this company's Medicare  
8 benefits over here and then their Medicaid plan over here,  
9 you may not want to go but so far in assuming that the two  
10 sides talk to each other really well. And so you could  
11 sort of say, "Okay. We're going to go further and sort of  
12 take other steps to ensure that this really does look like  
13 a single product.

14           DR. GRABOWSKI: Yeah. One final question, when  
15 you put up that figure of 17 percent were integrated, was  
16 that financial integration or actual care integration?  
17 Because I imagine financial integration was necessary but  
18 not sufficient for care integration, and you could think  
19 about exactly the point you just made. I could be in the  
20 same kind of product but not actually be truly integrated.

21           MR. ROLLINS: So the 17 percent had a mix of  
22 situations. It had about -- half of them were in FIDE

1 SNPs, where you're going to have some clinical care  
2 integration as well because they're supposed to use a  
3 single process. But the other half were in sort of these  
4 companion D-SNP and Medicaid plans, and I think in that  
5 area, it's less clear how much care coordination we have  
6 going on.

7 DR. CROSSON: Great. Thank you.

8 Clarifying questions?

9 Kathy.

10 MS. BUTO: So thank you, Eric, for a great  
11 chapter on an important topic.

12 I wondered whether we can differentiate the  
13 experience of the under-65 dual eligibles from the over-65  
14 dual eligibles in terms of their enrollment in FIDE SNPs or  
15 the MLTSS companion plans, whatever that arrangement is.  
16 Do we know how that breaks out? Are they both represented  
17 in these plans?

18 MR. ROLLINS: In most cases, yes. The share of  
19 people in the FIDE SNPs who are 65-plus, it's going to be a  
20 little higher. Two of the largest programs in  
21 Massachusetts and Minnesota that have been around for a  
22 long time and have substantial enrollment are just 65 only.

1 So they're going to be a little more heavily weighted, but  
2 in most states, these are plans that are serving both the  
3 under-65 and the over-65 populations.

4 MS. BUTO: Okay. And I guess one question I had  
5 as I was reading the material was, What exactly is wrong  
6 with the lookalike plans from your perspective? What don't  
7 we like about it?

8 From my perspective, if MA plans are interested  
9 in serving the dual eligibles, that's a good thing. So I'm  
10 wondering what we think is wrong with that, other than it  
11 may actually not help with the integration part as much as  
12 we'd like.

13 MR. ROLLINS: I think it's largely grounded on  
14 our view that we think integration is a worthwhile endeavor  
15 to pursue, both in terms that it can provide a better care  
16 experience for the beneficiary in terms of more coordinated  
17 care and hopefully better care, and we have some evidence  
18 of this, for example, from the evaluation of the integrated  
19 program that's in Minnesota.

20 So to the extent that you have lookalike plans  
21 out there that are similar in the sense of the extra  
22 benefits they offer, but they don't bring that care

1 integration and sort of bringing your Medicaid together and  
2 giving you sort of a single experience, I think that's the  
3 concern about lookalikes. They're diverting dual eligibles  
4 away from a more integrated product.

5 MS. BUTO: Okay. And the last question is, Do  
6 the MLTSS plans include personal care services, or are they  
7 just long-term care?

8 MR. ROLLINS: As with all things Medicaid, there  
9 will be some variation.

10 By and large, most of your MLTSS programs that  
11 the states are developing these days are fairly  
12 comprehensive. They will include personal care, home and  
13 community-based waiver services, and nursing home care.

14 As I did note in the paper, there are certain  
15 dual populations that aren't sort of as heavily into MLTSS  
16 programs yet, like those who had intellectual and  
17 developmental disabilities, but once they are in these  
18 programs, at least on the LTSS front, they are usually  
19 fairly comprehensive.

20 MS. BUTO: Thanks.

21 DR. CROSSON: I'm sorry. I'm not familiar with  
22 that term of art. Personal care services is what?

1 MS. BUTO: This would be personal care attendance,  
2 people who help with activities of daily living,  
3 particularly for the disabled.

4 DR. CROSSON: All right. Thanks.

5 Okay. Jon.

6 DR. PERLIN: Thanks.

7 Let me pile on the accolades. A terrific  
8 chapter.

9 I want to get a little more granular and find out  
10 if you can expand a little bit on what the components of  
11 integration, the care coordination were that made a  
12 difference. I would imagine that in that 17 percent that  
13 there were plans that yielded better outcomes for  
14 beneficiaries. Do you have any data, or how might you  
15 access the data as to what the distinguishing feature of  
16 better performance was?

17 And I ask that question having had the privilege  
18 of leading the VA Health System, which by virtue of its  
19 enrollment, our requirements really almost as a  
20 representation of dual eligibles, below the level of plan  
21 integration, is really a set of specific features of care  
22 coordination that lead to better outcomes in all

1 dimensions.

2 Thanks.

3 MR. ROLLINS: We have not looked at it sort of in  
4 that granular detail.

5 As I noted in the paper, the Bipartisan Budget  
6 Act does include a provision that is going to require us to  
7 sort of undertake this kind of analysis going forward once  
8 CMS sort of delineates sort of these levels of integration  
9 that D-SNPs are now going to be required to meet.

10 So I think once we have a better sense of which -  
11 - as part of that, we will have better information about  
12 what each D-SNP is going or not doing on the integration  
13 front. So I think as that evolves, we'll be in a better  
14 position to sort of get at that issue, which I think a lot  
15 of folks are interested in.

16 DR. CROSSON: Seeing no further clarifying  
17 questions, we'll move to the discussion.

18 So we have on Slide No. 15 some areas that I  
19 think Eric would like input into.

20 I would also like to get a sense -- you don't  
21 have to be explicit, but I'd also like to get a sense from  
22 the discussion, the level of support and certitude behind

1 some of these ideas. And the reason for that is, in the  
2 end, I think we need to decide whether we construct a  
3 chapter, which is informative, or we comprehensively or  
4 selectively come up with bald-faced recommendations, and  
5 that will depend a lot on, I think, what I hear.

6 So Paul and Dana are going to start. Let's start  
7 with Paul. No? I messed it up? Did I get my list wrong?

8 DR. MATHEWS: Pat and David.

9 DR. CROSSON: David and Pat. I'm sorry. I must  
10 have read something wrong.

11 MS. WANG: Thanks very much.

12 Eric, this was such a good chapter. I think it's  
13 a very confusing topic, and I think there were probably a  
14 lot of Commissioners who, like me, were drawing a lot of  
15 Venn diagrams to figure out what the overlapping issues  
16 were here.

17 And just by way of illustration, just to kind of  
18 -- I think it's relevant to the comments that I'm going to  
19 make. This is the world I live in. I have a mainstream  
20 Medicaid plan. So I got confused in the chapter when you  
21 said Medicaid plan. You meant an MLTSS plan.

22 Mainstream Medicaid plan, whose members age into

1 Medicare on a fairly regular basis into dual status; a D-  
2 SNP whose enrollment is full duals, at least in my case;  
3 and MLTSS plan which is responsible for -- it's a contract  
4 with the state Medicaid program that provides long-term  
5 post-acute care benefits, including what Kathy said,  
6 personal care hours, which is home attendant. It's not  
7 skilled. It's not skilled home health care, but it's to  
8 assist with the activities of daily living for aged and  
9 disabled. And the benefit will differ in different states.  
10 A FIDE SNP, a fully integrated dual eligible plan, which is  
11 essentially a combination of a D-SNP and the MLTSS in one  
12 integrated Medicare product. And I participate in the  
13 state's -- the demonstration for duals.

14 My MLTSS plan, mandatory enrollment, and I assume  
15 that that's true in many states. So somebody, a dual in my  
16 state, who wants to receive long-term care services must  
17 enroll in a plan. That's mandatory.

18 My MLTSS members are also enrolled in my D-SNP.  
19 About half are enrolled in Medicare fee-for-service, and  
20 the balance are enrolled in somebody else's D-SNP.

21 So part of my purpose here is to lay a  
22 foundation, but it's also -- if my fellow Commissioners

1 didn't get it, I'm looking for some sympathy here from you.

2 [Laughter.]

3 DR. CROSSON: I have to say I'm just exhausted  
4 listening.

5 MS. WANG: I am in one region. My products are  
6 pretty much with like a county exception or two. It's very  
7 overlapping.

8 But I think that this description points out the  
9 complexity of the task that Eric undertook because the  
10 Medicare program is a federal program. It's one program.  
11 It may have different flavors -- D-SNP, FIDE SNP, the MMPs,  
12 all of those. But it's 51 different Medicaid programs.  
13 There's different benefits. The states have their  
14 different ways of doing things, and so I say that just to  
15 kind of -- I think there's a need to be realistic about  
16 kind of one model fitting everywhere because it's probably  
17 going to take some shoehorning and backing up.

18 Another thing to observe is Medicare Advantage  
19 enrollment, D-SNP, FIDE SNP is voluntary. Voluntary. At  
20 least in my state, MLTSS enrollment is mandatory. So  
21 somebody who enrolls in MLTSS is going to make a choice  
22 that has to be respected based, I think, on beneficiary

1 choice and their caretaker's choice about where they want  
2 to go. So there's a very large chunk there.

3 Some states for MLTSS do procurements. They do  
4 an RFP, and they select the plans. And others sort of like  
5 let a thousand flowers bloom. so there's different ways of  
6 configuring that.

7 The other observation I had when reading the  
8 chapter was it's through the lens of describing integration  
9 as long-term care services.

10 Less than half of duals use MLTSS services, or  
11 they don't need them quite, they might at some point. But  
12 at any given time, fewer than half do. I think it's  
13 important, in my perspective, to recognize that D-SNPs have  
14 value in and of themselves, even when they are not  
15 providing long-term care services.

16 I think it is -- in the context of long-term  
17 care, I understand the statement that if they don't have a  
18 FIDE SNP or an MLTSS that they're not integrating care, but  
19 for duals who don't need long-term care, there's a lot of  
20 care coordination going on. So I think they're very  
21 valuable, and for that reason, I wouldn't sort of pull the  
22 trigger on them just because they don't have an MLTSS plan

1 associated with them.

2 I also think that the -- and I can speak  
3 firsthand. I do have MLTSS members who are also enrolled  
4 in my D-SNP who we try to persuade to move into the FIDE  
5 SNP, but they find their way in. They find their way into  
6 these two separate products.

7 It's not just silos. They're separate companies.  
8 They're separate products. They're set up separately.  
9 It's very hard to do real care coordination. Their  
10 enrollment is misaligned as well. They can change MLTSS  
11 plans and stay in the D-SNP and vice versa. So it's kind  
12 of doing that kind of attempt at virtual integration is  
13 very difficult.

14 So I'm with David about FIDE SNP being the  
15 solution here, and I'll come back to that in a second.

16 I think that a big issue that is not -- that you  
17 addressed, Eric, but that is difficult to solve is where  
18 behavioral health fits in because Medicaid programs have  
19 extensive behavioral health programs, and they are in  
20 varying degrees available in some of these integrated  
21 products.

22 It's a very complex program. It's typically

1 governed by different agencies in a state that have  
2 extremely specific criterion, at least from my observation.  
3 There's a different navigation and route through there.

4 I personally don't think that D-SNPs are even  
5 MLTSS's -- I would worry about their capability to manage  
6 the full Medicaid behavioral health benefit, but I think  
7 it's really important for duals. And so my preference  
8 would be to leave the behavioral health benefit in the  
9 mainstream Medicaid plan, which is administering it on a  
10 very large basis. And I'll explain how I think that this  
11 works.

12 So rather than looking at D-SNP and MLTSS as the  
13 right combination, I would say it's D-SNP plus FIDE SNP  
14 availability for people who want to choose Medicare  
15 Advantage route. Leaving the behavioral health benefit in  
16 the mainstream Medicaid plan that was associated with that  
17 member, because as you can tell, I do believe in having a  
18 family of products that are relevant to the member and  
19 having the Medicaid plan if there were a way, continue to  
20 manage the behavioral health benefit there.

21 To me, having MLTSS and mainstream Medicaid plan  
22 alignment then leads to two possibilities, and if there's a

1 D-SNP in the mix, it's enrollment in D-SNP when there is a  
2 need for long-term care services, go straight to FIDE SNP.  
3 The MLTSS plus mainstream Medicaid plan is then available  
4 for folks who choose not to go to a Medicare plan but want  
5 to stay in Medicare fee-for-service, and the behavioral  
6 health benefit is managed by the Medicaid plan for both  
7 populations.

8 I know you guys think I'm nuts, but this is what  
9 I think about.

10 I think that there are some clean-up issues that  
11 are important in there. I think that to the extent that  
12 there is D-SNP and a side-by-side MLTSS enrollment, it  
13 would be helpful if there were a seamless process to get  
14 them into the affiliated organizations or the parent  
15 organizations, FIDE SNP, because that's really where they  
16 should be.

17 And so some of the takeaways from this would be  
18 to focus on improving the FIDE SNP program. Eric, you  
19 mentioned it in here. There is a tremendous need to fix  
20 and align the enrollment process for a FIDE SNP because  
21 what happens today is that a plan is subject to the  
22 enrollment rules of each program. Somebody enrolls on

1 January 1st, their enrollment is effective on January 1st  
2 for one program and on February 1st for the second program.  
3 I mean, it's painful, and I think that one of the reasons  
4 that FIDE SNPs have not grown more in enrollment is that  
5 there's a very small window where you can enroll in both  
6 programs at the same time.

7           The demonstrations align to that, and I think  
8 that that is something that should be brought straight into  
9 the FIDE SNP program.

10           The other thing that would really improve the  
11 FIDE SNP program is aligning appeals and grievances.  
12 There's five levels of appeal for Medicare, four levels of  
13 appeal for Medicaid. The rules in a FIDE SNP essentially  
14 are if it's a Medicare-only benefit, you follow Medicare.  
15 If it's a Medicaid-only benefit, you follow Medicaid. If  
16 it's a benefit that's available from both programs, you  
17 pick.

18           It is so confusing for the beneficiary, and it is  
19 incredibly difficult to administer for a plan. The MMPs  
20 solve this problem as well by coming up with an aligned A&G  
21 process, and I think it's critically important to advance  
22 FIDE SNPs that these two critical issues be addressed.

1           I think that the example of the MMPs, the MMPs  
2 that were very successful, kudos to them. There were  
3 states that were less successful, as we know, but I think  
4 that you pointed something out in the paper, which is  
5 important to remember for any of these recommendations and  
6 suggestions that you've posited here, which is every market  
7 is different, and the degree of existing D-SNP penetration  
8 in a market does seem to have an impact on how you can  
9 develop one aligned model, for example, because if there's  
10 already many, many D-SNPs in the market, I think it's hard  
11 to put the genie back in the bottle and sort of say, "We're  
12 going to a New Jersey-aligned model kind of pattern."

13           I think that there are other things that can be  
14 done with seamless. I think Medicare did not make the  
15 seamless regulation as flexible as it could have been, and  
16 we can talk about that later. But I think that allowing  
17 more flexibility and seamless enrollment from mainstream  
18 plans into dual SNPs that are not what they call  
19 integrated, because there is on long-term care piece, but  
20 that have an affiliated long-term care plan or FIDE SNP  
21 would really further the cause of keeping people inside of  
22 one organization that has integrated products available to

1 them.

2           As far as the specific questions, partial benefit  
3 duals, I don't have any issue with that, and I think that  
4 you're right about separating them out.

5           Requiring D-SNPs to have MLTSS contracts, I think  
6 it should be FIDE if people are going to go down that  
7 route.

8           Using aligned enrollment, like I said, I think  
9 that there are difficulties. I think more flexibility is  
10 needed there, just based on kind of what's in the market  
11 already.

12           And should the higher standards apply only to  
13 plans and states that use Medicaid managed care? Again,  
14 Medicaid managed care, I think you mean MLTSS, right?  
15 Medicaid MLTSS. I don't think so. It's kind of, I think,  
16 in this effort of, hopefully, there will be many different  
17 options that have flexibility.

18           And should CMS have the authority to prevent  
19 these lookalike plans? I would say no because I do think  
20 that D-SNPs that don't provide long-term care are still  
21 very, very valuable, and MLTSS is a very specific thing.  
22 You have to know the Medicaid program. You have to know

1 long-term care. It's not an insurance company, really.  
2 It's like a provider insurance company mix, and so I  
3 wouldn't go that far.

4 That's it. Thank you.

5 DR. CROSSON: Pat, thank you.

6 David.

7 DR. GRABOWSKI: Great, thanks. So, Jay, to  
8 start, I'm highly supportive of crafting recommendations  
9 here, not just making this an informational chapter, so  
10 just to answer that question.

11 I think this chapter very much gets at the  
12 question of what's so special about special needs plans for  
13 duals, and I think many of us had hoped that what would be  
14 special about the D-SNPs is they would offer greater care  
15 integration. That hasn't been the case except for in a  
16 minority of plans because really what they've offered is  
17 these supplemental benefits like vision, hearing, and  
18 dental. Those are important, but I don't think that's  
19 quite what we had in mind when these plans were developed.

20 Similar to Pat, I'm much more optimistic about  
21 the FIDE-SNPs. I think we have a vehicle right now that's  
22 offering an integrated product. I would like to see us

1 kind of push towards that model. I think if we have to go  
2 through the D-SNP route, I like a lot of the ideas that are  
3 here. I don't have a problem with prohibiting kind of  
4 eligibility for partial duals, although I think covering  
5 them in separate D-SNP plans sounds fine to me. I think  
6 keeping them in the kind of products, this sort of menu of  
7 products, is positive. I don't want to see them -- I don't  
8 want to lose those partial duals. But I don't think they  
9 have any place in these integrated products.

10 I think Pat made a nice distinction there between  
11 those who need long-term services and supports and those  
12 who don't, and I think at least for those who need those  
13 services, requiring that D-SNP or hopefully that FIDE-SNP  
14 to have that contract I think is fundamental.

15 And in terms of aligned enrollment, I think  
16 that's a really important step here to make certain that  
17 you're placing individuals into, both on the Medicaid side  
18 and the Medicare side, a product that's working together.

19 I think these higher standards should apply  
20 everywhere. I don't think just applying them to states  
21 with Medicaid managed care makes a lot of sense.

22 And then, finally, I guess I'm not in favor of

1 CMS having the authority to prevent the use of look-alike  
2 plans. Once again, similar to Pat, if we want to get duals  
3 into kind of products that offer them additional benefits,  
4 that's a positive. I'd hate to siphon off folks who could  
5 be -- beneficiaries who could be in truly aligned products,  
6 but I like the idea that if they want to be in this kind of  
7 plan that largely offers supplemental benefits, they have  
8 that option.

9           So, once again, thank you for a great chapter,  
10 and I look forward to our further work on this issue.  
11 Thanks.

12           DR. CROSSON: Okay. Continuing discussion,  
13 Kathy?

14           MS. BUTO: I wanted to ask Pat in particular if -  
15 - because it does sound like the FIDE-SNP for the dual who  
16 needs both long-term care and regular services is something  
17 we'd like to promote. Is there anything we ought to  
18 consider from an incentive perspective to promote those  
19 from the Medicare side? I don't think Medicaid is going to  
20 come up with more incentives, but I'm just wondering if we  
21 could think about that, because saying we think this is a  
22 more desirable option I don't think is going to make it

1 happen unless there's some additional incentive payment  
2 associated with the integration.

3 MS. WANG: So FIDE=SNPs now -- you mean  
4 incentives for plans or for beneficiaries?

5 MS. BUTO: For plans [off microphone].

6 MS. WANG: For plans.

7 MS. BUTO: They get paid the same, don't they, as  
8 --

9 MS. WANG: Yeah, you're part of the Medicare bid.  
10 I think that it's -- I think removing barriers with the  
11 ones that I described, I mean, it is very hard to be a  
12 FIDE-SNP with those restrictions.

13 MS. BUTO: Right.

14 MS. WANG: If those were removed, it would be  
15 appealing to many plans who are committed to the dual  
16 population.

17 MS. BUTO: And I know you haven't -- you and I  
18 have talked about this before. You haven't mentioned the  
19 difficulty of beneficiaries transitioning from one of these  
20 categories to another. They may just need a D-SNP today,  
21 but next week it turns out they do need the long-term care  
22 services, how to make that more seamless and less

1 bureaucratic. So I just hope, Eric, that we could maybe at  
2 least touch on the fact that there may be factors that  
3 would make the FIDE-SNP more attractive as an option for  
4 plans -- and for beneficiaries, for that matter -- and that  
5 states would actually support.

6 DR. CROSSON: Marge.

7 MS. MARJORIE GINSBURG: I think this is a  
8 question for Pat. Is there an interest group, a  
9 professional association of programs like yours that meet  
10 periodically and strategize growth and money and stuff like  
11 that? That's question number one.

12 The other one is we had a very brief discussion  
13 before about the role of MACPAC, and since is the first  
14 time I'm aware of that we've talked about a program that  
15 involved both Medicare and Medicaid, has MACPAC been  
16 involved in any way with these discussions?

17 MS. WANG: I don't know about MACPAC, and there  
18 are associations that -- the commenter who said that she  
19 was from the SNP Alliance, who was -- that's an  
20 organization that is out there. But, you know, I think  
21 that because the Medicaid piece is so significant, at least  
22 from my perspective, you know, it's a very local product.

1 So you're probably going to be dealing with -- the Medicare  
2 side is not as complicated. Medicare is Medicare. If you  
3 have a D-SNP, you know what the integrated product is going  
4 to be. It's really the Medicaid side and working with a  
5 state. That's been my experience on some of the fine-  
6 tuning around that. So we don't tend to -- maybe it's just  
7 because we're not joiners. No, but, you know, we're not,  
8 but I think that there are organizations out there that  
9 work on this.

10 DR. CROSSON: Further comments?

11 [No response.]

12 DR. CROSSON: I'm not seeing any, and I think  
13 part of it is the fact that it's late in the afternoon, but  
14 part of it is the fact that this is really intricate and  
15 complicated. And it also involves a portion of health care  
16 that is not Medicare, and so it's not something we talk  
17 about all the time, and I think people have identified  
18 that.

19 Now, fortunately, with Eric and other members of  
20 the staff, we've kind of got our own expert to help us sort  
21 that through. So I think -- one second, Warner. I think  
22 we don't have as broad an input on this particular issue as

1 we often do, so I think we're going to be more dependent  
2 here on the judgment of the staff -- we always are, but  
3 particularly in this case -- as well as, I think, a couple  
4 of our Commissioners who live and think about this stuff.  
5 So my thought here, Jim, is I haven't seen -- I mean, David  
6 and Pat don't agree on anything, but I think -- don't agree  
7 on everything.

8 [Laughter.]

9 DR. CROSSON: But I have great hopes that in  
10 further dialogue and perhaps direct work with Eric and  
11 others, we can come to the point where we at the very least  
12 have a valuable informational chapter, and at least on some  
13 of these elements we can come up with a recommendation  
14 that, first of all, we all understand and, secondly, we can  
15 get behind. So I think that would be the goal.

16 Yeah, Warner.

17 MR. THOMAS: Just a brief comment, because I  
18 would concur with you, I think this is very complicated.  
19 So one of the things may be are there any ways to make this  
20 more simplistic? Because if we're sitting here having  
21 trouble kind of comprehending all of it, imagine if you're  
22 a beneficiary. And I do think the more integration we can

1 create between -- you know, for dual-eligible  
2 beneficiaries, I mean, we can do a much better job taking  
3 care of them. And it sounds like because of the  
4 fragmentation in some of these programs, it's very  
5 difficult to create an integrated experience or an  
6 integrated set of benefits. So I don't know if that can be  
7 a key part of the goals as well.

8 DR. CROSSON: You know, I think that's an  
9 excellent point because, you know, I think the beneficiary  
10 piece of this, to the extent that, you know, we can get  
11 this done in the work, would be a valuable addition.  
12 That's my own --

13 MS. BUTO: And, Jay --

14 DR. CROSSON: Yeah.

15 MS. BUTO: I'm sure it's -- I'll have to go back  
16 and look, Eric, but, you know, the share of costs to the  
17 Medicare program that this population represents is huge,  
18 and to Medicaid.

19 DR. CROSSON: It's huge, right.

20 MS. BUTO: And so, I mean, it's difficult, but it  
21 is kind of one of the things that has to be really looked  
22 at. I will say I was really surprised, like David, that,

1 you know, the D-SNPs had so little to do with Medicaid and  
2 that really the benefits were in supplemental benefits that  
3 are not really what you would consider, I think, or hope  
4 for better integration of care between the two funding  
5 streams. So, you know, I just think this is something we  
6 have to get our arms around one way or the other.

7 DR. CROSSON: Yep. Agreed. Yes, Paul.

8 DR. PAUL GINSBURG: There's one small comment I  
9 wanted to make, only because it didn't come up in  
10 discussion, but I think in reading the paper Eric wrote, he  
11 pointed out that the spending per beneficiary is  
12 dramatically different between full duals, partial duals,  
13 and beneficiaries that aren't duals. And this I think was  
14 behind his interest in separating the partial duals from  
15 the full duals and really both groups from the non-duals.  
16 And we need to always maintain that because we don't want  
17 to get a dramatic selection process.

18 DR. CROSSON: Okay. Eric, I hope this has been  
19 helpful, and we again thank you for taking us through an  
20 extremely complicated area in a way that I think has  
21 advanced our knowledge, perhaps not all the way we hoped it  
22 would be, but significantly forward. So thank you for

1 that.

2           And with that, I think the presentations and the  
3 discussion are over with, and we have now the opportunity  
4 for a public comment period. If there are any members, I'd  
5 like to see people line up, and I'll make a comment in a  
6 minute.

7           [Pause.]

8           DR. CROSSON: So thank you for being willing to  
9 talk to us, and I would ask you, please, if you could  
10 identify yourself and any organization or institution you  
11 belong to. We would ask you to keep your comments to about  
12 two minutes, and when my red light goes on here, two  
13 minutes will have expired. Thanks.

14 \*       DR. PHILLIPS: Absolutely. Thank you. Cheryl  
15 Phillips, Special Needs Plan Alliance, and a fantastic  
16 conversation, having spent the last many days reading the  
17 new proposed rule. This has actually been a refreshing  
18 conversation.

19           But I want to touch on I think many of us -- I'm  
20 a clinician and believe passionately in the value of  
21 integration. It has been a journey that we have set out  
22 for decades. There are a lot of barriers, and, Pat, you've

1 articulated them so well. If it were easy, we would have  
2 done it. Lots of barriers to integration, barriers at the  
3 state side, barriers at the plan side, barriers with  
4 dueling regulation. And I want to add another one, and I  
5 think it's an important test to why we haven't moved  
6 integration.

7 D-SNPs just became permanent this February. Up  
8 until now they were reauthorized at two- and three-year  
9 segments. Nobody wanted to put the money and the effort  
10 into escalating this. So I think we now have a platform.

11 But I think until we address the barriers, we  
12 have to look at the flexibility and create incentives;  
13 otherwise -- and I will disagree respectfully, David. I  
14 think that the look-alike plans will destroy integration.  
15 They will because they will become the least resistance  
16 pathway. If a plan can do that and not have a model of  
17 care, not have a MIPPA contract, not do care coordination,  
18 why on Earth would they do that? If the states can just  
19 close their eyes and not worry about a MIPPA contract,  
20 they'll go to the look-alikes. It's not inherently that  
21 they are bad, but they will stop integration.

22 So if our commitment is integration, I think we

1 have to look at not just what are the barriers, but what  
2 are some of the incentives, if you will, the flexibilities,  
3 and looking at the Medicare-Medicaid demonstration plans is  
4 a great place to start with enrollment and grievance and  
5 appeals.

6           And then, lastly, I think there is a value to the  
7 partial duals. I think what happens in a well-run D-SNP  
8 enhances their vulnerabilities as a population, but I would  
9 agree that we want to separate them if we're going to move  
10 towards fully integrated duals, so the SNP Alliance would  
11 support let's continue to allow partial duals and D-SNPs  
12 but separate.

13           Thank you.

14           DR. CROSSON: Thank you for your comments.

15           Seeing no one else at the microphone, we are  
16 adjourned until -- what time tomorrow morning?

17           DR. MATHEWS: 8:30.

18           DR. CROSSON: 8:30 tomorrow morning.

19           [Whereupon, at 4:13 p.m., the meeting was  
20 recessed, to reconvene at 8:30 a.m. on Friday, November 2,  
21 2018.]

22

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

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

Friday, November 2, 2018  
8:30 a.m.

COMMISSIONERS PRESENT:

FRANCIS J. CROSSON, MD, Chair  
JON B. CHRISTIANSON, PhD, Vice Chair  
AMY BRICKER, RPh  
KATHY BUTO, MPA  
BRIAN DeBUSK, PhD  
KAREN DeSALVO, MD, MPH, Msc  
MARJORIE GINSBURG, BSN, MPH  
PAUL GINSBURG, PhD  
DAVID GRABOWSKI, PhD  
JONATHAN JAFFERY, MD, MS, MMM  
JONATHAN PERLIN, MD, PhD, MSHA  
BRUCE PYENSON, FSA, MAAA  
JAEWON RYU, MD, JD  
DANA GELB SAFRAN, ScD  
WARNER THOMAS, MBA  
SUSAN THOMPSON, MS, RN  
PAT WANG, JD

B&B Reporters  
29999 W. Barrier Reef Blvd.  
Lewes, DE 19958  
302-947-9541

| AGENDA   | PAGE |
|--|------|
| Examining the Medicare Advantage quality bonus program |      |
| - Carlos Zarabozo.....                                 | 3    |
| Medicare Advantage encounter data                      |      |
| - Andy Johnson, Jennifer Podulka.....                  | 94   |
| Public Comment.....                                    | 136  |

P R O C E E D I N G S

[8:30 a.m.]

1  
2  
3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21  
22

DR. CROSSON: Okay. I guess we can get going here.

Good morning. I think it's time to start the morning session. We've got two issues this morning to take on, both related to the Medicare Advantage program. The first presentation and discussion is going to be a presentation of some thoughts with respect to the Medicare Advantage quality bonus program. Carlos, you're on.

\* MR. ZARABOZO: Thank you. As Jay mentioned, for your breakfast presentation we're going to talk about the quality bonus program in Medicare Advantage.

This slide outlines the presentation, which begins with a summary of the current quality bonus program, followed by a review of the contract consolidation issue that the Commission has looked at extensively and which has been partly resolved by a recent legislative change. Then we'll discuss other specific issues and possible solutions. I'll mention here that CMS has just released a proposed rule dealing with some of the issues, and we're still evaluating the proposals in that rule. I will conclude

1 with a discussion of a different financing mechanism for  
2 the QBP program that would be budget neutral.

3           The MA quality bonus program was introduced by  
4 legislation and has been in place since 2012. The program  
5 provides bonuses to MA plans based on their overall average  
6 star rating. There are 46 measures tracked, each with  
7 different weights that are used to arrive at a weighted  
8 overall average. Bonuses are available for contracts at or  
9 above an overall average of 4 stars. The bonus takes the  
10 form of a 5 percent increase in plan benchmarks, or 10  
11 percent in some counties. As you know, the benchmark is  
12 the bidding target for MA plans. When plans bid below the  
13 benchmark to provide the Medicare benefit, a portion of the  
14 difference has to be used to finance rebates, which are  
15 extra benefits for plan enrollees. The portion or share of  
16 the difference between the bid and the benchmark used for  
17 rebates is specified in the statute as varying by a plan's  
18 star rating, ranging from 50 percent for the lowest-rated  
19 plans to 70 percent for plans at 4.5 or 5 stars.

20           Beneficiaries can see overall star ratings and  
21 the results and stars for the 46 individual measures by  
22 using the Health Plan Finder tool at the medicare.gov

1 website. Star ratings are updated each year at the  
2 beginning of October for the October-December annual  
3 election period. The posted star ratings reflect the most  
4 recent results, but in choosing among plans, the benefit  
5 packages that beneficiaries will see, which are a major  
6 factor in beneficiary decisionmaking, are benefit packages  
7 based on the star rating from a year earlier because those  
8 were the ratings available to plans when they submitted  
9 their bids in June for the following year.

10           For a number of years, the Commission has been  
11 concerned with the use of the MA contract as the reporting  
12 unit for quality measures and the determination of star  
13 ratings. Contracts can cover wide, disparate geographic  
14 areas. Currently, about 40 percent of HMO and local PPO  
15 enrollment is in contracts that cover states that do not  
16 border each other.

17           In the last five years, contracts have gotten  
18 larger and larger because of a CMS policy that allows  
19 contracts to merge or consolidate to get a bonus-level star  
20 rating. What happens is that if, for example, a sponsor  
21 has a contract with a 4-star rating and one with a 3-star  
22 rating, the sponsor can decide to merge the two contracts

1 and choose the 4-star contract as the so-called surviving  
2 contract. The contract that was at 3 stars disappears and  
3 is subsumed under the 4-star contract with a 4-star rating  
4 applying to all enrollees. This is the case even if the 4-  
5 star contract has very low enrollment and the 3-star  
6 contract is a much larger contract.

7           The result is unwarranted additional program  
8 payments under the bonus program and inaccurate information  
9 for beneficiaries. The consumed contract which is being  
10 absorbed by the 4-star contract will immediately acquire a  
11 4-star rating for both bonus purposes and in terms of what  
12 is displayed on Health Plan Finder. What was actually a 3-  
13 star contract is immediately classified as a 4-star  
14 contract on Health Plan Finder.

15           The Commission addressed the issue of unwarranted  
16 bonus payments with two recommendations in the March 2018  
17 report. The first recommendation essentially would freeze  
18 contract configurations for the purposes of reporting  
19 quality and determining stars. So in the example I just  
20 used, one contract area would maintain its 4 stars and the  
21 other contract area would stay at 3 stars. We also  
22 repeated a recommendation made in 2010, which was to have

1 quality data reported at the local market area level, with  
2 stars also determined at that level.

3           Recent legislation has partly addressed the  
4 consolidation issue by revising current policy so that,  
5 beginning in 2020, in the case of a consolidation, the  
6 consolidated or surviving contract will get a new star  
7 rating that is the weighted average of the quality results  
8 for the two contracts. So in my example of a 3-star  
9 contract merging with a 4-star contract, if the two  
10 contracts had equal enrollment, the likely result would be  
11 a contract at 3.5 stars. In such a case, the sponsor would  
12 be giving up bonuses under the 4-star contract through this  
13 merger. This is the kind of consolidation we are unlikely  
14 to see going forward, but sponsors still have the  
15 opportunity to consolidate contracts when it can be  
16 expected that the averaging boosts a contract that was  
17 previously below 4 stars when merged with another contract  
18 at 4 or more stars.

19           We will now turn to specific issues with the  
20 current system that is the basis for determining star  
21 ratings.

22           The Commission has established a set of

1 principles to apply to quality measurement systems. The  
2 principles call for using a small set of meaningful  
3 outcomes-based measures and reducing the reporting burden  
4 on providers and plans. Consistent with those principles,  
5 in MA, where up to 46 measures are used for star ratings,  
6 the reporting burden could be reduced by eliminating  
7 process measures and administrative measures. Plans could  
8 continue to track process measures, and CMS would treat  
9 administrative performance as a compliance function.

10           The Commission has also advocated using claims-  
11 based measures, the MA equivalent of which would be  
12 encounter data. The burden of reporting could be  
13 diminished, and the uniformity of measurement as well as  
14 the comparability with fee-for-service could be enhanced by  
15 having measures based on MA encounter data that could be  
16 compared with fee-for-service claims-based quality results.

17           Another issue is that the current system has both  
18 a "cliff" and a "plateau." If a contract has an overall  
19 rating below 3.75 stars, which is rounded to 4, it does not  
20 receive any bonus payments. The plateau issue is that  
21 contracts above 4 stars receive the same benchmark increase  
22 as 4-star contracts. The limited incentives to reach a

1 level above 4 stars are that the 4.5- or 5-star ratings  
2 have a slight increase in the rebate share, and for 5-star  
3 plans, they can enroll beneficiaries outside of the annual  
4 election period; 5-star plans are also highlighted in  
5 Health Plan Finder, giving them an advertising advantage.

6 Looking to the recent work the Commission has  
7 done on quality incentive programs for hospitals, one  
8 approach that could address the cliff and plateau issue is  
9 to have a continuous scale for determining financial  
10 rewards.

11 For most of the MA star measures, CMS uses what  
12 we refer to as a tournament model to evaluate plan  
13 performance and to group that performance into the 5  
14 different star levels. Each year CMS determines new "cut  
15 points" for assigning measure results into the 5 star  
16 groups -- meaning that every year there is a clean slate  
17 and the tournament, or competition, among plans determines  
18 which contracts fall into which star category, regardless  
19 of where the cut points might have been in the preceding  
20 year, for example. This means that in a tournament model,  
21 overall quality can decline and there will still be 5-star  
22 plans.

1           In the context of the number of contract  
2 consolidations we have seen and the number of new contracts  
3 participating in MA, another issue with the tournament  
4 model is that the composition of the 5 star groups can  
5 shift with either an upward or downward direction in the  
6 cut points for different star levels, with sometimes  
7 unexpected results from one year to the next.

8           A possible solution again is to use a continuous  
9 scale to determine bonus payments and to establish pre-set  
10 targets that promote improvement; however, determining an  
11 appropriate pre-set target is also a difficult task as  
12 illustrated in the mailing material with the example of the  
13 kidney disease monitoring measure that had a very low pre-  
14 set threshold in the early years of the quality bonus  
15 program.

16           The CMS proposed rule would change the method of  
17 cut point determinations while still using a tournament  
18 model that addresses some of the issues with the current  
19 model. CMS also proposes putting limits on year-to-year  
20 changes in cut points.

21           One of the concerns with the quality bonus  
22 program is whether it can ensure a level playing field that

1 allows an apples-to-apples comparison for bonus purposes.  
2 Currently, CMS makes an adjustment to a contract's overall  
3 star rating based on the contract's share of low-income  
4 enrollees and beneficiaries entitled to Medicare on the  
5 basis of disability. For these populations, there are  
6 systematic differences in the results for certain measures  
7 that lead to the adjustment.

8           For most of the measures subject to adjustment,  
9 contracts with high shares of the two populations have a  
10 modest increase in their star rating. But there are also  
11 measures for which these plans show better performance, so  
12 the adjustment would be in the opposite direction. Our  
13 analysis suggests that another category of MA enrollee for  
14 which an adjustment should be considered is for enrollees  
15 of employer-group waiver plans, who have systematically  
16 better results than beneficiaries who are in MA but do not  
17 have their MA coverage through an employer- or union-  
18 sponsored retirement plan for Medicare beneficiaries.

19           Possible solutions here are to make an adjustment  
20 in the overall ratings for the employer-group population,  
21 along the lines of the low-income/disabled adjustment, or  
22 remove the employer-group enrollees from the star

1 calculations.

2           We looked at specific measures in the quality  
3 bonus program and found issues with some of the measures.  
4 In the case of the patient experience measures collected  
5 through a member survey, the Consumer Assessment of Health  
6 Plans and Providers survey for MA, we found that the cut  
7 points for the star levels fall within a very narrow range.  
8 The table on the slide shows that there is a difference of  
9 only one or two points in the cut points for the 5 star  
10 levels. This contrasts with the measure tracking whether  
11 diabetics receive necessary eye exams, which is a measure  
12 with a much wider difference across the cut points.

13           While the CAHPS cut points are very close to each  
14 other, and most contracts have results that are within a  
15 very narrow range, there are differences among contracts in  
16 their CAHPS performance at the tails of performance, with a  
17 few contracts having very low results and others, also a  
18 small number, having relatively high results.

19           A possible solution is to have the overall star  
20 rating affected only when a contract has a very high level  
21 of performance or a very low level of performance. Other  
22 contracts would be in a "hold harmless" situation of

1 receiving 4 stars, for example, or otherwise not having the  
2 CAHPS results affect their relative bonus status.  
3 Alternatively, a general approach of using a continuous  
4 scale that we have talked about as applying to all measures  
5 could address this issue.

6           We have also found issues with the risk  
7 adjustment system used for the MA hospital readmission  
8 measure.

9           One issue is that the readmission measure is  
10 risk-adjusted to establish whether or not a readmission is  
11 to be expected for a given patient when considering factors  
12 such as the person's age and health status. If in a given  
13 MA plan every patient who was readmitted could have been  
14 expected to be readmitted, the observed, or actual, rate of  
15 readmissions matches the expected rate of readmissions --  
16 that is, the ratio is 1.0. But if a plan's observed or  
17 actual rate of readmissions is higher than expected, the  
18 ratio would exceed 1.0. If a plan had twice as many  
19 readmissions as were to be expected, the observed-to-  
20 expected ratio would be 2.0 -- readmissions occur twice as  
21 often as in a plan where every readmission is an expected  
22 readmission.

1           What we have observed about the readmission  
2 measure is that, although you might expect a range of  
3 readmission rates across contracts, you would not expect  
4 too much variation within a single contract, given that the  
5 measure is a risk-adjusted measure. However, we found  
6 that, consistently across all contracts, if you look at  
7 admissions included in the readmission measure, but  
8 separate beneficiaries who died during the year from those  
9 who did not, every contract has a higher observed-to-  
10 expected ratio for the members who died during the year.  
11 The average across all contracts with at least 1,500  
12 admissions in the year was a two-fold difference in the  
13 observed-to-expected ratio when separating admissions among  
14 those who died versus those not dying in the year.

15           Another issue with the readmission measure is  
16 that the current minimum number of readmissions for a  
17 contract to get a star rating in this measure is 10. So in  
18 the 2018 star ratings, the single 1-star contract had 4  
19 readmissions out of 16 admissions. At the other end, many  
20 of the 5-star plans also had a small number of admissions.  
21 These results are probably not statistically valid.

22           As for solutions, CMS and NCQA are aware of and

1 working on the risk adjustment issue. The CMS proposed  
2 rule includes a provision to raise the minimum denominator  
3 to 150 admissions from the current 10.

4 A larger issue that can be viewed as a leveling-  
5 the-playing field issue has to do with the financing of the  
6 MA quality bonus program. The MA quality incentive program  
7 is not like other such programs in Medicare. The MA  
8 quality bonus program consists of increases in county  
9 benchmarks, including in counties where the benchmarks  
10 without any bonus add-ons are at or above 100 percent of  
11 fee-for-service. The program expends additional funds, and  
12 there are no penalties that might result in program  
13 savings. This is different from fee-for-service quality  
14 programs that are either budget neutral or produce program  
15 savings.

16 When the Commission has described what it would  
17 envision for a quality bonus program in Medicare Advantage,  
18 it has always been on a budget-neutral basis, with both  
19 bonuses and rewards.

20 This slide repeats what the Commission said in  
21 1999 and in 2004 regarding how to structure a bonus program  
22 for Medicare's private plans. Again, it was to be budget

1 neutral and would have bonuses and penalties in the sense  
2 that a small share of plan capitation payments would be  
3 withheld (such as 1 percent or 2 percent) to be  
4 redistributed to the highest performing plans.

5 I'll conclude with this slide for your  
6 discussion, which is the list of the issues that we have  
7 discussed and for which we have proposed possible  
8 solutions, and then for further discussion the matter of  
9 whether the bonus system should be a budget-neutral system  
10 based on withholds and redistributions, consistent with the  
11 Commission's principles regarding reasonable equity between  
12 MA and fee-for-service.

13 I look forward to your discussion.

14 DR. CROSSON: Thank you, Carlos. Very clear, as  
15 usual.

16 Let's take clarifying questions. Brian.

17 DR. DeBUSK: Let me find the -- bear with me.  
18 You were walking us through the proposed changes to the  
19 quality system, and let me see where that starts. Bear  
20 with me. Starting on Chart 6, and it looked like you were  
21 walking us through sort of a cadence that we've seen in  
22 other things, like your proposed changes in the hospital

1 value-based purchasing program as well.

2 Just to clarify, could you sort of compare and  
3 contrast, just walk me through the hospital value-based  
4 program as proposed in June 2018 and what you're proposing,  
5 sort of what's similar and what's different?

6 MR. ZARABOZO: I think if you're saying what  
7 might be -- it could be the same, that is to say, use what  
8 we would be using for the hospital value-based program and  
9 applying it to the MA program, right?

10 DR. DeBUSK: So you're saying even the same  
11 domains?

12 MR. ZARABOZO: No, no. It would be whatever  
13 measures we would be using in MA.

14 DR. DeBUSK: That's what I was getting at. Walk  
15 me through. So it would be different or subtly different  
16 domains.

17 MR. ZARABOZO: Well, see, one point that is made  
18 in the paper is that it would be nice if the measures were  
19 the same measures. For example, the readmission measure,  
20 as I talked about at length in the paper, we typically say  
21 this is a good measure to look at. So you would look at  
22 readmissions in hospitals. But as I pointed out in the

1 paper, there are some differences in MA with regard to  
2 readmissions that need to be taken into account. So you  
3 would want to have a comparable readmission measure for  
4 purposes of comparing MA to fee-for-service. But within  
5 MA, the readmission measure would be treated just like the  
6 readmission measure in fee-for-service in terms of a  
7 continuous scale of rewards.

8 DR. DeBUSK: And then it would be to a domain --  
9 one of the domains, and then it would be risk-adjusted and  
10 peer-grouped and --

11 MR. ZARABOZO: Right, right.

12 DR. DeBUSK: -- prospective target. So that's --  
13 I was trying to gather that from the reading materials and  
14 this, but you're taking us down that path, just to be  
15 clear, correct?

16 MR. ZARABOZO: Well, the issue would be: Does  
17 the Commission want to go down that path in Medicare  
18 Advantage?

19 DR. DeBUSK: Okay. I just wanted to make sure  
20 that we were going -- okay. Thank you.

21 MR. ZARABOZO: I'm not taking you anywhere,  
22 really.

1 [Laughter.]

2 MR. ZARABOZO: If I'm taking you anywhere, you're  
3 driving because I don't drive.

4 DR. MATHEWS: Brian, if I could try and add a  
5 little clarification here, we are indeed trying to conform  
6 to the same set of principles that we articulated in our  
7 June report this year with respect to how we're handling  
8 what we're doing in MA here.

9 DR. DeBUSK: Okay. And then one other question,  
10 you were talking about the readmission measure, and I'm  
11 just barely beginning to learn about this, but I know CMS  
12 on the non-MA side uses that random effects model that you  
13 guys introduced me to. Is this the same -- do they use the  
14 same model --

15 MR. ZARABOZO: No, no. The current MA model is  
16 different.

17 DR. DeBUSK: Is there any reason that we couldn't  
18 have used the same random effects model in --

19 MR. ZARABOZO: Well, in speaking with Ledia, I  
20 think the issue was it was thought that MA should have an  
21 MA-specific model?

22 DR. DeBUSK: Because?

1 MR. ZARABOZO: You'll have to speak to Ledia  
2 about that. Here she comes, and fortunately her name is  
3 already set up.

4 MS. TABOR: So, like Carlos says, the risk-  
5 adjusted models are different. It's two different measure  
6 developers, two different kind of sets of expert panels  
7 that are advising the measures. So what I would say is  
8 that according to the Commission's principles, we would  
9 like consistent risk-adjusted models, but they are  
10 different right now.

11 DR. DeBUSK: So would you consider the CMS random  
12 effects model that's used on the non-MA patients for  
13 readmissions calculations to be adequate? I mean, is it a  
14 competent model?

15 MS. TABOR: I am not a statistician. There's  
16 pros and cons to using different risk-adjustment models,  
17 whether it's just fixed effects or not. That could be a  
18 separate Commission discussion.

19 MR. ZARABOZO: But in the paper, we said some  
20 person over at CMS should look to see whether or not that  
21 model works for MA and test that model within fee-for-  
22 service to see whether we have the same issue in fee-for-

1 service that we have in MA, which is if you look at the  
2 people who died during the year and those who did not, do  
3 you get the same results?

4 DR. DeBUSK: Thank you.

5 MR. ZARABOZO: Yeah. That's the Test 1 and Test  
6 2 in the paper.

7 DR. CHRISTIANSON: Let's start here with Jonathan  
8 and move up.

9 DR. JAFFERY: Thanks.

10 Just a quick question. You referred in Slide 5  
11 to a few previous reports about reporting quality at the  
12 local market level, which seems to be maybe a significant  
13 issue with the continue -- how do we define local market?

14 MR. ZARABOZO: At the time, we defined the local  
15 market as the metropolitan statistical area for  
16 metropolitan areas, and then the remainder of a state was  
17 grouped into what's referred to as health service areas,  
18 not the Dartmouth health service areas, but the National  
19 Center for Health Statistics had developed health service  
20 areas for the non-metropolitan areas, so that's the way we  
21 were defining it.

22 But we're open to other definitions of what is a

1 local market.

2 We also separated -- if, for example, in the case  
3 of an MSA that crossed two states, we separated the two  
4 MSAs from the two states.

5 DR. CHRISTIANSON: Bruce?

6 DR. PYENSON: Thank you very much.

7 Just a background question or a foundation  
8 question here. We have a complicated structure for bonuses  
9 and quality metrics that's evolved over years, and I think  
10 -- am I correct in saying that some of the suggestions here  
11 would, in effect, scrap it and we'd have the opportunity to  
12 start all over again? Because I'm thinking there's a  
13 number of the HEDIS-type measures that don't fit in well  
14 with our principles.

15 There's methods of measuring that we don't think  
16 are quite -- are good, and we think perhaps the scoring  
17 mechanism, the Star point system and the way that's applied  
18 doesn't fit well with our principles.

19 So it almost sounds like -- is there anything  
20 left that fits with our principles? And I think that's  
21 okay, but it almost seems as though we really have an  
22 opportunity to decide if this is the future for Medicare

1 Advantage.

2 Let me ask the question.

3 [Laughter.]

4 DR. PYENSON: What about the current structure  
5 fits within the MedPAC principles?

6 MR. ZARABOZO: Well, this is similar to Brian's  
7 question of what direction are we going in. If you move  
8 towards what we're proposing for the hospitals, it would be  
9 very different from the current structure. The question  
10 would be what measures do you retain, if any, and our  
11 comment that you could remove the process measure, the  
12 administrative measure should be dealt with as not being  
13 quality measures. And you're limited to a small number of  
14 measures, and you would use this continuous -- so it would  
15 be very different from the current system, but some of the  
16 measures may survive into --

17 DR. CROSSON: Kathy and then Jaewon.

18 MS. BUTO: So I was struck by the Commission's  
19 recommendation back in 1999, which may seem to make a lot  
20 of sense and I guess was followed up by more specifics of  
21 how to reward exceptional performance and penalize -- I  
22 guess, operationally, how do you withhold a certain amount

1 of capitation and so on and so forth.

2 I'm just wondering. Given the fact that such --  
3 I think it's 75 percent of plans are bonus-eligible or get  
4 bonuses. How much distinction is there? I mean, when you  
5 think about exceptional performance, it feels like a lot of  
6 the plans are kind of in the same place from a quality  
7 bonus standpoint. Do we feel that if the measures were  
8 different, we could make distinctions, or are there  
9 distinctions there that are not being amply rewarded from  
10 your perspective?

11 MR. ZARABOZO: Well, it's 75 percent of the  
12 enrollees are in bonus-level status.

13 MS. BUTO: Right.

14 MR. ZARABOZO: You could just raise the threshold  
15 for five-star -- four-star performance really is the bonus  
16 level of performance, do something other than tournament  
17 model and say we recognize some of the measures that appear  
18 to be topped out to being this. So you wouldn't want to  
19 use those measures.

20 But where there are differences, you would say  
21 here is the new five-star level, which will result in only  
22 10 percent or 20 percent of the enrollment reaching this

1 level.

2 MS. BUTO: The other thing is I was struck in the  
3 paper by the fact that beneficiaries generally do not  
4 appear to use the Star system to select plans. Then I  
5 wondered quality systems still make sense from the  
6 standpoint of the program making distinctions or  
7 potentially providing some bonuses, but should there be  
8 some aspect from your perspective that captures what  
9 beneficiaries really care about in plans as part of a  
10 refined system?

11 MR. ZARABOZO: Well, the intention of the Star  
12 system is to capture what is important to beneficiaries.  
13 That's why you have these number of measures, including the  
14 patient experience measures, and it is hoped that  
15 beneficiaries will use the Star ratings to choose among  
16 plans.

17 MS. BUTO: But they don't.

18 MR. ZARABOZO: Well, yes. Mostly, they do not,  
19 based on our site visits and so on and focus groups.

20 MS. BUTO: Yeah.

21 MR. ZARABOZO: They usually do not.

22 DR. CROSSON: Jaewon.

1 Marge, I got you next after Jaewon.

2 DR. RYU: So I had a question about the employer  
3 group waiver plans. You allude to the fact that they --  
4 pound for pound, quality is higher there. I think you  
5 mentioned that their cost shares are on average lower. Is  
6 that predominantly what drives the fact that quality tends  
7 to be higher there? Do we know anything about the  
8 socioeconomic status of that group?

9 MR. ZARABOZO: Well, they would tend to be higher  
10 income people, right.

11 DR. RYU: Okay.

12 MR. ZARABOZO: But we don't know about the cost  
13 sharing, actually. On the specific measure that was in the  
14 paper, that doesn't have cost sharing for anybody.

15 DR. RYU: I see.

16 MR. ZARABOZO: So the benefit packages are more  
17 generous for the employer group.

18 DR. RYU: Then the other question I had was  
19 around the consolidations. The health plans that are  
20 driving that, do you have a sense of what the  
21 characteristics of those plans are? I'm guessing they're  
22 mostly for profit and national, but is that valid?

1           MR. ZARABOZO: That is valid, particularly the  
2 national point, because many of the plans that are sitting  
3 here, for example, cannot consolidate. There's nothing to  
4 consolidate with.

5           DR. CROSSON: Marge.

6           MS. MARJORIE GINSBURG: Just a quick sort of  
7 3,000-foot-level question. I kept thinking in reading  
8 this, where's the evaluation for fee-for-service, and then  
9 thinking, gee, that would be a little hard to do. You can  
10 go to any doctor you want in the community. How do you  
11 begin to consolidate? But, of course, there are ways of  
12 comparing hospital admission rates and a number of things.

13           I think there has been discussion previously  
14 about introducing an evaluation for fee-for-service, and I  
15 wonder if you could just briefly sum up where you are on  
16 that.

17           MR. ZARABOZO: Well, currently, the CAHPS  
18 measures are compared between fee-for-service and Medicare  
19 Advantage on sort of a wide geographic level, and we have  
20 always said -- in 2010 -- that we want to be able to  
21 compare fee-for-service to Medicare Advantage, which is why  
22 we bring up the point, if we had claims-based measures, we

1 could use fee-for-service claims and Medicare encounter  
2 data, which are the equivalent of claims to make this kind  
3 of comparison.

4 So this is one of our goals, if you want to put  
5 it that way or the program goals, really, because even CMS  
6 would like to be able to do this kind of comparison, I  
7 think.

8 MS. MARJORIE GINSBERG: So it's on the radar.

9 MR. ZARABOZO: Right. This is definitely on the  
10 radar screen, and that's the hope of using claims-based  
11 data.

12 DR. CROSSON: Karen.

13 DR. DeSALVO: One of the questions I was going to  
14 ask, Kathy already raised about consumers using the Stars  
15 ratings and what about them has made it not so friendly.  
16 We know that this is often a difficult issue to get people  
17 to assess quality.

18 I wondered if in your site visits, you thought  
19 about talking with brokers or others who might be using  
20 that data.

21 MR. ZARABOZO: We have talked to brokers. The  
22 SHIPs use the data. The health counseling people use the

1 Medicare, the health plan finder.

2           The brokers, we've got sort of a mixed reaction  
3 from brokers. Some of them say we don't use the Star  
4 ratings. We know the plans in our area. We know which one  
5 is better than another, which is best for this kind of  
6 person, whether this kind of person is better to be in a  
7 Medigap plan and so on.

8           MS. MARJORIE GINSBURG: Interesting.

9           MR. ZARABOZO: So even the brokers have sort of,  
10 as I say, a mixed reaction to these, the stars.

11           MS. MARJORIE GINSBURG: And I wanted to  
12 understand a little bit, Carlos, about the small area  
13 quality issue that you guys bring up in the paper. I just  
14 didn't follow all the logic of how important it is to be  
15 able to track on the local market versus the consolidated  
16 plan across the country.

17           MR. ZARABOZO: Right. So the example that I gave  
18 of the Florida plan that has like 80 percent of its  
19 enrollment in Florida, so all the quality measures are  
20 based on what's happening in Florida, really.

21           And so the people in Oregon that are a member of  
22 the same contract see the Star rating that reflects what is

1 happening in Florida probably doesn't have very much to do  
2 with what is happening in Portland. Right, right. And  
3 there are several other states involved there too, so yeah.

4 DR. CROSSON: Dana.

5 DR. SAFRAN: Thanks.

6 It's a really important paper and really nicely  
7 done. I have four questions.

8 One is when you're talking about the possibility  
9 of having fewer measures and simplification as we talk  
10 about on the hospital. You point to administrative  
11 performance and say that could be treated as a compliance  
12 issue. Would that actually relieve a reporting burden?

13 MR. ZARABOZO: Not really, actually, because a  
14 lot of those measures are tracked by CMS. They have the  
15 complaint tracking module and the audit function and so on.  
16 So it's already kind of removed, in a sense, so yeah.

17 DR. SAFRAN: So it would simplify the program --

18 MR. ZARABOZO: Right. It would --

19 DR. SAFRAN: -- but it wouldn't change the  
20 reporting --

21 MR. ZARABOZO: Right. And if you say that much  
22 of the Stars represent, that they represent clinical

1 quality. No, they represent more than clinical quality.

2 So this would say, well, let's go back to clinical quality.

3 DR. SAFRAN: Yeah. Okay, thanks.

4 My second question is on the employee plans --  
5 and this is a little where Jaewon was going, but I just  
6 wonder whether we know -- it seemed in the paper that it's  
7 the characteristics of the people in the plans plus the  
8 benefit structure that may be causing the difference, like  
9 lower out-of-pocket cost sharing and so forth. And so I  
10 was just curious whether, as you think about a possible  
11 adjustment that would include the employer plans, would the  
12 data be available to adjust for the characteristics we  
13 think are driving it as opposed to adjusting for whether  
14 some of these in an employer plan? Because that seems like  
15 kind of a blunt instrument.

16 MR. ZARABOZO: Well, if you think employer group  
17 status is a proxy for income, that would be the kind of  
18 information -- I mean, based on Jay's question -- because  
19 already we're adjusting for income with the low income.

20 So this just says there is another group of  
21 people who have low income. You have what you might call  
22 middle income and relatively higher income among

1 beneficiaries, which is the employer group waiver people.  
2 They're typically in that category.

3           And I think the differences are such that it's a  
4 good proxy for saying employer group waiver as a  
5 characteristics represents a characteristic that should be  
6 adjusted for.

7           DR. DeBUSK: On this --

8           DR. SAFRAN: Go for it.

9           DR. DeBUSK: I see where you guys were going with  
10 that.

11           Just one quick question. Is the EGWP a  
12 characteristic that you put into the adjustment  
13 calculation, or if we're moving more towards Ledia's  
14 unified model, wouldn't peer grouping --

15           MR. ZARABOZO: Yes. Peer grouping would handle  
16 that because, as I pointed out, there are a lot of  
17 contracts that are heavily employer group waiver, so they  
18 would be peer grouped.

19           DR. DeBUSK: But if you just threw it all into  
20 the same peer grouping mechanism and stratified it by SSI  
21 percentage, would the EGWP plans just fall into the --

22           MR. ZARABOZO: No. What I'm saying, in response

1 to Dana essentially, that you would have three categories  
2 of income, if you want to look at it that way. That you  
3 would have the SSI percentage. You would have the non-SSI,  
4 and among the non-SSI, you have the EGWP and the non-EGWP.  
5 So it's three kind of groups.

6 DR. DeBUSK: But we stratify our current peer  
7 grouping mechanism as 10 deciles. Are we going to a  
8 different --

9 MR. ZARABOZO: Well, for example, for the  
10 disabled and currently in MA, there are only five that are  
11 quintiles because the percentage in plans, it doesn't reach  
12 like 50 percent or so. The low income is a different  
13 matter.

14 DR. SAFRAN: Okay. So my other two questions,  
15 one is I'm liking your suggestion about getting more  
16 geographically proximate unit of analysis. Have you looked  
17 at for how many other measures that are currently in the  
18 program would plans have adequate sample sizes to be  
19 measured on those things?

20 MR. ZARABOZO: Yeah. The reason I use the risk  
21 cancer screening measure so often for analysis is that it's  
22 a measure that is population-based measure, and it's not

1 medical record sampling measure.

2           So the medical record sampling measure, as I  
3 discussed in the paper, which are many in the HEDIS system,  
4 those would need to have a bigger sample.

5           Similarly for the patient experience measure, the  
6 CAHPS, what the CAHPS people say is you need 100 to have  
7 reasonable CAHPS results for a given area, if you want to  
8 put it that way.

9           Now, CAHPS used to be done on an area level, as  
10 you seem to know. Yes.

11           DR. SAFRAN: Yeah. Okay. We'll come back to  
12 that in the second round.

13           MR. ZARABOZO: Okay.

14           DR. SAFRAN: So then my final question -- and I  
15 should know this, but I don't -- the 5 percent bonus, I  
16 know that you say that gets added to the benchmark. I'm  
17 trying to figure out what that actually means.

18           So does that mean that an MA plan that has done  
19 well and is a 4 or above has 5 percent added to its budget,  
20 or how much funding --

21           MR. ZARABOZO: In an area that is 115 percent  
22 fee-for-service, the benchmark becomes 120 percent of fee-

1 for-service.

2 DR. SAFRAN: So they have a larger budget for  
3 taking care of people because they're providing better  
4 quality?

5 MR. ZARABOZO: Right.

6 DR. CROSSON: Well, so they have a larger  
7 benchmark to bid against.

8 DR. SAFRAN: Yeah.

9 MR. ZARABOZO: Right.  
10 So this matters in the case of extra benefits.  
11 They have a better ability to offer extra benefits.

12 DR. SAFRAN: Yes.

13 MR. ZARABOZO: They can increase. They can if  
14 they want to increase their extra benefits.

15 DR. SAFRAN: Right.

16 MR. ZARABOZO: They're not required to do so.  
17 When they get more money, it's a matter of --

18 DR. SAFRAN: Is there a reason that the bonus  
19 wouldn't be paid out as an actual bonus as opposed to  
20 adjusting the benchmark, or is that part of what you're  
21 trying to propose in your --

22 MR. ZARABOZO: Well, I think, yes, the 1999 and

1 2004, I would view as it's just a bonus. It's an actual  
2 bonus paid out. After the year of performance, you get a  
3 bonus.

4 DR. CROSSON: Jon.

5 DR. CHRISTIANSON: So if they don't have to pay  
6 it back, they can treat it as an actual bonus, right?

7 MR. ZARABOZO: Right. Yes.

8 DR. CHRISTIANSON: So, in effect, if you want to  
9 treat it as a bonus, you can.

10 DR. CROSSON: Well, but there's a time element.

11 Okay. Let's see where we are. Brian, we already  
12 got you. Pat and then Jonathan.

13 MS. WANG: Thanks, Carlos. As usual, just an  
14 incredible amount of detail and really, really insightful  
15 analysis.

16 I am a little confused about how the phenomenon  
17 of contract consolidation and the size of some of these  
18 contracts and sort of the non-contiguous nature of one  
19 contract would affect -- I mean, you have already pointed  
20 out how it would affect some of the sample sizes and try to  
21 get to a geographic area, but on the specific notion of  
22 peer grouping, how do you do that? Does the size of some

1 of the contracts at this point and the kind of geographic  
2 dispersion affect in any way the ability to peer group? In  
3 the past, folks have talked about peer grouping by low-  
4 income status, for example. Can you find the relevant plan  
5 in a geographic area or otherwise to do peer grouping when  
6 the contracts are so big now?

7 MR. ZARABOZO: Well, now the peer grouping -- I  
8 mean, the way they do the categorical adjustment index is  
9 what percentage of low-income people you have, what  
10 percentage of disabled do you have, but it is strictly on a  
11 contract basis. So if you have a contract covering 11  
12 states, none of which is bordering each other, they just go  
13 into the mix as whatever percent they have of low income  
14 and so on.

15 If it was at the geographic level, then the peer  
16 grouping would be many, many more units to be peer-grouped,  
17 and possibly a better peer grouping in the sense that a  
18 company might have a D-SNP, for example, in one area and  
19 not in another. In the area where they have a D-SNP, they  
20 would be peer-grouped with D-SNP kind of entities.

21 MS. WANG: So getting down to a smaller  
22 geographic unit of measurement seems important?

1           MR. ZARABOZO: Right. And that would, I think,  
2 improve the peer grouping, which is why we made the comment  
3 about the underpinnings of the current system. When you  
4 have these large contracts, it doesn't make sense, in a  
5 way.

6           MS. WANG: Right, right.

7           The second question is, Can you share more of  
8 your thoughts about how you would achieve or how one could  
9 achieve budget neutrality if you wanted to with the current  
10 starts taking the approach of carving out but in a budget-  
11 neutral way? How would that work?

12           MR. ZARABOZO: Well, I think it's a -- so let's  
13 say everybody is being paid at 100 percent of fee-for-  
14 service. You would instead pay, if you're doing a 1  
15 percent you would be paying 99 percent of fee-for-service  
16 and we're withholding 1 percent, as it works through the  
17 payment system, risk adjusted and so on. And then that  
18 money is used to give bonuses to the highest-performing  
19 plans, so that the low end, the people that are not  
20 essentially bonus eligible, would have been paid 99 percent  
21 in that year. They're not going to get any additional  
22 money. Other plans, there could be plans where they were

1 paid 99 percent but they will get 9 percent back, or, you  
2 know, the maximum bonus amount.

3 MS. WANG: So that presupposes, then, a complete  
4 reform of the benchmarks as well, in your example.

5 MR. ZARABOZO: That particular example, and what  
6 was proposed in 1999 and then 2004 would have been in that  
7 way.

8 MS. WANG: Yeah. Okay. Thank you.

9 DR. CROSSON: Jonathan.

10 DR. JAFFERY: Thanks. So we've talked a bunch  
11 about trying to get some better comparisons with fee-for-  
12 service performance and thinking about the ACO models that  
13 have a set of 33 metrics and 4 domains, the mix of CAHPS  
14 surveys and claims data and medical record clinical data.  
15 Have you thought about trying to get some synergy with  
16 those metrics and what it would take, and then sort of as a  
17 related thought, thinking about, you know, following on  
18 Pat's last question, at least in the next-gen program for  
19 next year, moving toward a quality withhold, which it's not  
20 totally clear to me all the details of it yet but I don't  
21 think it's going to be budget neutral. I think it's going  
22 to be a net savings. And just thinking about how do we, as

1 a Commission, recommend things that really have some equity  
2 across the different programs, both for participants as  
3 well as comparisons?

4 MR. ZARABOZO: Yeah. I think for purposes of  
5 comparison we would like essentially uniform measures  
6 across all the sectors, in a sense, so that the ACO measure  
7 can be directly compared to an MA measure, and, you know,  
8 if you do a separate non-ACO fee-for-service, if you want  
9 to approach it that way -- see, these are all comparable  
10 measures across these three sectors. And we've said that  
11 already in a report, that we want the ability to compare in  
12 a given market ACO's MA plans, and, well, of course, ACOs  
13 are part of fee-for-service but you can separately say non-  
14 ACO results are this.

15 DR. JAFFERY: Because I was hearing a lot about  
16 comparisons to, for example, the hospital based.

17 MR. ZARABOZO: Right. So the readmission  
18 measure, we want something to be able to compare to. And,  
19 you know, you look to it as, well, this seems like a no-  
20 brainer, readmissions. It's claims-based and you can do  
21 this easily.

22 DR. CROSSON: Bruce.

1           MR. PYENSON: Carlos, could you talk a little bit  
2 about how changing the current rebate system, based on  
3 stars, changing that to a bonus system, a withhold bonus,  
4 paid at the end of the year, how that would change the bid  
5 process and the process of offering supplemental benefits.

6           MR. ZARABOZO: Well, should I take this, Jim, or  
7 should I --

8           DR. MATHEWS: You can start talking and I'll --

9           MR. ZARABOZO: So I would imagine -- let's say  
10 it's a 1 percent withhold, so everybody gets 99 percent, so  
11 that's what you're dealing with is a benchmark. So you do  
12 whatever benefit package you're going to do, 99 percent.  
13 And I would think that instead of saying, you know, 50  
14 percent, 65 percent, whatever, 70 percent, it would be the  
15 entire difference between bid and benchmark is what is  
16 available for rebates, right, so no discounting off of the  
17 rebate because you're already, actually, you know -- in the  
18 end you'll be at 100 percent, so there doesn't seem to be a  
19 reason to have that percentage difference in the rebate  
20 levels.

21           But, yeah, it's a bid. You know what the target  
22 is, which is 99 percent, and then after that you get a

1 bonus, and what you do with the bonus is up to you, you  
2 know, as a plan.

3 DR. CROSSON: Okay. Seeing -- Pat.

4 MS. WANG: In that scenario could a plan, in your  
5 thinking, put the bonus into benefits for the members,  
6 because that is a very structured process now through the  
7 bid, in your thinking about this.

8 MR. ZARABOZO: Well, again, this is just me  
9 talking. I don't know that we would say you're obligated  
10 when you get a bonus to put it into extra benefits. It's  
11 your bonus. I don't know that we tell other providers  
12 that, you know, here's what you have to do with this money.

13 MR. PYENSON: But presumably --

14 MR. ZARABOZO: You are back to bidding against  
15 the 99 percent. Every year you are bidding against the 99  
16 percent, essentially, right? So it is a true bonus in the  
17 sense that it's, yeah.

18 MR. PYENSON: And you can bid whatever you want,  
19 the difference between the bid and the benchmark --

20 MR. ZARABOZO: Right.

21 MR. PYENSON: -- all of it's used to fund  
22 supplemental benefits.

1 MR. ZARABOZO: Right. Now, of course, we haven't  
2 gone to this level of detail in talking about that. I  
3 mean, and I think we might in the future, do that.

4 DR. CROSSON: Jaewon, another question?

5 DR. RYU: Just on this point, and maybe this is  
6 what you were asking, Pat. Mechanically, though, if you  
7 get it as a bonus, would you even be able to put it into  
8 benefits? Was that where you were going, because I'm kind  
9 of confused on that too.

10 MR. ZARABOZO: Well, if it you did it as a bonus  
11 that means you have extra money. I mean, you, as a plan,  
12 can say, well, we will bring down our bid, essentially,  
13 because we have this extra money.

14 DR. CROSSON: In the next year.

15 MR. ZARABOZO: Yeah. In the year in which you  
16 receive the bonus dollars, or, yeah, in which you have the  
17 bonus dollars available to you. Right.

18 DR. RYU: I got it. Thank you.

19 DR. CROSSON: Okay. Seeing no more questions  
20 we'll go to the discussion period. We've got -- can we put  
21 up the last slide, 14? So we've kind of got -- I mean,  
22 these are connected to the bonus program but we've kind of

1 got two bodies of proposal here. One has to do with, you  
2 know, kind of fixing the current program, the first set of  
3 small bullet points, and the second one is a question of  
4 whether we should recommend converting the current program  
5 to a budget-neutral program.

6           So I think in the discussion period I would like  
7 to, to the extent that you have interest, comment on both  
8 of those two things. And we have Dana and Paul who have  
9 offered to start. Yeah, so, Dana, why don't we start with  
10 you.

11           DR. SAFRAN: Thanks. So this paper is really  
12 extremely well done and lays out so many important issues.  
13 There's a lot there in the MA quality program. And, in  
14 particular, I think your overarching framing about the  
15 concerns around the inaccurate information that the current  
16 Stars program structure yields for beneficiary choice and  
17 the unwarranted bonuses being paid because of some of the  
18 features are really important things for us to keep in mind  
19 as we talk through some of your specific questions. The  
20 issues you raised, that we've raised before about  
21 consolidation are really important ones and I'm glad to see  
22 us tackling them again. Your suggestions around aligning

1 the methods here to the ones that we are recommending over  
2 on the hospital side I think are important, and the issues  
3 that you flagged, which I don't believe we've talked about  
4 in the slides but are in the paper, around new and small  
5 plans and the way they're treated are I think important  
6 too.

7           So I guess starting with the issues around  
8 consolidation, you know, I think that absolutely we should  
9 do what we can do to move toward -- move further toward  
10 disallowing that but also toward shifting the unit of  
11 measurement, as you are proposing in the paper, closer to  
12 where the member beneficiary is actually getting care, to  
13 your point about provide as accurate as possible  
14 information. It's probably not the reason that  
15 beneficiaries aren't using the information but it certainly  
16 doesn't help us encourage them to use it when we know that  
17 the information they might get if they did use it doesn't  
18 actually represent the truth of what their care might look  
19 like in their market. So I think that's extremely  
20 important. I do think we have to do a pretty robust look  
21 at what does that mean for available sample sizes, what  
22 would it mean for expanding CAHPS data collection, you

1 know, or revering back to market level CAHPS data  
2 collection and so forth.

3           Which kind of takes me to your question about  
4 reducing the number of measures, and you might be surprised  
5 by my point of view on this, but I don't think we're ready  
6 for that yet in this program. I see this as very different  
7 from the hospital program, for example, where I think we  
8 really are ready to go towards our principles of outcomes-  
9 oriented measures and have a very robust and multifaceted  
10 view to inform beneficiaries and to inform those who are  
11 running the program about the most important differences in  
12 hospital performance that need attention.

13           I don't think the same is true for Medicare  
14 Advantage plans, like of like ACOs, right? They are  
15 responsible for end-to-end, every aspect of care, and I  
16 think if we -- unfortunately we're not at the state where  
17 if we remove the HEDIS measures and if we remove the  
18 administrative measures that we actually have enough left  
19 that gives us confidence that we are giving good  
20 information to beneficiaries upon which to choose and a  
21 good basis for differentiating and rewarding plans  
22 differently. So I would say no, not yet, on that.

1           You didn't say anything in the paper, or at least  
2 I didn't catch it if you did, about the health outcomes  
3 survey, which we talked about a little bit yesterday. But  
4 I would say we want to actually see what we can do to  
5 elevate the patient-reported measures, and to something to  
6 help plans see where they can differentiate on the HOS  
7 measures, because I know, you know, there has been no  
8 differentiation, and we talked a little bit yesterday about  
9 some of the reasons why that might be. I don't think it's  
10 because there can't be differentiation. I think, you know,  
11 and I've seen that there are things that provider systems  
12 can certainly do to improve those functional outcomes in  
13 this subset of the population, which is probably a large  
14 share of Medicare beneficiaries who have conditions that  
15 lead to impaired functioning.

16           So I think we should do something in our  
17 recommendation that really elevates the importance of those  
18 and CAHPS. And on CAHPS, as we already said, you know,  
19 collecting enough data that we've got market-level  
20 information, but I might also suggest two other things.  
21 One is, you know, the industry is kind of getting warmed up  
22 to net promoter scores, which are used in so many other

1 industries and haven't been used in health care. And, you  
2 know, for those here who aren't familiar with them it's,  
3 you know, a one question that has to be the first question  
4 in a survey so that it doesn't get context-biased about  
5 whether somebody would recommend, in this case the health  
6 plan, to family and friends. And the health care industry,  
7 overall, does really poorly on their promoter scores  
8 compared to lots of other industries, you know, down there  
9 around the same as cable companies.

10           So I think it would be really potentially very  
11 important to recommend adding this into the CAHPS survey  
12 and trying to shift reporting -- I know we're focused here  
13 on the quality Stars program, but since we do talk in the  
14 chapter about the lack of use of the measures, you know, we  
15 know that the general public and older people, in  
16 particular, most value, in quality measures, the measures  
17 that have to do with what did other people say. And in  
18 this day and age we really ought to be able to have a  
19 Medicaid compare site that enables us to show them even  
20 what do people like me say, you know.

21           So, you know, pulling those measures out and  
22 potentially supplementing CAHPS with net promotor scores

1 and not just having the stars there, which are filled with  
2 lots of things that beneficiaries don't care about or  
3 assume they have no control over, or assume are fine.

4           A couple of last points. One is I absolutely  
5 support your recommendation to shift to absolute versus  
6 relative, you know, getting rid of the tournament, also  
7 getting rid of cliffs. And the last thing was -- I forget  
8 who over on that side of the table saying it. Maybe it was  
9 you, Karen. Maybe it was you, Marge. But I really do  
10 think we should be saying something here about alignment of  
11 measurement across Medicare plans so that beneficiaries  
12 actually have information to inform a choice, not just of  
13 which MA plan but to what you were sharing, Carlos, about  
14 the brokers, and, you know, their sort of informal way of,  
15 well, we kind of know which plans are better. We ought to  
16 actually have comparable data for how Medigap plans  
17 function compared to Medicare Advantage plans and just help  
18 people inform like what is their best option.

19           So thanks. Thanks for the great content that you  
20 put forward for us to discuss.

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

22           DR. PAUL GINSBURG: Yeah. I also want to

1 compliment Carlos on the terrific job he did on this  
2 presentation. He's shown us that the problems with star  
3 ratings are numerous and serious. And, you know, we know  
4 that beneficiaries do not use them. That may be a positive  
5 in many cases, where beneficiaries certainly have a  
6 geographic should not use them, and all the problems that  
7 have been brought up, you know, underline it. The problem  
8 is even if the beneficiaries aren't using it the plans are  
9 using it, and the plans are using that to devote their  
10 resources to pulling themselves up on different dimensions  
11 to get star ratings. So they're still dangerous when they  
12 don't work well, even if consumers don't use them.

13           So I really question whether we, as taxpayers and  
14 beneficiaries, get much value for the \$2 billion a year  
15 that we spend on star bonuses.

16           So I support a comprehensive review, as Carlos  
17 has done, and a really comprehensive restructuring. I do  
18 believe that there is promise, potential for star ratings  
19 to have value and do good but we need a lot of changes.

20           On the six specific issues that Carlos mentioned,  
21 I'm comfortable with all of them except the tournament  
22 model, and I've been waiting here, since I've been on

1 MedPAC, and knowing that tournament models are dirty words,  
2 to say that I see some virtues in tournament models in some  
3 situations. Basically they work when it's not clear what  
4 the target should be, either because we don't know what the  
5 gold standard is or, more commonly, we don't know what's  
6 practical as far as the speed of moving towards the gold  
7 standard. There's always a risk that, you know,  
8 particularly with net bonus model, you know, the standard  
9 is set easy, everyone gets it, and then there's a political  
10 resistance to making it tougher because they're all  
11 enjoying the ride. So I think we need to be selective as  
12 to where tournament models are useful and where they're  
13 not.

14           Now I strongly support making this budget  
15 neutral, and I think it was foolish decision that the  
16 policymakers made to make this upside only, because of the  
17 political dimension, you know, that now there's a large  
18 political force that wants to maintain this system with  
19 upside only because they're benefitting to the tune of \$2  
20 billion a year. So, in a sense, the sooner this can be  
21 moved towards budget neutrality the better because it gets  
22 more difficult over time as this becomes more and more

1 entrenched, and I think policymakers clearly do understand  
2 that. So thank you.

3 DR. CROSSON: Thank you, Paul. Further  
4 discussion. Let's start down there with -- did I see your  
5 hand, Jon?

6 DR. PERLIN: Yeah. Thank you. Let me add to the  
7 accolades. Really terrific chapter and thoughtfully  
8 presented. I appreciate that a great deal.

9 You know, if you start with this sort of primary  
10 question, what is the utility of these star measures, I  
11 mean, it's really to help the beneficiary make an informed  
12 choice. I think the data that we have before us suggests  
13 that it's not serving that purpose.

14 And, Jay, as you so nicely weighed out, the two  
15 fundamental questions, budget neutrality and fixing the  
16 program, and I think in that regard there is some degree of  
17 interrelationship. So let me just say, at the outset, that  
18 I agree with others to suggest that this should be budget  
19 neutral.

20 You know, I think one of the challenges in the  
21 health care ecosystem is a diffusion of effort based on  
22 permutations of measurement rather than a consolidated

1 approach that really aligns focus on the same measures.  
2 And so I think we can gain more traction in some of the  
3 areas of quality, safety, you know, consumer or patient  
4 experience, et cetera, with more parsimony around focus on  
5 measures. And that's great. I think there's a principle  
6 that's just that we should, to the extent possible, aim to  
7 align measures across the different programs, be they ACOs,  
8 be it fee-for-service, and, frankly, be at the measures  
9 that are at the hospital level as well.

10 I think there has to be a consolidated or  
11 consistent philosophy of measurement. You know, the notion  
12 of the budget neutrality really responds mentally to the  
13 concerns that you've raised in your very thoughtful  
14 presentation but also, again, the parsimony with  
15 inconsistency of philosophy with all the other elements, be  
16 it at the provider level, hospital-acquired conditions are  
17 all downside, readmissions are all downside. Only value-  
18 based payment is neutral. So I think there is an argument  
19 also there for consistency.

20 In terms of a couple of the areas, and I'm just  
21 generally agreeing, I just want to highlight a couple of  
22 things. I think Paul raised some really good points on

1 tournament model. You know, there are times where we have  
2 to have absolute in times tournament works, and I'm going  
3 to invoke the Warner Thomas curve here, where they may be a  
4 place where you actually have a tournament model but only  
5 after achieving some acceptable threshold. And, you know,  
6 the challenge is what measures that are ambitious yet  
7 realistic so they actually invite traction toward improved  
8 performance, and we have to concede that there are areas  
9 where we don't know what the threshold is. We don't know,  
10 at some point, while the goal of avoidable harm should be  
11 zero, there may be some finite number of infections in the  
12 area, and I realize that different population of preventing  
13 early elective delivery, it's not 100 percent at 39 weeks.  
14 There's some judgment between fetal and maternal distress  
15 and we can't absolutely specify 100. Even though that's a  
16 laudable aspiration, it's impossible to distinguish.

17           So I think there is utility in terms of a  
18 measurement structure that gates some improvement in  
19 performance, probably higher over time, probably informed  
20 by the literature about what's possible, and then  
21 ultimately parsed by relative performance in some way that  
22 helps to differentiate for consumers what the difference in

1 performance is at different levels. So I suggest this  
2 notion of a gate or a threshold and then some  
3 stratification.

4 I agree with Dana in terms of not, you know,  
5 constraining the set, just outcomes measures, but  
6 ironically, for a slightly different reason. I think there  
7 is utility in process measures, and if you don't believe me  
8 I'll do a little experiment with you. How many of you wear  
9 a seat belt when driving. Come on, Commissioners, a show  
10 of hands.

11 [Show of hands.]

12 DR. PERLIN: Yeah, that's a process measure, not  
13 an outcome measure, and I assume you didn't want to  
14 experience the outcome measure. But I think we just proved  
15 that there is an intense link between the process and the  
16 outcome. And so if there are areas where the evidence is  
17 really compelling, it's not a bad reason. And, by the way,  
18 I didn't risk-adjust for who's a good driver or bad driver  
19 among us, so he gets a bye on this one. And that proves  
20 the point. Not all measures apply to all folks.

21 A final issue is that I do think there's a role  
22 for developing sort of information or experimental or

1 learning measures, and I really like Dana's notion of  
2 expanding our concept of differentiation through novel  
3 approaches such as net promoter score. In fact, you know,  
4 I think when we think about the generations that will be  
5 aging into the Medicare program and increasing familiarity,  
6 I just think of my nonagenarian father who was scanning  
7 Open Table for reviews. I think we need to think about the  
8 ways in which consumers communicate with each other in  
9 other domains and hope that there is some room not for  
10 accountability measures but for a dialogue that creates an  
11 opportunity for learning measures that may, in fact,  
12 achieve a level of evidentiary support that allows them  
13 ultimately to become accountability, but perhaps equally,  
14 if not more importantly, help consumers to become informed  
15 about meaningful differences amongst their choices.

16 Thanks.

17 DR. CROSSON: Let me just make one comment,  
18 because I thought, Dana, that you were going there, and Jon  
19 almost as well. But in thinking about, you know, the  
20 measures that we use, there is a difference between  
21 measuring an MA plan's performance and measuring a  
22 hospital's performance in the sense that the hospital,

1 we're really measuring clinical -- you know, we're heading  
2 towards clinical outcomes.

3 In the case of MA, we've got that, but we also  
4 have the insurance functions, whatever you want to call  
5 them, that the MA plan itself is responsible for and should  
6 be accountable for to the consumers or the beneficiaries.

7 DR. PERLIN: Can I come back on that point?

8 DR. CROSSON: Yeah.

9 DR. PERLIN: Yeah, I think your point is well  
10 taken, and there are some measures that relate more to the  
11 administration. And I neglected to say I think there's one  
12 other aspect, which is that we've had a penchant for  
13 measuring points or specific services as outcomes. I think  
14 the other area of experimentation, particularly for an  
15 insurance function, where I thought you might be going, is  
16 integrating a variety of services potentially from  
17 different providers over time may require a bucket of  
18 measures that look more like episode measures than perhaps  
19 the types of measures we've been using, again, parsing  
20 those perhaps into the learning set.

21 Thanks.

22 DR. CROSSON: Okay. Further -- do you want to

1 comment on that again?

2 DR. SAFRAN: Commenting on that, you know,  
3 there's an exact parallel on the commercial side with NCQA,  
4 and, you know, the NCQA annual ratings of health plans  
5 include a percentage that is based on hundreds of NCQA  
6 standards that are burdensome to report, you know, take a  
7 lot of effort and resources to improve, but they're core  
8 health plan functions that probably the general public  
9 couldn't give a hoot about. But, you know, they do get  
10 rolled into what NCQA does when it gives its ratings of  
11 health plans, and they're very important things. So I  
12 think that, you know, your point, Jay, about the insurance  
13 function and needing that to be included here is part of  
14 what maybe both Jon and I were getting at, but saying, you  
15 know, not so fast with getting rid of measures.

16 DR. CROSSON: Further commentary? Brian.

17 DR. DeBUSK: First of all, thank you for a great  
18 chapter. It was certainly well done and gave us a lot to  
19 think about. I really applaud the technical fixes that you  
20 identified. I have to admit, in a blanket statement I  
21 agree with all of them. I really think that getting the  
22 geographic unit right, though, going to a MedPAC unit, is

1 probably going to be the linchpin of a lot of the things  
2 that you're proposing here, because I think that's -- you  
3 know, as we go forward and start doing some of this peer  
4 grouping and risk adjustment, we have to have the units --  
5 sort of I digress for a second, but it makes no point in  
6 trying to measure SSI percentages for the purposes of peer  
7 grouping if you're going to spend three-state non-  
8 contiguous states. So I do think that getting that  
9 geographic unit right may be a real linchpin.

10           But I doubly applaud the larger effort that  
11 you're looking to harmonize this, you know, in terms of the  
12 selection of population health-based -- you know, a small  
13 number of population health-based measures, the peer  
14 grouping mechanism, the use of prospective targets. It was  
15 really nice to see some familiarity as you were proposing  
16 these changes, trying to see the bigger picture and address  
17 the technical fixes at the same time. I really, really  
18 like that.

19           The one I wanted to talk about, though, the  
20 EGWPs, it felt like you were going to try to segment the  
21 EGWPs and the plans with like the D-SNPs and things into  
22 different compartments, like entirely different data sets.

1 I'm just curious to see if we could put them -- if we could  
2 treat them as one, but then in the peer grouping mechanism  
3 stratify them, say, on SSI percentage and just see if  
4 they'll sort themselves out from there, because, you know,  
5 there could be some subtle differences.

6           What if I have a look-alike plan that emerges  
7 that, you know, really should be a D-SNP but it's a SNP  
8 because all the changes to the recommendations we made --  
9 well, the things we discussed yesterday came through. I  
10 mean, you can imagine that it might be hard just to simply  
11 say, well, this is an EGWP and -- I mean, would an EGWP  
12 that served, say, your lower-income people look a lot like  
13 an ordinary MA plan?

14           So my one thought would be, if we could just lump  
15 them all together, broken out appropriately by MedPAC  
16 geographic unit, stratify them based on SSI percentage, and  
17 just see if the peer grouping mechanism -- I'm not saying,  
18 you know, do that at all cost. But it would be interesting  
19 to have an initial look and see if peer grouping alone got  
20 us over that hump.

21           The other thing I noticed, it was kind of a  
22 clever sleight of hand because the peer grouping mechanism

1 that I thought I heard you propose wasn't just SSI  
2 percentage. It was SSI and percentage of disabled. It  
3 almost sounded like we shifted toward a composite measure.

4 MR. ZARABOZO: That is the current MA system.

5 DR. DeBUSK: Right.

6 MR. ZARABOZO: Right.

7 DR. DeBUSK: But if we're going to use that in  
8 peer grouping, you know, we're not going to use it in the  
9 index, and the determination of the index to make the  
10 adjustment, I'm under the impression that we're going to  
11 peer group to make the adjustment going forward. Or was  
12 that just wishful --

13 MR. ZARABOZO: Well, I mean, you can peer group,  
14 you can say for -- you can combine the two and say the peer  
15 grouping would be based on -- well, the extreme would be  
16 percent of EGWP, percent of low-income, percent of  
17 disabled, that's what determines the peer grouping.

18 DR. DeBUSK: I thought it was -- it was nice to  
19 see us move toward a composite measure because, you know,  
20 you could be critical of using just SSI percentage for your  
21 peer grouping mechanism. I'm just wondering if you go to a  
22 composite measure, put all the data together, and then

1 stratify into deciles as opposed to having three separate  
2 compartments or trying to treat EGWP as a parameter. Does  
3 that make sense?

4 DR. MATHEWS: Brian, I think this is something we  
5 can absolutely entertain. We'll go back to the office and  
6 figure out, you know, the analytics here.

7 DR. DeBUSK: Okay.

8 DR. MATHEWS: And I think our tentative plan is  
9 to come back in the spring, and we may have something for  
10 you there.

11 DR. DeBUSK: Okay. Out of the weeds then. All  
12 good.

13 Let's see. Final point. I really do have a  
14 large bias toward using domains that can cut across the  
15 different payment systems. So, for example, when you were  
16 talking about the readmission measure, if the random  
17 effects model is what they're going to go with, I think we  
18 should probably go with it across both payment systems. So  
19 there needs to be a large bias toward that.

20 And then, finally, on the bottom of Slide 14, I  
21 do support the budget-neutral component. I think, to  
22 Paul's point, that's a good idea.

1 Thank you.

2 DR. CROSSON: Okay. Pat.

3 MS. WANG: Again, great work. Just going through  
4 this somewhat, the issues that you've outlined, on the  
5 cliff and the plateau issue, I agree with the others, the  
6 cliff is a terrible thing, and I actually think it's driven  
7 some of the contract consolidation work because it's such  
8 an all-or-nothing, so continuous scale for bonus payments,  
9 all for it.

10 Tournament model, you know, I appreciate Paul's  
11 comments on this, but I will tell you, at least from a sort  
12 of like having experienced it, it's -- I understand what  
13 Paul is saying in theory. If you actually look at the  
14 changes in the cut points on certain measures year to year,  
15 though, they're just not explicable. And I think that that  
16 is part of the puzzlement. You know, if CMS is -- you  
17 know, we've seen double-digit jumps in, you know, cut  
18 points for certain measures that seem impossible, and I  
19 don't know on a population health basis how you'd make that  
20 kind of -- how you achieve that kind of change in a year.  
21 So the CMS proposal may be to at least put parameters  
22 around content changes. It's really an issue. You know, I

1 appreciate what Paul is saying, and you pointed out the  
2 difficulty with one of the measures in setting a set  
3 threshold. But there's probably something in between  
4 there.

5           The EGWP issue is really an interesting one. The  
6 solution that you suggest in here makes sense. I would  
7 just note that there are other subsets of Medicare  
8 Advantage that you could -- I would suggest further  
9 examination. I mean, you had noted something about the  
10 EGWP and the disenrollment and the irrationality. You  
11 know, the fact that if you're an employer group program,  
12 you're not disenrolling because your employer is saying  
13 this is the plan you're in, this is how you get your  
14 benefit. And the strangeness of excluding the  
15 disenrollments from the numerator for EGWP but leaving them  
16 in for the denominator are things that -- I just would --  
17 it raises the issue that even underneath that, there are  
18 other subsets. So if you're a D-SNP, there is -- starting  
19 in 2019, you can change plans every quarter. If you're an  
20 I-SNP, you perform really, really well on the readmission  
21 measure because all of your members are custodial in a  
22 nursing home. There are differences like that also that

1 drive some of the cut points for the different star levels,  
2 and I think it's worth looking at.

3 CAHPS, thank you, because every year we've looked  
4 at this and said this just doesn't make any sense. There's  
5 like a point difference between the different star levels.  
6 I am with Dana in sort of wanting to figure out if there's  
7 a better way to capture the member experience of care, but  
8 the CAHPS survey to me is -- and this just is hanging the  
9 bell on the cat. It's irrational to assign a star level --  
10 I'm not even comfortable with the potential solution that  
11 you put forward, which is to sort of say if you're below  
12 this level, you're 1, and everybody's in the middle, and  
13 then there's a 5.

14 If you look at Slide 10, the difference that  
15 separates 1 star to 5 stars on CAHPS customer services, 4  
16 points. That's barely significant. And to say if you're  
17 at 88, you're 1 point, and if you have 4 points -- that  
18 doesn't make sense. I mean, I think in the short term,  
19 this is a star measure that is weighted at 1.5. I would  
20 down-weight it because of the unreliability of this  
21 phenomenon and work towards something better.

22 On HOS, I think it's a similar -- again, you

1 know, the sample size is so small. HOS is very important,  
2 and I think that it's something that plans look at for  
3 signals about what's going right, what's going wrong,  
4 where's there a potential issue. But when sample size is  
5 so tiny that, you know -- and I can speak from the  
6 experience of a plan -- is so small that the 90 percent  
7 confidence interval includes both the 1-star and the 3-star  
8 cut point, and the plan is assigned 1 star, you just  
9 question the validity of that result. So there's got to be  
10 a better way to either get a better sample size or have a  
11 better measure of that.

12           On readmission measures, this is very, very  
13 important, and I think that you raised something very  
14 important with the issue around death. The one thing I'd  
15 urge us to think about with the readmission measure is to  
16 try -- this is one where hospitals really are getting  
17 signals from their own fee-for-service readmission  
18 incentive program, and to the extent that we possibly can  
19 align the readmission measure with what hospitals recognize  
20 as their performance or their score in fee-for-service, it  
21 would be really important.

22           So right now, obviously, you know, in MA plans

1 it's all-cause. In fee-for-service it's certain  
2 conditions. Fee-for-service, thankfully, moved to peer  
3 grouping, but I had to spend a lot of time on the phone  
4 with a very important provider serving a very underserved  
5 community who as a result of the first round of peer  
6 grouping said, "I just got my results, and I am at the  
7 top," you know, "And how come you're telling me that I've  
8 got all of these problems?" Just trying to even explain  
9 through that thicket of people who are busy, you know,  
10 trying to do the best for their patients, like it's  
11 measuring this, it's measuring that, it's peer-grouped,  
12 it's not peer-grouped.

13           You know, I wonder when we talk about the very  
14 important topic of SES whether we can build on some of  
15 those things. For example, in the readmission measure, if  
16 there's a recognition that the hospitals are in peer  
17 groups, maybe we can adapt that construct in developing the  
18 star measure that plans are evaluated on rather than coming  
19 up with something completely different, simply to make the  
20 conversation with very busy providers easier. In the short  
21 term, though, the idea of excluding outliers, as you  
22 describe on Slide 11, I think is really a good idea.

1           Moving towards budget neutrality and looking at  
2 the recommendation on Slide 13, you know, I appreciate the  
3 response that you provided before, Carlos, because when the  
4 Commission developed this approach, we have to really  
5 remember something. The way of setting MA plan premiums  
6 was completely different than it is now. There was one  
7 approach that applied to all plans in the country, whatever  
8 it was, the AAPCC or whatever it was. Bruce will remember.  
9 There is now a variation of benchmarks that plans bid  
10 against, from 95 percent to 117 percent, 115 percent of  
11 fee-for-service that, candidly, has no scientific or  
12 empirical basis. It was a political -- you know, that was  
13 what the ACA kind of produced at the end, and I think that  
14 it was being negotiated up until the end.

15           I think that the discussion of budget neutrality  
16 and kind of redoing the concept of the bonus is a very  
17 important discussion, but that it really has to be  
18 accompanied by a reexamination of fundamentally how the  
19 benchmarks work, and in Carlos' response, he sort of  
20 posited everybody is at a 100 percent-ish benchmark to fee-  
21 for-service. And then you can start talking about a  
22 rational way to make it budget neutral and do withholds and

1 paybacks. But absent that, I would just caution us from  
2 kind of making an irrational situation with the current  
3 benchmark system worse.

4           The points that you made about the measurement at  
5 small areas, especially for the CAI, which is sort of the  
6 SES adjustment now in MA, were really important, and I  
7 think that the issue of sort of small sample size and, you  
8 know, the contract consolidations, geographic limitation  
9 would help. But I would just, you know, underscore the  
10 importance of moving to even better SES adjusters. ASPE is  
11 working on this; others are working on this. And, you  
12 know, I think perhaps at some point we can get past the CAI  
13 and on to better measures, and I think that we need to keep  
14 pushing on that.

15           Finally, I agree with the comments made before  
16 about trying to really recommend an end date for the low  
17 enrollment plan phenomenon and the new plan phenomenon. I  
18 think it invites gaming, and it's just not a good thing.

19           And I think that was it for my comments, so thank  
20 you. Also, I do agree with the comments that Dana and Jon  
21 made and that Jay brought out. An insurance company is not  
22 a provider, and I think that we have to be careful about

1 assuming that the approaches towards quality metrics for  
2 providers just translate. There are -- HEDIS and many of  
3 the Star measures I believe have really improved care for  
4 beneficiaries, and they particularly have in the case of  
5 plans that are sort of getting the credit for it themselves  
6 as opposed to getting the credit for work that was done by  
7 a plan on the other side of the country. But I don't want  
8 to lose sight of the fact that just because we're very  
9 discouraged by the contract consolidation phenomenon -- as  
10 a regional plan, I've been hurt by that, and I think that  
11 it's distorted the whole discussion around stars. But  
12 underlying that, it's important work for plans to keep  
13 doing.

14 Thanks.

15 DR. CROSSON: Okay, thank you. Kathy.

16 MS. BUTO: Okay, so I'm going to express a  
17 minority view, which is I am not a fan of quality bonus  
18 plan approaches. In other words, I think Medicare has a  
19 lot of bonus programs. I think what Medicare doesn't do  
20 very well is set quality standards and then hold everybody  
21 or all plans to those standards. That would be my  
22 preference, recognizing that's difficult to do. But I

1 especially am troubled by them when they don't affect,  
2 don't seem to affect beneficiary choices. So the original  
3 intent, which was to provide information to help  
4 beneficiaries choose plans, doesn't seem to be realized,  
5 yet at least.

6           And so as I look at the paper, which I thought  
7 was brilliantly done, I wondered if we could flesh out the  
8 budget-neutral approach further, because I note the  
9 original work was done in 1999, but it seems to me that the  
10 idea of really trying to move the bar and reward  
11 exceptional performance and penalize subpar performance is  
12 something we should seriously look at.

13           I think a lot of these other changes are  
14 important, but it strikes me we'll be in the same situation  
15 where most plans -- or most beneficiaries in plans will be  
16 in plans that meet the new criteria and then sort of where  
17 are we.

18           The other thought I had -- and I really liked  
19 Dana's suggestion about sort of the, I guess, net promoter  
20 score -- is that what you called it? And Pat mentioned as  
21 well other measures that would capture beneficiary  
22 experience better. Jonathan and I were calling it the

1 "Yelp measure," something that would actually help you make  
2 these choices, and that people would look to.

3           So as I think about a withhold system, a budget-  
4 neutral system, and I think somebody mentioned that ACOs  
5 are moving in that direction, if we were to pursue that  
6 approach for MA -- recognizing I think Pat has brought up  
7 some important points about some of the limitations, given  
8 the way the payment for MA plans is structured under ACA.  
9 If we were moving in that direction, I think we ought to  
10 consider possibly a half percent or some smaller withhold  
11 from fee-for-service payment that would not be available  
12 for bonuses, that would be a withhold to go into payment  
13 for high-performing managed care plans or plans that better  
14 manage beneficiary care -- again, the idea being to try to  
15 migrate some of the incentive for providers to join more  
16 organized plans.

17           So just a thought. As long as we're thinking  
18 about withholds in the managed models, I think we ought to  
19 consider that. And some of that could go back into, say,  
20 the hospital readmissions reward system or other fee-for-  
21 service systems or just be withheld and then redistributed  
22 through more managed approaches.

1           So those are my thoughts, and I really like the  
2 work here, but I would like to see us think about a more  
3 robust system that would try to move the bar and reward  
4 high performers and penalize low performers.

5           DR. CROSSON: Jon.

6           DR. JAFFERY: I want to reiterate my support for  
7 trying to move to better alignment with the ACO metrics,  
8 and I appreciate the points that have been made about some  
9 specific health plan metrics that we shouldn't lose sight  
10 of.

11           I don't know that I would see that it would be  
12 absolutely necessary that we have 100 percent alignment  
13 between ACO measures and the MA measures, but the more that  
14 that Venn diagram has overlap, I think would be  
15 advantageous and not just so that we could do comparisons  
16 or even beneficiaries might be able to make comparisons.  
17 But provider groups are increasingly taking care of  
18 beneficiaries who are in both ACOs and MA plans, obviously  
19 not an individual beneficiary, but they have patients in  
20 their practices in both types of programs.

21           Being able to align towards improvements in the  
22 measures that are very related to clinical care would be, I

1 think, helpful for -- good for beneficiaries, helpful for  
2 providers, and frankly helpful for the MA plans as well who  
3 sometimes struggle to move those measures when they're  
4 really dependent on the provider groups.

5           Just a couple other quick points. I would be  
6 very supportive -- I am very supportive of the smaller  
7 geographic units. I'm not sure what the best approach is,  
8 but I think in the absence of anything right now, the MSAs  
9 and health services areas seems to make some sense.

10           Then in terms of budget neutrality and maybe to  
11 follow up on a couple of Kathy's points, looking at this  
12 and talking about reasonable equity between MA and fee-for-  
13 service, I think we do want to get there and move more in  
14 this direction, but again, that doesn't get us to real  
15 equity in the ACO programs, which are now operating on  
16 either some sort of withhold of which you can maybe get up  
17 to 100 percent benchmarked against yourself of that back.  
18 And, generally speaking, I think programs don't get quite  
19 100 percent, the way it's structured, or you have some sort  
20 of small reduction in your shared savings, a percentage  
21 based on your quality scores.

22           It is a different model than even I think what's

1 proposed here. Over time, I'd like to see those things  
2 come together more consistently.

3 DR. CROSSON: Great.

4 Bruce.

5 DR. PYENSON: Well, thank you. This is very  
6 thought-provoking. My compliments to you, Carlos.

7 I'd like to convince my fellow Commissioners to  
8 try to look at this almost backwards from the ultimate  
9 results of what we're calling quality measures and how that  
10 flows into the bid process that drives whether a health  
11 plan survives or not or makes money or not because the  
12 particular quality measures, which are often put together  
13 with an embroidery needle, are averaged, scored with  
14 questionable data and fed into a vast engine called the  
15 annual ritual of the bid process, where a health plan  
16 struggles to produce a rebate that a bid below the  
17 benchmark that it can use to provide extra benefits and get  
18 members.

19 And that's the financial consequence of these  
20 decisions, that a health plan -- not so much the  
21 profitability. That's there, but the ability to provide  
22 those extra supplemental benefits to buy down the Part D

1 premium, all of that is the ultimate result of a plan star  
2 rating, and that's a very onerous, difficult process, an  
3 iterative process. It goes through lots of cycles  
4 annually.

5           And if we think about that and the kinds of  
6 incentives it's created for plans, the MA plans that do  
7 well on that have a lot of really smart people looking for  
8 every angle they can and working intensely to model the  
9 different options and the different opportunities and the  
10 different threats in that process.

11           So while we're talking about a particular measure  
12 that might be -- we're arguing whether or not it affects  
13 quality. The ultimate -- the reason MA plans care about  
14 that is the ultimate bid process.

15           So, if we start from that kind of approach, I  
16 think we can resolve many of the issues along the lines of  
17 the short- to medium-term solutions, but also come up with  
18 a much, much better system of developing bids that would  
19 actually really do something to promote quality faster.

20           I think this is very much connected with the next  
21 presentation on encounter data because this could all, in  
22 my opinion, be driven by encounter data if we only had it.

1           So I'm sympathetic with a lot of what was said.  
2 I think it's a great discussion, but if we flip this on its  
3 head and have a bit more information, almost looking  
4 backwards at what Carlos characterized as out there on a  
5 different way of doing bids, I think we can go backwards  
6 and really fix the system.

7           DR. CROSSON: Okay. Further comments?

8           David.

9           DR. GRABOWSKI: Great. Thanks, Carlos, for a  
10 great chapter.

11           I agree with others that the Medicare Advantage  
12 quality bonus program is broken, and I like a lot of the  
13 fixes that we've been discussing.

14           I wanted to push us a little bit on what's the  
15 goal here, and I've kind of heard two goals. The first --  
16 and I think that's the main focus of the chapter -- how do  
17 we create a better mousetrap? How do we create a better  
18 measure to use to award plans?

19           There's also some discussion -- and Karen and  
20 others have picked up on this -- as how do we create a  
21 measure to help beneficiaries choose higher quality plans,  
22 and the point I want to make is you could fix the first and

1 do very little about the second.

2           And I think Dana is pushing us in this direction  
3 with your net promoter score.

4           I think this goes beyond measures, however, that  
5 we could even get the measures correct, and still, there's  
6 a lot of other barriers here, the complexity of the  
7 decision, decision aids, the choice architecture.

8           So I would push us to think a little bit more  
9 about how MA beneficiaries or beneficiaries more generally  
10 choose plans. What are the variables that go into that?  
11 Are they actually using the star rating, and would they use  
12 a star rating even if it was one that sort of reflected  
13 measures that they care about?

14           I think the problem is probably deeper than that,  
15 so I just want to have us kind of think more broadly about  
16 kind of choice here and quality from a beneficiary  
17 perspective.

18           Thanks.

19           DR. CROSSON: Jon.

20           DR. CHRISTIANSON: Yea. Just a couple of  
21 comments on the comments.

22           Back to Paul's comment on tournament models, I

1 think you did a good job of talking about what the pluses  
2 of tournament models are. In the private sector, the world  
3 is littered with fee-for-service-based, pay-for-performance  
4 programs that have used benchmarks and found that the  
5 payers are not happy because they find they're paying for  
6 historical quality, but they're not seeing the improvement  
7 at the low end that they had hoped for.

8           But I think that just kind of illustrates, in my  
9 opinion, at least sort of a false dichotomy to say we're  
10 going to have to use benchmarks or tournament. So I think  
11 the private sector, it's usually a meld between the two,  
12 some sort of incentives to reward the low-end performers  
13 for improving, but at the same time acknowledging that  
14 really high-end performers can't improve much. But we want  
15 to reward them for being high-end performers, and that's  
16 where the benchmark comes in.

17           So we need to think about not is it benchmarks or  
18 is it tournament, but is there some combination again, as  
19 Paul, I think, pointed out, depending on the type of  
20 measure where we can be smarter about designing or  
21 recommending rewards?

22           Then I want to go back to Karen's earlier comment

1 in the question period, which I think was right on target,  
2 the comment about, well, do brokers use these stars in  
3 their recommendations, and it's not just that.

4           The way we sort of get this information about how  
5 stars are used is through specific surveys where the  
6 questions tend to be "Have you seen X?" and then "If you've  
7 seen X, have you used X?" So we sort of funnel down, and  
8 what we miss there are situations where people are getting  
9 advice from others.

10           Do people go to hospitals and compare websites to  
11 look at X? Is that how I ask a question? US News and  
12 World Report has a comparison among health plans, and they  
13 distill their comparison down from the Star System, so  
14 maybe that. Maybe you go to your neighbor, Jerry, and say,  
15 "What plan are you in?" and Jerry tells you. And you  
16 always trusted Jerry, so you go with Jerry's plan. Jerry  
17 might have used the Star system. That doesn't turn up in  
18 the survey.

19           So, in some ways, when you look at these survey  
20 results, you've got to think of them as really baseline  
21 data on how useful these stars are, how they're used in  
22 terms of choosing plans.

1           Paul probably wouldn't be happy about that if we  
2 don't think the start system really represents something we  
3 want people to choose plans based on.

4           The other thing is more along David's line, which  
5 is this is a very confusing and time-intensive choice on  
6 the part of beneficiaries. If you think about it, it's not  
7 do we want to choose one MA plan versus another and let's  
8 go look at the stars. It's there's traditional Medicare,  
9 and there's a supplemental plan, and then there's a drug  
10 plan. Then when we put that together, let's compare it to  
11 our Medicare Advantage plan, and we want to get the drug  
12 plan through that.

13           By the time you go through all of this, how  
14 important do we really expect or want that Star system to  
15 be in people's choice?

16           Then the choice costs are very high. Who is in  
17 play at any given year, it doesn't really make sense for a  
18 lot of beneficiaries to go through this process every year.  
19 It's just too expensive relative to the benefits for them.

20           So back to what you were saying, David, I think  
21 it's a very complicated overall process, and we sort of get  
22 hung up in the stars.

1           The other thing about stars is there are two  
2 components, two things we might want to have happen. We  
3 want people to -- if they were good measures of  
4 performance, to start into high-star plans. Great.

5           The other thing we'd like plans to do is compete  
6 for beneficiaries where part of that competition is based  
7 on stars. We don't have to have everybody choosing based  
8 on stars to have robust competition. In any market, if you  
9 have a few well-informed consumers that are in play, you  
10 have an incentive for people to deliver a better product.

11           So who knows? If 12 percent of people say they  
12 choose based on the Star system, that may be enough for  
13 this second thing we want to have the Star system to  
14 accomplish, which is to get plans to compete based on  
15 quality.

16           So I think it's a really complicated situation  
17 here, and I think we need to get the Star system right, but  
18 as David was saying, it's part of a much broader issue that  
19 we probably need to address in a more comprehensive manner.

20           DR. PAUL GINSBURG: Yeah. I've heard a lot of  
21 really good comments around the table, and something Jon  
22 said just made me think to bring up the point that usually

1 when we talk about consumers' better information, we're  
2 initially mostly concerned that the market is driven to  
3 produce value, quality. We're not so concerned that each  
4 individual consumer makes the right decision, and we may  
5 find tradeoffs in this area between making sure the plans  
6 have the right incentives and being as helpful as possible  
7 to a large number of consumers.

8 I think Jon's point that basing something on what  
9 your neighbor recommends and the neighbor used the star  
10 rating, that's as good as you using the star ratings.

11 I had one other comment on what Pat said about  
12 the budget neutrality. I'm not sure that having the  
13 quartiles with the 115 down to 95 is a problem with that.  
14 If it was, I think it would be pretty simple to fix it, so  
15 that the 1 percent was based on the 95 percent rather than  
16 -- or the 115 percent rather than on 100 percent.

17 I think Carlos could probably figure that out so  
18 that that's not a problem.

19 I'm really glad I brought up the tournament model  
20 because they really had a lot of wise comments that I agree  
21 with. In addition to that being Pat's model on stability  
22 and commenting on stability, I think it's really important

1 that there be some stabilizers so that there aren't  
2 unexpected jumps in what cut points are from year to year,  
3 and that might make the tournament process much more  
4 acceptable to the people being rated as well as I think,  
5 hopefully, everyone else.

6 MS. BUTO: Jay, can we ask Carlos how many of  
7 these would require legislation versus can be done now?

8 DR. CROSSON: Sure.

9 MS. BUTO: Done now, given a year of rulemaking.

10 [Laughter.]

11 MS. BUTO: Do you know, Carlos? Are they all --

12 MR. ZARABOZO: Well, I would say rulemaking, in  
13 general, I think --

14 MS. BUTO: Including --

15 MR. ZARABOZO: The one about consolidation  
16 legislation.

17 MS. BUTO: Legislation, Okay.

18 MR. ZARABOZO: Yeah.

19 MS. BUTO: And the budget-neutral one would  
20 require --

21 MR. ZARABOZO: Yes. Sorry.

22 DR. CROSSON: Warner?

1 MS. TABOR: If the domains change.

2 MR. THOMAS: Just a brief comment. I mean, I  
3 agree with the alignment of the measures between especially  
4 the ACO models and MA because, as Jonathan indicated, from  
5 a provider perspective, it would certainly provide more  
6 ease.

7 And I would agree with Dana that, I mean, if you  
8 look at these measures, we are improving care, and we do  
9 continue to improve on these measures across the industry.

10 If you compare to traditional fee-for-service,  
11 not measuring these things -- we measure them in APMs. We  
12 measure them in MA. We don't measure them in fee-for-  
13 service, and think about how many people we have in  
14 traditional fee-for-service.

15 So we're sitting here kind of debating back and  
16 forth some of these measures, and I agree that they could  
17 be better. But then we have a whole large piece of the  
18 population that we really don't measure ambulatory quality,  
19 and there's really not a lot of risk associated in the fee-  
20 for-service area.

21 I mean, we've got MIPS now, but it's not  
22 material. It's not as significant as what you're talking

1 about here in MA.

2 I think having better alignment makes a lot of  
3 sense.

4 And I also agree with Pat's point that even when  
5 you get to a certain cut point and on the CAHPS measures, I  
6 mean, I think that's a key piece. If you get to a certain  
7 cut point, maybe you're good enough. Maybe that extra  
8 point or two points between a 3-star and a 5-star and the  
9 CAHPS are probably not a material change in the experience  
10 of the member, frankly. So I think this idea of you've got  
11 to hit a certain threshold, and maybe you're high enough.  
12 I think that's something that we need to think about,  
13 especially when we have such a tight range.

14 I mean, going from a 1-star to a 5-star and  
15 having four points, that's -- I mean, it's pretty hard to  
16 discern that from an experience perspective. So I think  
17 those are things that need to be looked at as we finalize  
18 the chapter.

19 DR. CROSSON: Dana.

20 DR. SAFRAN: Just a couple of quick reactions to  
21 those important points.

22 One is that on the last point that Warner was

1 just making, one of the things that we've done -- and we do  
2 use absolute performance targets, as I've talked about  
3 before -- is that as the gap between the Gate 1 target and  
4 the Gate 5 target starts to get very small, we do just  
5 shift to having like one target and call it Gate 5. You  
6 have that cliff issue, so you have to deal with that  
7 carefully, but I'd be happy to share sort of offline how  
8 we've handled those and how I think it's played out in  
9 terms of provider response. Do we see like erosion of  
10 performance and kind of what happens?

11 But the stability point of having absolute  
12 targets and the willingness to share best practices has  
13 been one of the really important benefits of everybody  
14 having the same performance targets and knowing they will  
15 not change over the X years of the contract -- in our case,  
16 five -- and that Gate 5 represents the outer limit of what  
17 is empirically shown to be possible to achieve. So we  
18 don't have to worry that we're settling for mediocrity.

19 The other thing I just wanted to say, because I  
20 think it's important, it relates a little bit back to our  
21 conversation yesterday, where we were saying like should we  
22 care whether the MA plan passes on risk or shares risk with

1 a provider organization.

2           There was something in what Warner was just  
3 sharing that reminded me to share with all of you that in  
4 our experience with our MA plan providers, some are at  
5 risk. Most are not. And my team is responsible for the  
6 ways that we share performance improvement data, and we do  
7 a lot of that on the commercial side.

8           And I just heard two weeks ago from my team that  
9 for over a year, we've been sharing the same kind of gaps-  
10 in-care data with our providers for Medicare Advantage, and  
11 the providers aren't even pulling down the lists.

12           So it just does strike me that, yes, these  
13 measures matter, and plans, I can tell you work like crazy.  
14 It's very competitive right now to try to perform well on  
15 Stars. Getting four stars and getting the bonus that is  
16 associated with that is extremely important. Getting five  
17 stars and having an open enrollment period all year long,  
18 very important, though some plans worry about whether that  
19 will bring them adverse selections, so just to share that  
20 perspective.

21           But we should not kid ourselves and think that  
22 these things don't matter and plans aren't working on them.

1 I think they're working hard on them. I think you've heard  
2 a lot that there are aspects that matter, and there is this  
3 interesting data point that we have that our providers are  
4 hungrily gobbling up all the data we give them on the  
5 patients where we have put them at risk or created  
6 incentives and not even looking at the data we're sharing  
7 with them, where we're not offering those benefits.

8 DR. CROSSON: Okay.

9 DR. DeSALVO: I just want to second that last  
10 point that Dana made, and that's all I'll say.

11 DR. CROSSON: Okay.

12 DR. DeSALVO: The provider risk really matters.  
13 I missed yesterday, but I would think we have to consider  
14 the whole continuum and the integration of services.

15 DR. CROSSON: Okay. Marge.

16 MS. MARJORIE GINSBURG: I wanted to just comment  
17 briefly on the topic of the consumer being the wise  
18 decision-making about what plan, what type of plan they  
19 join.

20 I know that MedPAC does a lot of research and a  
21 lot of focus groups, often with clients themselves, and I  
22 speak with all bias as a SHIP counselor to ask whether --

1 and suggest you do if you haven't -- whether you've ever  
2 done really targeted surveys or focus groups with the  
3 people that run the SHIP programs in various parts of the  
4 country because they are the ones.

5 I mean, I can tell you, of my clients, what do  
6 they ask about when they're newly enrolled in Medicare,  
7 about how they make their decision if they're newbies or  
8 what their issues are when they need to change their mind  
9 or they move to the area and they're brand-new?

10 But it's the people who run the SHIP programs and  
11 who have hundreds, if not thousands of case examples of how  
12 people -- what they think about when they make their  
13 decisions because everybody knows the SHIP programs are  
14 completely nonpartisan. We're not there to direct but to  
15 give them the tools to decide.

16 So that's really a question for you Carlos. Have  
17 you talked to SHIP programs before on this area about how  
18 consumers make decisions?

19 MR. ZARABOZO: We do talk to SHIP counselors.  
20 For example, one comment was, well, we used the starts as  
21 tiebreakers. So if we have two plans that are seemingly  
22 good for the beneficiary, if one has a better star rating,

1 then they'd point out it's a better star rating. But we do  
2 talk to SHIP counselors on these issues, yes.

3 DR. CROSSON: Okay. I know we've run over  
4 significantly. I think we'll be able to catch up in the  
5 next discussion. That will be interesting to watch.

6 But I do want to make a couple of comments to add  
7 a little perspective here. On the issue of moving to  
8 budget neutrality, I was actually here on the Commission in  
9 2004 when we first put the issue of Medicare bonuses on the  
10 table in a boldface recommendation to Congress.

11 The thinking at that time was relatively simple.  
12 We were embarking at that point in a multiyear attempt to  
13 bring the revenue in Medicare Advantage into alignment with  
14 fee-for-service Medicare. In fact, it had exceeded -- that  
15 what Medicare was paying through Medicare Advantage for the  
16 care of beneficiaries had vastly exceeded the expenditures  
17 in Medicare fee-for-service.

18 In so doing, I think the sense of the Commission  
19 at the time was if we're going to do that, don't we need to  
20 make some statement about quality? And, in fact, while  
21 over a period of years, resources were being pulled away  
22 from the MA plan -- and I think appropriately so -- would

1 there be a place for a counter -- a set of counter-  
2 incentives for plans to focus their resources on quality?  
3 And this is consistent with, I think, positions that the  
4 Commission has taken on almost all issues.

5           What transpired subsequently -- so the idea was  
6 relatively simple, as has been laid out. It was let's do a  
7 withhold, a budget-neutral payment that could be  
8 redistributed, and the intent at the time was to a  
9 relatively circumscribed number of plans who were really  
10 exceptional in quality. That was the idea that we had at  
11 the time.

12           As this has evolved over the last 14 years, as a  
13 number of people have pointed out, it's become quite  
14 different. If you had asked me in 2004, do we intend for  
15 75 percent of plans to receive extra payments above and  
16 beyond the baseline? Not at all.

17           Now, that having been said, I think as Pat  
18 pointed out, much has changed in the way Medicare Advantage  
19 is being paid over that period of time as well.

20           So I just want to make clear to everybody that  
21 there's some aspects of this we have not discussed here in  
22 terms of if we go to budget neutrality, what is the

1 baseline revenue assumption that would be used in then  
2 setting that new program and that new budget-neutral  
3 program? We do need to discuss that.

4           And I would draw your attention to the last two  
5 lines of the final bullet point there, which is as we move  
6 in that direction, it's going to be essential that we do it  
7 in a way that is consistent with our fundamental principle  
8 that we are trying to move towards an environment in which  
9 there is -- and you can use different terms here, a "level  
10 playing field" or "reasonable equity" among the different  
11 Medicare payment mechanisms. Jonathan, I would include  
12 ACOs in that.

13           As we move forward with this -- and I think we're  
14 going to come back in the spring, Jim; is that right? I  
15 just want to point out that this will require due  
16 consideration to how we do it and what the impact is, and  
17 that it's consistent with our long-term goals that we've  
18 expressed many times over many years for this idea of a  
19 level playing field.

20           With that, thank you, Carlos, for an excellent  
21 chapter, and this was a great and detailed discussion.

22           We'll move on to the final presentation.

1 [Pause.]

2 DR. CROSSON: Okay. So are you guys ready?

3 We're going to move ahead to an issue we've been discussing  
4 for a number of years here and that is the current state of  
5 Medicare Advantage encounter data and what could be done to  
6 improve that and speed it along. Andy and Jennifer in  
7 here. Jennifer is going to start off.

8 \* MS. PODULKA: Great. Thank you. Today Andy and  
9 I will present information on Medicare Advantage encounter  
10 data, and this is in follow-up to the more detailed  
11 presentation on these data that we gave this past April.  
12 We will begin with background on how the data came to be  
13 collected and summarize the findings from our efforts to  
14 validate the encounter data files. We will discuss the  
15 expected outlook for encounter data going forward. And  
16 finally, we will introduce some proposed policy options for  
17 the program for your input.

18 And first, though a note on terminology. MA  
19 organizations sign contracts with Medicare to deliver the  
20 MA benefit to enrollees. These contracts can include one  
21 or multiple plan benefit packages, and all of our analyses  
22 were conducted at the contract level, but we will also use

1 the terms "MA organization" and "plan" interchangeably  
2 today.

3 MA encounter data have a long history that began  
4 with the Balanced Budget Act of 1997, which required the  
5 collection of encounter data for inpatient hospital  
6 services and also permitted the Secretary to collect  
7 encounter data for other services. Efforts to collect  
8 these data proceeded with some starts and stops.

9 Then, in 2008, CMS amended MA regulations to  
10 resume collection of detailed encounter data for all  
11 services from the MA organizations for risk adjustment and  
12 other purposes. Finally, in January 2012, CMS began  
13 collecting such data from plans.

14 We now have access to MA encounter data for 2012,  
15 '13, '14, and preliminary files for 2015. The preliminary  
16 files for 2015 are the same data that CMS recently released  
17 for public use. Data are collected through each of the six  
18 provider types or settings shown here, and encounter data  
19 are similar to claims data in that they are expected to  
20 include diagnosis and treatment information for all  
21 services and items provided to enrollees.

22 We have validated the MA encounter data files to

1 determine if they are ready for use in various analyses and  
2 risk adjustment. Our methodology includes two main  
3 categories. First, we checked if each plan successfully  
4 submitted any encounter data for each of the six settings.  
5 We also compared the plans' reported enrollees to CMS's  
6 database that tracks MA plan offerings and beneficiaries'  
7 enrollment.

8           It is important to know that when plans submit  
9 encounter data, CMS's system performs automated front-end  
10 checks before accepting each record. Errors or problems  
11 cause the system to reject the submission, which means no  
12 record will appear in the encounter data files unless the  
13 plan resubmits the data. In other words, if encounters are  
14 not present in the data, we can't tell if that is a result  
15 of the plan not submitting or the system not accepting the  
16 record.

17           And for the second step of the validation, where  
18 available, we compared MA encounter data to other data  
19 files that include information on MA utilization. For  
20 these comparisons, rather than trying to validate all data  
21 elements, we instead focused on first- and second-order  
22 questions. First, we checked to see that the same

1 enrollees who received a service that is documented in the  
2 encounter data are also identified in a comparison dataset.  
3 And also, where possible, we checked that dates or service  
4 matched or were at least similar.

5           Our validation efforts found three broad  
6 categories of issues in the encounter data. First, plans  
7 are not successfully submitting encounters for all  
8 settings. In 2015, only 80 percent of MA contracts have at  
9 least one encounter record for each of the six settings.  
10 Second, the encounter data include a small number of  
11 records that attribute enrollees to the wrong plan. The  
12 paper goes into more detail, and the key takeaway is that  
13 this issue will require a change in data processing to  
14 address it. And third, encounter data differ substantially  
15 from data sources used for comparison. We will focus on  
16 this one on the next slides.

17           We compared the encounter data to other sources  
18 that document MA utilization, and these four are the  
19 independent or external data in that they are derived from  
20 information reported by providers, including hospitals,  
21 dialysis facilities, home health agencies, and skilled  
22 nursing facilities.

1           For 2015, 90 percent of enrollees reported in  
2   encounter data as having an inpatient stay were also  
3   included in data reported by hospitals. However, of these  
4   inpatient stays in encounter data, only 78 percent had  
5   dates or service that matched to the hospital-reported  
6   data. Similarly, 89 percent of enrollees reported in  
7   encounter data as having dialysis services were also  
8   included in data reported by dialysis facilities, and the  
9   enrollee match rates were 47 percent for home health and 49  
10   percent for skilled nursing.

11           There no independent data source for assessing  
12   the completeness of physician visits, outpatient services,  
13   and certain other Part B services. The best available  
14   comparison for some of these comes from Healthcare  
15   Effectiveness Data and Information Set or HEDIS, which is  
16   not an external data source but is based on plan summaries  
17   of their internal utilization data that they report to CMS.  
18   So we compared the encounter data to these three plan-  
19   generated sources that document MA utilization.

20           We found that 46 percent of MA contracts reported  
21   the same total number of physician office visits, plus or  
22   minus a factor of 10 percent, in both HEDIS and encounter

1 data. Match rates for emergency department visits and  
2 inpatient stays were lower at 10 percent and 27 percent,  
3 respectively. And for those contracts that report outside  
4 of this range of matching plus or minus 10 percent there  
5 were errors on both side, so contracts can report both  
6 extra encounter visits and extra HEDIS visits.

7           And now I'll turn it over to Andy for the next  
8 section.

9           DR. JOHNSON: I want to start by highlighting the  
10 value complete encounter data could have for the MA  
11 program. Detailed encounter data are the best vehicle for  
12 learning about how care is provided to MA enrollees. An  
13 important function of the program is ensuring that the  
14 Medicare benefit is administered properly to all  
15 beneficiaries.

16           Second, plans use flexible payment methods, care-  
17 management techniques, robust information systems, and  
18 beneficiary incentives to provide efficient care. We would  
19 like to evaluate these policies using encounter data in  
20 order to inform and improve Medicare policies.

21           Finally, administering the MA program requires  
22 the use of fee-for-service claims and many single-purpose

1 data submissions from plans and providers. Complete  
2 encounter data could replace several data collections and  
3 would ensure that the program relies on data that are  
4 internally consistent and conform to program rules.

5           Even though we found the 2015 encounter data to  
6 be incomplete in several ways, the results do show a small,  
7 incremental improvement over the 2014 data. Given the  
8 current incentives, we anticipate that this incremental  
9 improvement will continue; however, we are concerned that  
10 data completeness is not being assessed, and there isn't a  
11 framework to look for items and services that are not  
12 reported in encounter data.

13           Given the potential value of complete encounter  
14 data, we consider completeness is addressed by current  
15 feedback and incentives. Report cards show plans the total  
16 number of submitted, accepted, and rejected records by  
17 service category, and include regional and national  
18 benchmarks for each. Report cards also compare inpatient  
19 encounters to those reported by hospitals, but the metric  
20 only has an informational purpose, and is not linked to an  
21 incentive for improvement.

22           CMS recently implemented a set of encounter data

1 performance metrics assessing the timing of submissions,  
2 and comparing each plan's encounter data to the plan-  
3 submitted risk adjustment, or RAPS data. Thresholds for  
4 these metrics are designed to identify outlier plans with  
5 data submissions substantially below reasonable  
6 expectation. Plans that did not meet the thresholds could  
7 be required to follow a corrective action plan, but would  
8 face no other penalty.

9           Finally, encounter data are used to identify  
10 diagnoses for risk adjustment, which provides an incentive  
11 to submit some physician, inpatient, and outpatient  
12 encounter records. However, it does not provide an  
13 incentive to submit records for other types of services or  
14 for encounters that do not reveal additional diagnosis  
15 codes.

16           Based on the current feedback and incentives,  
17 plans and stakeholders report that more recent years of  
18 data are better. However, we believe CMS and plans should  
19 now focus on encounter data completeness.

20           To do this, we start by considering how to data  
21 completeness. There several opportunities to improve upon  
22 the current situation. The best strategy is to find

1 evidence of MA service use in independent data sources.  
2 External data sources come from providers in the form of  
3 patient assessments and information-only claims.  
4 Constructing metrics of completeness based on external data  
5 sources gives a measurable sense of whether all MA  
6 encounters are being reported. Available sources mostly  
7 cover inpatient and post-acute services; notably lacking is  
8 information about physician and outpatient services.

9           Data generated by plans can also be used to  
10 assess encounter data. However, comparisons to plan-  
11 generated sources test whether plans' data processing is  
12 internally consistent. Inconsistencies could identify  
13 missing encounter records, but such comparisons cannot  
14 determine that all encounters have been reported.  
15 Available plan-generated sources cover a wide range of  
16 services.

17           For all comparisons, metrics could be constructed  
18 with an appropriate degree of specificity, ranging from  
19 matching beneficiaries in both data sources, to matches  
20 that require consistent providers, dates, procedures, and  
21 other data elements.

22           Finally, providing feedback to plans about the

1 completeness of their encounter data based on these metrics  
2 is a necessary step to encouraging more complete  
3 submissions.

4           Over the next few slides, I will discuss policy  
5 options for increasing incentives to submit encounter data,  
6 starting with expanding the performance metric framework.  
7 The other options include applying a payment withhold for  
8 encounter data submission and using Medicare Administrative  
9 Contractors, or MACs, to collect encounter data directly  
10 from providers.

11 These options are not mutually exclusive. An overall  
12 strategy could apply a mix of options in varying degrees.

13           Performance metrics currently focus on the timing  
14 of encounter submissions, and comparisons to plan-generated  
15 RAPS data. Their purpose is to identify outlier plans with  
16 poor submissions. One way to expand this framework is to  
17 add completeness metrics based comparisons to external and  
18 plan-generated data sources. Reporting for these metrics  
19 could also be improved beyond whether or not a threshold  
20 was met, to include specific information about missing  
21 encounter data.

22           Finally, the current enforcement mechanism

1 focuses on low-performing outliers. Although, this  
2 mechanism could be strengthened, we find that the use of a  
3 single threshold to identify outlier plans does not address  
4 the scope of incompleteness in encounter data.

5 Our analysis found the lack of completeness to be  
6 a broad issue with nearly all plans needing at least some  
7 improvement. Therefore, applying a low threshold would  
8 leave many plans with incomplete data to go without an  
9 incentive to improve, and a more strict threshold would  
10 classify the majority of plans as low-performing outliers.  
11 An enforcement framework that might fit this situation  
12 better is a payment withhold.

13 A payment withhold offers a direct financial  
14 incentive to submit complete encounter data. It could  
15 build off the performance metric framework by replacing the  
16 current set of outlier thresholds and penalties. To  
17 implement the policy, a percentage of each plan's monthly  
18 payment could be withheld, thus correlating the size of the  
19 withhold with enrollment in the plan and the number of  
20 expected encounter records to be submitted. A range of  
21 withhold return rates could tie each plan's performance  
22 with the amount to be returned to the plan.

1           For example, plans with good performance could  
2 receive their full withhold in return, plans with near good  
3 performance could receive most of their withhold, and so  
4 on. Hence, the withhold return would be proportional to  
5 the performance of each plan, and any penalty would match  
6 the level of incompleteness in their data.

7           Withhold return rates could start at a generous  
8 level, with a high rate of return being easy to attain, and  
9 then become more strict so that either encounter data  
10 become more complete or less of the withhold is returned.  
11 If all MA plans collectively submit complete encounter  
12 data, the withhold policy could be phased out.

13           Finally, providers contracted with MA plans could  
14 submit encounter data directly to Medicare Administrative  
15 Contractors. This option would fundamentally change the  
16 structure of encounter data collection, and should be  
17 considered a fallback option. MACs currently process fee-  
18 for-service claims for all A and B services, and hospital  
19 information-only claims for MA enrollees. Hence, providers  
20 are familiar with the process.

21           For A and B services in MA, MACs would apply fee-  
22 for-service data edits to ensure that submitted records are

1 complete before forwarding them to plans for payment  
2 processing. For MA supplemental services, MACs could  
3 forward records directly to MA plans without any  
4 processing. MACs currently forwarding claims to Medigap  
5 plans and Medicaid agencies with cost-sharing obligations.

6           There are two options to implement this policy.  
7 The first would require all MA plans collectively to meet a  
8 timeline of completeness thresholds. A missed threshold  
9 would trigger the use of MACs to collect encounter data  
10 from all MA plans, thus maintaining consistent data  
11 collection policy for all MA encounters. The second option  
12 would apply completeness thresholds to individual MA plans.  
13 A missed threshold would result in the use of a MAC for  
14 that plan, but other plans would continue to submit their  
15 own encounter data. Under this option, plans that prefer  
16 to use a MAC to process and submit encounter data could  
17 elect to do so.

18           Here is a summary of the options for assessing  
19 completeness and increasing incentives to submit complete  
20 encounter data. Aspects of all three incentive options  
21 could be applied together by expanding performance metrics  
22 to better assess completeness, applying a payment withhold,

1 and establishing a timeline of completeness thresholds that  
2 would trigger the use of MACs to collect encounter data.

3           If encounter data become complete, the withhold  
4 policy could be phased out and the use of MACs would not be  
5 triggered. However, if encounter data continue to lack  
6 completeness even with a withhold policy in place, the  
7 trigger would result in using MACs to collect encounter  
8 data. In any scenario, the assessment of completeness will  
9 continue to be relevant as the uses of encounter data  
10 expand.

11           Back to you, Jay.

12           DR. CROSSON: Thank you, Andy and Jennifer. We  
13 will be open for clarifying questions.

14           Bruce and John.

15           MR. PYENSON: Thank you very much. This is  
16 really a terrific examination of the challenges with  
17 encounter data. And in reading through the various methods  
18 you use to try to test is the data complete or not I'm  
19 reminded that that's a very frequent problem for actuaries  
20 who have to certify financial amounts or calculate  
21 reserves, that is how do you know if the data you've been  
22 given is complete. And that's true whether it's an actuary

1 outside the company or inside the company.

2           And there are several techniques that are used.  
3 You're always trying to find other sources that you can  
4 compared to, but one of the advantages in using company  
5 data, company claims data is to compare the total amount  
6 paid to the checks that the company has written. So if  
7 there's money going out that's more than what's in your  
8 claims data there is problem. You know you're missing  
9 something, and if you can't reconcile it maybe it's a  
10 different kind of problem going on.

11           So I'm wondering where that kind of technique,  
12 looking at the actual dollar amounts and getting that -- I  
13 recognize different plans have different ways of paying and  
14 so forth, but a lot of them and a lot of the categories are  
15 fee-for-service. So what would it take to get the actual  
16 dollars through the system as a way of validating the  
17 completeness?

18           DR. JOHNSON: That's a great question and the  
19 current barrier is that situations where the arrangement  
20 between the plan and the provider is capitated, the payment  
21 amounts are not required to be submitted on encounter data.  
22 So any analysis would have to take account of that and I

1 think get fairly complicated quickly.

2 DR. CROSSON: Okay. Jon.

3 DR. CHRISTIANSON: So a comment and a question.

4 The comment is just that, you know, this chapter, like a  
5 lot of stuff we've been writing about encounter data, it  
6 tends to come across as just sort of a lot of technical  
7 problems, and I just want to reaffirm that as we pass a  
8 third of our beneficiaries in Medicare Advantage plans, and  
9 that rate, if not going up steadily may even be increasing,  
10 this becomes less of a technical problem but more of a real  
11 strong concern I think that we should all have about  
12 knowing what's going on in the Medicare program.

13 The question is for you, Andy, and maybe I just  
14 don't remember this from the chapter very well. Why is MAC  
15 the fallback position? Can you give me an argument for why  
16 it maybe should be our first strategy in trying to deal  
17 with this problem?

18 DR. JOHNSON: I think mainly practical, that the  
19 current situation is plans submitting encounter data on  
20 their own. Some of them have set up their internal  
21 processes to submit counter data. Others contract with  
22 third-party vendors to process the data and submit to CMS.

1 So considering that we're in that framework now it's  
2 considering it would be a major change to the program.

3 MS. BUTO: Also I think --

4 DR. CHRISTIANSON: My thought about that is it  
5 needs a major change, and hasn't worked, and we've been  
6 trying to get it to work for years and years and years. So  
7 I guess I would encourage us to think about whether there  
8 are real advantages to the MAC program that would increase  
9 the likelihood we would get good data, and I'm not sure  
10 about that, I guess. I don't understand that part of it.

11 MS. BUTO: Jon, if I could just interject here, I  
12 think we'd also have to do an assessment of the cost of the  
13 MACs to do this.

14 DR. CHRISTIANSON: Sure.

15 MS. BUTO: Because the data are, you know, not in  
16 good shape particularly for the kind of processing they do,  
17 and a lot of what they do is automated. So I think we'd  
18 have to do some kind of an analysis or get feedback on how  
19 big a burden is that going to be for them.

20 DR. CHRISTIANSON: Yeah, exactly. And that would  
21 all be part of thinking about MAC as an option, not so much  
22 as a fallback, if this continues to not work and how much

1 longer do we want to say continues to not work.

2 DR. CROSSON: Okay. We'll start with Jon.

3 Questions?

4 DR. PERLIN: Thanks. Again, terrific work on  
5 this chapter. My comment really tags on to Jon's, but in a  
6 slightly different way.

7 In the materials, on page 46, you noted that,  
8 "Although we did not speak with providers about this idea,  
9 we believe providers would experience no greater burden  
10 than providing services to fee-for-service beneficiaries  
11 and potentially could experience significant simplification  
12 in submitting claims."

13 I would just offer that may be worth a  
14 conversation because I would like to understand the basis  
15 for that, at least in some of my preliminary discussions.  
16 I mean, it's doable, but it is -- according to the  
17 reconnaissance I did, it would substantially change the  
18 process. And to the other impact, I think it's worth  
19 really understanding the impact on the MAC in two  
20 dimensions. One is in the dimensions discussed as to  
21 what's automated and what's not, but the second is what's  
22 the impact on their work flow with respect to the remainder

1 of the claims. And, third, what's then the derivative  
2 impact on cash flow for all the providers who are then  
3 working through the MACs who have increased their burden  
4 substantially, as I agree with Jon, at a growing rate?

5 Thanks.

6 DR. CROSSON: Questions? Warner.

7 MR. THOMAS: So maybe I'm just not totally  
8 understanding this, but it seems like for traditional fee-  
9 for-service Medicare, the MEDPAR data we feel is pretty  
10 good. Is that accurate?

11 DR. JOHNSON: Yeah [off microphone].

12 MR. THOMAS: And so what is -- I mean, is it the  
13 plans that are a challenge here? Where do we think the  
14 issue is and the process of why it's hard to get the data?  
15 I guess what we've heard, when we've talked about this  
16 previously -- I think Craig brought this up. I don't know  
17 if Dana did, but I know Craig had when he was here, that  
18 the plans are trying, but they seem like they have a tough  
19 time interacting with whoever the intermediary is to accept  
20 the data. So do we have a sense of where the challenge is,  
21 and is it really the plans are not trying to do it? Or is  
22 it a process issue?

1 DR. JOHNSON: I don't know that we can pin down  
2 the exact issue, meaning allocating which areas are of more  
3 importance, but certainly providers not submitting all of  
4 the data elements is one issue. Whether or not plans are  
5 looking at collecting every record for all items and  
6 services might be an issue where some of the feedback to  
7 plans is currently about the overall volume of records  
8 being submitted, and increasing volume is seen as good, so  
9 it's just a framework of how plans address their encounter  
10 submissions. So I don't think that's a great answer to  
11 your question.

12 MS. PODULKA: I'd add that, in case this was part  
13 of your question, based on our conversations with  
14 stakeholders, earlier in the process CMS and their  
15 contractor may have been introducing some significant  
16 obstacles. We don't hear that that's the case anymore, so  
17 we can't say, oh, if the agency changes the way they accept  
18 and process the data, this would clear up. If that was the  
19 situation, we'd be coming to you today with a different set  
20 of policy options.

21 In addition to what Andy noted, we've also heard  
22 from plans and other stakeholders that some of the issue

1 might be initially submitting a record, getting it bounced  
2 back for some error or issue, and then the plan needs to  
3 decide how many resources to devote to chasing down and  
4 correcting the error. And, you know, the incentive is  
5 built right now, if you've got your risk scores in  
6 sufficiently to match up with RAPS, then, you know, maybe  
7 there's some residual of problem claims that you find that  
8 the juice really isn't worth the squeeze to go fix them and  
9 get them resubmitted.

10 DR. JOHNSON: A final point I think that we've  
11 heard is where the arrangement between the plan and the  
12 provider is capitated, the payment is not tied on a fee-  
13 for-service basis, so there's not an individual record  
14 coming through, and that may be one of the areas where  
15 there's more missing data.

16 MR. THOMAS: So they're capitated, they're not --  
17 essentially, providers aren't dropping claim because  
18 they're just getting the capitations so they don't drop  
19 claims. Okay. Thanks.

20 DR. CROSSON: Yeah, I mean, I have to say in my  
21 own experience, that was a significant issue for our  
22 organization where, you know, our medical group is

1 capitated, we just delivered the services. We had plenty  
2 of oversight and quality and everything of that nature.  
3 But the notion of having the physicians have to, you know,  
4 fill out and code for the services, once that became a  
5 requirement -- and it came from the commercial side as well  
6 as Medicare -- it was just an added expense, and  
7 essentially we were training -- we had to retrain -- not  
8 even retrain, but we had to train physicians in something  
9 that they didn't have to do previously and was not viewed,  
10 quite honestly, by physicians as adding any value.

11 On this point, or just -- yeah, go ahead.

12 MS. BRICKER: Just to clarify then, so once  
13 you're receiving a capitated payment, how does the plan or  
14 the provider know if that was sufficient or not if there's  
15 no detail of care sort of provided? Wouldn't you want --  
16 wouldn't the plan want to know, like did I give too much or  
17 wouldn't the provider say, whoa, that's not even coming  
18 close to covering it?

19 DR. JOHNSON: I think that's a good question. I  
20 don't have an answer except that if the capitation is for  
21 all services, it could be just a portion of the total  
22 revenue coming into the plan passed directly on. That does

1 not include the administrative costs of plans providing  
2 their service.

3 MS. BRICKER: So we're not aware that plans  
4 require that level of detail from providers to suggest that  
5 the capitation is adequate.

6 DR. JOHNSON: That's right.

7 DR. CROSSON: Pat.

8 MS. WANG: If I could just respond to that? A  
9 very typical form of capitation is for primary care  
10 physicians, and so unlike fee-for-service, you're right,  
11 you know, you're not getting an individual claim in for  
12 every office visit or what have you. But what plans will  
13 do or many plans will do is look at the quality metrics  
14 that we just described for the members who have chosen  
15 those folks as their PCP. You know, you can tell a lot  
16 from gaps in care and whether the care is being well  
17 managed.

18 The whole point of capitation is to allow a  
19 primary care doctor to get away from it's got to be, you  
20 know, an office visit that I can bill because of this and  
21 this, and they may instead want to spend like an hour on  
22 the phone with their member just talking through an issue.

1 So we tend to view it more from sort of, you know, frankly,  
2 quality as the backstop to whether the care that's being  
3 delivered is good.

4 DR. CROSSON: On this point, Jon.

5 DR. PERLIN: Absolutely. In doing my homework  
6 for this section, I asked exactly that question: How does  
7 it happen, Amy, in terms of providing the information?  
8 What I found out, at least in our organization, is that  
9 provider submit claims versus encounter data to the MA  
10 organization, the claim submissions, electronic  
11 transaction, consistent with coding and reporting  
12 guidelines, report on diagnosis and procedures that are  
13 specified in guidelines for each patient encounter, that  
14 is, the specific instructions from that MAO.

15 Actually, in our organization, we don't  
16 differentiate the code assignment based on whether it's  
17 Medicare fee-for-service or MA. But understand there may  
18 be other situations in which information may be less  
19 complete because that was fundamentally the question I was  
20 trying to understand. One, where is the breakdown in terms  
21 of getting the information? Two, wouldn't the MAO need  
22 certain levels of detail?

1           So, you know, it might seem at one level it's a  
2 distinction without a difference, but it would introduce a  
3 parallel process which may have tracks of reporting both at  
4 the MAO as well as potentially a MAC, with potentially  
5 different requirements in terms of specifying, and with  
6 respect to the transaction with the MAC would have, as you  
7 so nicely articulated, a degree of not only requirements  
8 for information submission, but validation, checks, and  
9 concomitant edits and things of that sort that really do  
10 make it less than a trivial process.

11           Thanks.

12           DR. CROSSON: Okay. Karen.

13           DR. DeSALVO: So in the first place, I'm all  
14 about data liquidity, and when I was in government, in the  
15 federal government, our policy agenda was about making this  
16 information available for research purposes, for clinical  
17 care, et cetera, and that sort of leads me to my question  
18 for you all, because I didn't really see it in the chapter,  
19 and I don't know if I'm off on a tangent here. But how do  
20 things like Blue Button or MyHealthEData and the  
21 expectations that CMS is going to have in 2020 for MA plans  
22 to share data impact this need?

1 DR. JOHNSON: That's not something we've looked  
2 into yet, but we certainly can. I think the decision to  
3 release encounter data publicly to researchers might signal  
4 that there is a similar process available for  
5 beneficiaries, but that's something we really need to look  
6 into before --

7 DR. DeSALVO: Yeah, because I think the test use  
8 case is to intermediaries that can make it available for  
9 business cases but also for research cases and then for  
10 individuals. And that's certainly the pathway of  
11 continuity policy that CMS is still on that we were on  
12 before and that, frankly, the Hill put into 21st Century  
13 Cures.

14 So thinking about is that already, you know, a  
15 runway and that's going to make this work easier? The  
16 accuracy isn't solved by that, I understand, but the  
17 availability and the timeliness might be.

18 DR. CROSSON: David.

19 DR. GRABOWSKI: Just in case people aren't aware,  
20 ResDAC recently made the 2015, I think, encounter data  
21 available to researchers, and my understanding is a lot of  
22 researchers are lining up to get those data. So there are

1 going to be a lot of people working with these data.

2 DR. JOHNSON: And as Jennifer mentioned, I  
3 believe that's the same version of the files we used in our  
4 analysis.

5 DR. CROSSON: Warner and then --

6 MR. THOMAS: This is actually on -- I'm not sure.  
7 What is Blue Button?

8 DR. DeSALVO: So Blue Button is an effort to  
9 create doorways to the data via an application programming  
10 interface, which is an API, that makes it easier to release  
11 data initially for the beneficiary to know what kind of  
12 utilization and encounter information they had, and then  
13 has been extended so that now it is using more modern  
14 technology to release it to allow us to aggregate and  
15 present the data in a more experienced, friendly way. I  
16 say "we" as a country. So Blue Button 2.0 is the version  
17 announced in this calendar year, I think, by the  
18 Administrator to improve that work.

19 There is, as part of that suite of expectations,  
20 a platform called MyHealthEData, which is also CMS-led, and  
21 she announced it at Datapalooza last spring, that is  
22 designed to not only see that the Part A, B, and D data is

1 available, but then they also want to encourage C, so  
2 Medicare Advantage. And Medicare Advantage plans by 2020  
3 will need to have that data released and our experience is  
4 we're sort of gearing up for that to be the case. And,  
5 again, that's about data availability and thinking that it  
6 definitely changes the landscape of who can aggregate data.  
7 so not only for research and for policy purposes but for an  
8 individual to have a long-term health record to know all of  
9 the care experience that they had. And that you see  
10 manifested in some of the smartphone applications that are  
11 creating long-term health records.

12           And, Warner, that grew out of a recognition that  
13 when we digitized the care experience through implementing  
14 electronic health records, that was going to be one bucket  
15 of data, but there was a lot of other richness in the  
16 claims information that could be helpful. And I mentioned  
17 Congress and 21st Century Cures because though from a  
18 policy standpoint we require these doorways to the data,  
19 these APIs, and electronic health records, and we were  
20 pushing it also for claims data, Congress in 21st Century  
21 Cures added an expectation legislatively in statute that  
22 the EHR systems have these nonproprietary APIs, these

1 doorways to the data that people could easily get a key to,  
2 but there are also some additional expectations on the  
3 provider community about sharing.

4           So there's a policy pathway that I think is sort  
5 of a modern technology approach that's designed for  
6 appropriate data liquidity not only for individuals but for  
7 other use cases, and, again, it doesn't get you so much to  
8 the accuracy issue, which I fully appreciate -- and maybe  
9 while I've got my mic on, I'll just mention something about  
10 that, which is that to this point about capitation, there's  
11 a small percent of these individuals who are probably in  
12 some kind of a really capitated or flexible model, and it  
13 raises for me over the long term this interesting concept  
14 that the notion of an encounter is changing dramatically on  
15 the front edge of the way we deliver care. And to Pat's  
16 point, it could be a phone call; it could be a group visit.  
17 There are experiential ways that we're going to be working  
18 on improving patient outcomes that may not even be captured  
19 in the data. So the encounter stuff is great, but it's  
20 like the today world, and to make sure we're moving the  
21 system to a future world where outcomes and experience are  
22 better, we're going to have to already start thinking about

1 what data will we need to make sure that people are getting  
2 the right amount of service for the right outcomes.

3 MS. PODULKA: Could I just jump in? One thing I  
4 wanted to clarify, Andy mentioned capitated arrangements  
5 between plans and providers, and that's certainly one area  
6 that impacts the sort of price data that might show up in  
7 the encounter data.

8 There are also numerous situations where MA plans  
9 carve out certain benefits and maybe subcontract with an  
10 entire entity. You might carve out behavioral health or  
11 some of your post-acute care, and so that's not just a  
12 capitated arrangement with a provider group. That's a  
13 whole segment of your benefit package that's under a  
14 separate subcontract that might also affect data  
15 availability.

16 DR. CROSSON: Thank you. That's helpful. Pat.

17 MS. WANG: Have you guys had recent conversations  
18 with CMS over the level of reporting that they may be  
19 planning to give back to plans? Jennifer, you had noted  
20 that some of the early obstacles that plans had reported,  
21 you know, of sort of data exchange or just feedback were  
22 clunky. It's still pretty sparse, the reporting back from

1 CMS, even for plans who scrub, scrub, scrub. Do you know  
2 whether they have plans to increase the frequency, level of  
3 detail, specificity so that plans that try to hit 100 have  
4 enough information to know what's not getting through and  
5 why?

6 DR. JOHNSON: I think they're planning for  
7 changes to the feedback is in process right now. Actually  
8 since writing the chapter, several memos have come out  
9 adding new potential plans. So far, it does seem to be  
10 like the report card is proposed to be expanded to include  
11 the number of missing or values in error for a certain set  
12 of basic data measures, which makes sense. I have not seen  
13 in any of that planning a focus that would specifically  
14 focus on completeness, though. Still, the comparison of  
15 inpatient stays to the MEDPAR data that's provided in the  
16 report cards is the only real metric of completeness.

17 DR. CROSSON: Okay. No more questions. I think  
18 we'll start with the discussion. I think we have the final  
19 slide up there, so I would ask that folks think about  
20 providing input into these two areas to help Andy and  
21 Jennifer perhaps come back with some more narrowed  
22 recommendations at some point. And we'll start with Bruce.

1           MR. PYENSON: Well, thank you very much, Andy and  
2 Jennifer. This is a terrific presentation and terrific  
3 work, and I think it's just one of the most important  
4 things for the future of Medicare to -- future of Medicare  
5 Advantage, which, as we all know, is no small portion of  
6 the program and growing year after year. So having that  
7 kind of information on an encounter basis, and as the  
8 interactions, what actually happens to patients, is  
9 incredibly important.

10           I would like to just say a couple of things to  
11 frame my view of answering these questions.

12           In the real world of data, we know the data is  
13 never perfect, and it changes -- the information and what  
14 the information represents changes over time because the  
15 world is changing. And there's a balance between wanting  
16 perfect data and wanting it all, and I think the balance  
17 that happens in the rest of the private insurance world is  
18 worked out in favor of having lots of detail and then  
19 figuring out what parts of it are reliable and what parts  
20 aren't.

21           And so I think the framing of assessing  
22 completeness as compared to some of the other

1 characteristics is the right way to go and to find ways to  
2 make that data as complete as possible.

3 I think the use of that and the carrot and the  
4 stick that we have for the plans could be very much tied up  
5 with the resources the plans are spending on risk  
6 adjustment and Stars, and the previous session identified a  
7 lot of the detail in the process, much of which is very  
8 expensive because it's not based on claims. So to tie the  
9 two together I think is very, very important and gives us  
10 an opportunity to offer something to the plans, a bit of a  
11 carrot as well as a stick.

12 I've certainly been frustrated with the lack of  
13 availability of the data and even the quality of the data  
14 that's available privately. But in the commercial world,  
15 by contrast, there's huge databases commercially available,  
16 you know, well-known names -- Truven MarketScan and others  
17 -- that have been out there for decades and, yes, sometimes  
18 the data is not as clean as others, and there's ways to  
19 deal with that. The lack of that on the Medicare Advantage  
20 side is puzzling because so many organizations use the same  
21 systems for both. So I'm thinking this issue is not nearly  
22 as hard to solve as many of the other things we talk about,

1 but finding the right carrots and the right sticks can get  
2 us there very quickly, and then leave it up to the  
3 organizations and the people doing the work to figure out  
4 what's good quality and what's not good quality in terms of  
5 the data itself.

6           So I'm very encouraged by this discussion, but I  
7 would focus on let's make sure we get the data, and even if  
8 it's not perfect, let's go for completeness first.

9           DR. CROSSON: Okay. Pat, Warner, Dana.

10           MS. WANG: Thank you for bringing this back to  
11 us. It's a really good -- it's much deeper and, you know,  
12 you keep going deeper and deeper into the subject which I  
13 think is really, really helpful. It's incredibly important  
14 that this happen and that we find a way to collect as  
15 complete and then as ultimately as accurate data on the MA  
16 programs so that people know what's going on in it.

17           A couple of suggestions. I do think that it  
18 would be important. You mentioned in the report the  
19 importance of reporting from CMS. I would just encourage  
20 us to sort of make more specific, robust suggestions. As  
21 you note, the only report that comes back is for inpatient  
22 shadow bills, so if we expect completeness, you know, plans

1 need a lot more information than that to try to understand  
2 what wasn't accepted, why wasn't it accepted. I think you  
3 had mentioned an idea in the paper about doing a report  
4 with a beneficiary matched by data service. I mean, so  
5 just so that there's an appreciation, the work to make sure  
6 that this flows correctly is painstakingly detailed.

7 I mean, you know, people who work on this are  
8 going to look by beneficiary, date of service. They would  
9 love to get an annual report that actually matches accepted  
10 encounters with dollar amounts so that they can actually go  
11 back to paid claims and validate to see that things are  
12 going through. And if they are not going through or  
13 somehow the dollar amount, for example, is coming out a  
14 different way then can do a deep dive, understand what it  
15 is, talk to CMS, and try to figure out how to improve that  
16 reporting.

17 But I think this is really critically important.  
18 And CMS is really busy, but if this is a priority then I  
19 think, you know, a very specific focus and set of  
20 expectations has to be matched by, you know, accurate  
21 reporting to the plans and faster reporting than currently  
22 exists.

1           The idea of sort of carrots and sticks, as Bruce  
2 said, I mean, I do think that it's important for the  
3 progression that started and then kind of went backwards  
4 about doing risk adjustment based on an increasing reliance  
5 on encounter data is very important and shouldn't be  
6 forgotten in the recommendation. So just kind of plow  
7 forward with that. It will create a lot of attention that.

8           For the other elements of it I would be inclined  
9 to say let's get the other sort of provider types, the ones  
10 that you profiled that are particularly missing -- the home  
11 health and the long-term care, things like that. There's  
12 no reporting source for a plan to even see what's being  
13 accepted and what's not, and why it's not being accepted.  
14 I think that we have to accelerate the process of helping  
15 plans to understand what's going on so that they can get  
16 the information in.

17           The idea of the MACs is a very interesting one.  
18 I would hold it out as a last resort. I have concerns about  
19 it. You know, frankly, I think the way that it was posited  
20 in the chapter is the providers would actually send their  
21 claims to the MAC, which would then take those, submit  
22 encounters, and then forward the claims on to the MA.

1 Speaking for myself, I have enough trouble making sure that  
2 every claim I pay is accurate and timely, and it's just the  
3 prospect that there might be yet another party in the  
4 middle makes me really nervous.

5           The other thing is that, you know, in addition to  
6 scrubbing things and doing analytics for up-front payment  
7 integrity issues, you know, prepayment reviews, sort of  
8 maybe adjustments after the fact. I am not sure that the  
9 quality of the information that you would get if you just  
10 relied on a first pass MAC encounter submission -- you  
11 know, I think that there would be gaps there. So I would  
12 hold that out as the ultimate stick if there were a plan  
13 that just really showed that it could not do this.

14           But to somebody else's point, some plans have  
15 built tremendous infrastructure around that. If they are  
16 Medicare plans they have been submitting encounter data to  
17 the state for years and years and are very comfortable with  
18 encounter data submissions. On this one, for Medicare  
19 plans with that sort of infrastructure, it's more a matter  
20 of tell me, give me more information and I will make  
21 everything right. But, you know, for a plan like that I  
22 think kind of thing, you have to go to a MAC now would be

1 extremely inappropriate.

2 DR. CROSSON: Warner.

3 MR. THOMAS: So I would concur with Pat that I  
4 think MAC would be a last resort.

5 I guess when I first started hearing this I  
6 always thought that this was really a plan issue, and the  
7 more we hear about it the more we understand there's a lot  
8 of opportunity for improvement probably in both sides of  
9 this equation, and I would just hope that our report about  
10 it is very balanced about that and clear that there's --  
11 you know, I think we're hearing from Pat that there's just  
12 not a feedback mechanism from the entities that are  
13 receiving this data and don't even know if it's correct.

14 So I think it's hard for a plan -- I think we've  
15 heard this from a couple of folks that are in the insurance  
16 world that it's hard for a plan to do this well when they  
17 don't have a willing participant on the other side working  
18 with them to get the data. So I think we need to be  
19 balanced about that.

20 But I do think, kind of going back to the  
21 discussion we had earlier this morning, where we talked a  
22 lot about 5 stars and incentives and payments, I mean, we

1 just need to tie this whole situation into the same  
2 discussion. And I think if we put dollars around this,  
3 whether it be a withhold or whether it be upside -- and I  
4 think Bruce's point about some should be a carrot and a  
5 stick probably depends on, you know, give people a certain  
6 amount of time but then if they can't get it done, you  
7 know, they can't be 5 stars, they can't be 4.5 stars. I  
8 think you'll find that people get a lot more motivated.

9 I think the other thing it just says that's  
10 striking me is that if we have a lot of plans that are not  
11 getting fee-for-service data, you know, we're not able to  
12 really do a fair fee-for-service comparison on MA. You  
13 know, it strikes me, I mean, there may be a lot more things  
14 being done in MA plans that we just don't have claims data  
15 about, and then we compare to fee-for-service where we do  
16 have all the claims data and I'm not sure we're necessarily  
17 an apples-to-apples comparison of how the MA products, you  
18 know, compare to a fee-for-service situation if we have a  
19 lot of providers. And I agree with you, Jay. I mean, if  
20 you're capitated, I mean, why are you submitting claims? I  
21 mean, we are capitated and we do it because we like to look  
22 at the equivalent of it. And I do think that would be

1 important data for the plan to have as well as for CMS to  
2 have in kind of evaluating these plans going forward.

3           So I think we need to tie specific upside and  
4 penalties to it over time. I think we need to be clear  
5 that the government needs to kind of step up and do their  
6 rightful job here and provide the right feedback. But it  
7 is -- you know, it's hard to assess these programs if you  
8 don't have -- and assess how, you know, members are doing  
9 in the programs if you don't have the information about  
10 what's happening.

11           DR. CROSSON: Thank you. Dana.

12           DR. SAFRAN: Yeah, so great discussion, great  
13 chapter. I'm struggling with what feels like almost a  
14 paradox that we're dealing with and that I think has been  
15 touched on by a few people's comments, which is, on the one  
16 hand, the idea of not having complete and accurate  
17 information about the care that beneficiaries are  
18 receiving, and an increasing share of beneficiaries, in  
19 part of the Medicare program makes us all very nervous.

20           On the other hand, as we're trying to encourage  
21 alternative payment models, including Medicaid Advantage  
22 but ACOs, and moving toward big dot measurement, I worry

1 that we are kind of perpetuation a fee-for-service mindset  
2 by the, you know, document and tell us everything you do.  
3 And I can, in my own experience, I've seen this and watched  
4 physicians in our network struggle with it as they say,  
5 "Well, I would love to, you know, do more over the phone  
6 with Blue Cross members, but you don't pay me for that."  
7 It's like, but you are in a global budget contract, so if  
8 that's the best way to deliver care, just do it, right?  
9 And so I feel like we have to find a path forward that  
10 doesn't undercut the very challenging shift away from that  
11 fee-for-service mindset, but at the same time doesn't leave  
12 us, you know, without information about what's happening to  
13 beneficiaries.

14           So it feels like a pretty tough conundrum and I  
15 don't know the answer. I know that, you know, technology  
16 is going to be an important part of the answer, and I know  
17 that, you know -- I heard recently about a company called  
18 OODA that may allow for real-time claims adjudication so  
19 that patients don't get surprises in their bills, so that  
20 providers are able to like get assurance right in the  
21 moment about what the payer is going to pay. And I don't  
22 know. As I'm sitting here, like some sort of real-time

1 something that happens when a person is getting some kind  
2 of service, wherever it is, even if it's remote, is  
3 starting to feel like maybe that's a way we capture  
4 information.

5           But the last piece of it, in addition to not  
6 wanting to perpetuate a fee-for-service mindset, I worry  
7 about adding administrative burden, right. Like we hear  
8 all the time about one of the biggest drivers of our higher  
9 costs, and I don't know if I believe this but I know it is  
10 a very big driver relative to other countries, is the  
11 administrative aspects of care.

12           You know, and I was recently told by one of our  
13 folks who came over from a provider organization that for  
14 every doctor they hire they hire one medical assistant to  
15 help with getting patients in the room and one medical  
16 secretary to help with all the paperwork and all the coding  
17 and all the everything else. And, you know, that was  
18 stunning to realize. And so that's the other worry is how  
19 do we make sure we have the complete information we're  
20 talking about and not add to burden.

21           The last thing I'll say is I think we need to get  
22 really crisp and clear about what are the reasons that we

1 need complete data, and, you know, what are the purposes?  
2 We need data for risk adjustment. We need data to  
3 evaluate, you know, what's happening with beneficiaries and  
4 which systems are doing better, and once we know our  
5 purposes then what are the data fit for purpose and how  
6 much data and how complete does it actually have to be as  
7 we try to solve for this.

8 So those are my thoughts.

9 DR. CROSSON: Okay. Further discussion?

10 [No response.]

11 DR. CROSSON: Seeing none, Andy, Jennifer, thank  
12 you for the presentation. I think you've got some good  
13 input here and we look forward to hearing from you again in  
14 the future.

15 That said, we have completed our work for the  
16 November session. Now we have time for a public comment  
17 period. If there are any of our guests who would like to  
18 make a comment please come to the microphone.

19 [Pause.]

20 \* DR. CROSSON: Seeing none we are adjourned until  
21 our December meeting. Safe travels, everybody. Thank you  
22 for the good work.

1                   [Whereupon, at 11:20 a.m., the meeting was  
2 adjourned.]

3  
4  
5  
6  
7  
8  
9  
10  
11  
12  
13  
14  
15  
16  
17  
18  
19  
20  
21